How can state-financed hospitals increase their extrabudgetary funding?

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WHAT ARE THE POSSIBILITIES THE HEALTH CARE SYSTEM REFORM OPENS TO MUNICIPAL CLINICAL HOSPITALS - THE MAIN FORM OF MEDICAL FACILITIES THAT OFFER GENERAL HOSPITAL BENEFITS TO THE POPULATION; AND WHAT CHALLENGES WILL HOSPITALS FACE?

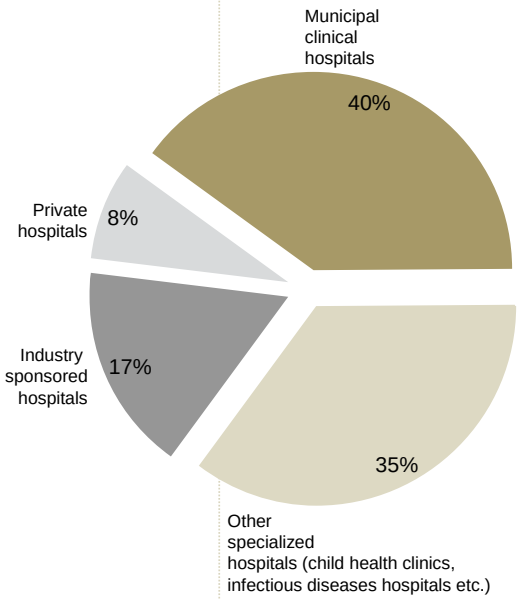
The government have been trying to reorganize and improve the current health care system over the last years. Thus, the national priority “Health” program was implemented from 2005 to 2011, and in January 2013, after 5 years of pilot testing, a system of one-channel financing was implemented for state-financed and public hospitals in the Russian Federation. In December 2012, Government Resolution No 2511-r approved of the “National Program for Health Care Development in the Russian Federation” until 2020.

Patients and medical personnel - you and us - will assess the results and efficiency of transformations. This article discusses the possibilities opened by health care system reform to municipal clinical hospitals (MCH) - the main form of medical facilities that offer general hospital benefits to the population, and what challenges hospitals will face.

According to the Moscow Health Care Department (Exhibit 1), about 140 hospitals offer medical services to inpatients in the city. A main part (75%) of capital’s hospitals are state-financed (40%) and specialized clinics (for example, mental health clinics, child health clinics, infectious diseases hospitals). Other hospitals are industry-sponsored (17% of all hospitals) and private (8%). Over 200,000 patients were treated in Moscow municipal clinical hospitals in 2012.

Exhibit 1.
75% of all hospitals in Moscow are state-financed hospitals

Number of hospitals in Moscow, 2013
100% ≈ 140 hospitals



Example of a standard state-financed hospital

Number of physicians:
200 - 700

Number of beds:
1,000 – 2,000

Number of health care services:
6 - 20

Number of patients per annum:
20,000 – 60,000

Average stay in hospital: **12-15 days**

Average bed occupancy rate:
87-93%

Number of out patients per annum:
25,000 patients on average

Sources: public information, company reports, Moscow Ministry of Health Care, RBC Analysis, MCG Analysis

Municipal clinical hospitals are state-financed health care providers with a wide range of services for public. An average Moscow municipal clinical hospital has about 1,000-2,000 beds, 500-1,000 physicians and nurses, and 40,000 treated patients each year. From 2011 to 2013, Moscow authorities spent over RUB36 bln for repair of Moscow hospitals (including municipal clinical hospitals). This money was spent on capital repairs of the buildings - a majority of which were built in the 1950-60s and have been deteriorating after the USSR collapse.

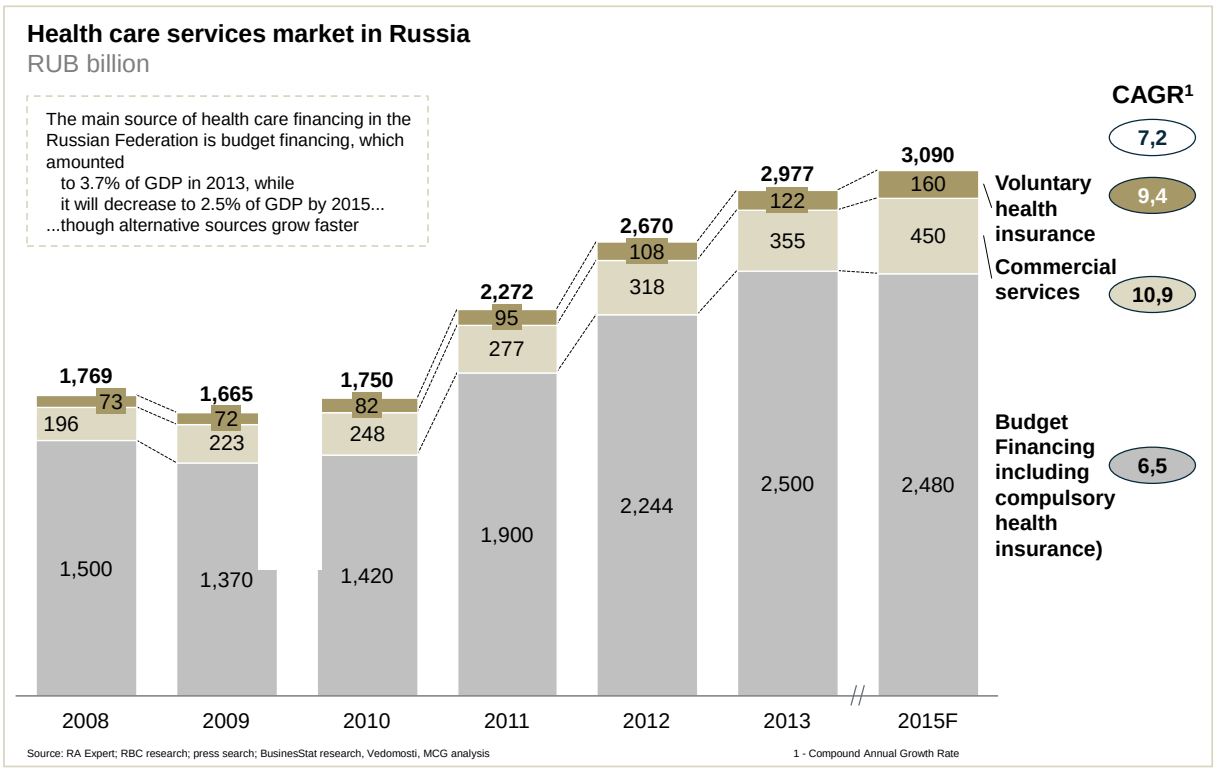
As a part of the priority “Health” program, Russian hospitals received up-to-date equipment for effective diagnostics and control over treatment progress. Many state-financed hospitals continue implementation of electronic systems for setting appointments and recording of patient visits; they plan further computerization of case records. Russian hospitals, including municipal clinical hospitals, continue working over improvement of preventive and treatment services provided to the public.

WHAT ARE THE KEY SOURCES OF RUSSIAN HEALTH CARE SYSTEM FINANCING?

The Russian health care system is financed from 3 main sources - the budget funds (including budgets of federation subjects and money from the Compulsory Medical Insurance Fund); money from voluntary health insurance and money paid by patients (commercial services).

Exhibit 2 shows that **money from the budget** was and still is the main source of financing: it will account for 84% of all sector financing in 2013.

Exhibit 2.
Budget funding of the RF health care sector is gradually being replaced with alternative sources of funding



Methods of budget money allocation have changed a lot over the last years.

First, Federal Law No. 323-FZ On Fundamental Health Care Principles in the Russian Federation, which allows patients to select hospital, was adopted in 2012. The new money allocation rules establish a direct connection between financing from the budget with the number of treated patients and not with treatment costs. Therefore, the new law motivates municipal clinical hospitals to increase the number of treated patients and to cut inefficient and unreasonable treatment costs. For information: expenditure standard for inpatient treatment in Moscow amounted to RUR99,000 in 2012.

Second, in January 2013 a one-channel budget-financing system was introduced to the hospital network. Such resolution was adopted by the Government upon completion of the pilot project implemented in 19 Russian subordinate entities from 2005 to 2011. According to the new scheme, financing for each treated patient come from the Compulsory Medical Insurance Fund (according to the standard, all main costs of patient servicing are covered, and not selective 30-50% as it used to be) and not from two sources (they used to be the Compulsory Medical Insurance Fund and the budget). According to the new rules, money from the budget is allocated from the budget for the purposes of capital repairs and acquisition of fixed assets for significant (over RUR100,000) amounts. The one-channel system is designed to motivate municipal clinical hospitals to cut inefficient and unreasonable treatment costs and to improve their self-reliance in appropriation of received funds.

Other financing sources in health care include **commercial services**, i.e. money received by clinics from commercial services provided and servicing of patients who hold voluntary health insurance policies.

Commercial services may be provided by all Russian health care facilities irrespective of their form of ownership. After their emerging in the 1990s, commercial medical services have taken a certain niche, though their growth rate directly depends on two factors - increase in population income and hospital capabilities to provide such services. Low income of population, rather ambiguous rules for provision of such services by state-financing institutions and possibility of getting free medical services of the same level are main factors that hinder provision of commercial services by municipal clinical hospitals. Nowadays almost all municipal clinical hospitals offer commercial services to public (first, they include extra comfort wards and servicing of patients without compulsory health insurance), but only a small share of them have concluded contracts for servicing under voluntary health insurance.

Experts say that population coverage with voluntary health insurance policies (according to our estimates, 15-20% of Russian population) is close to saturation. Large companies that obtain voluntary health insurance to compensate for medical services provided to their employees are already in the system. The private voluntary health insurance is neither in demand among consumers, nor popular with insurers (they are concerned with risks that policyholders may have some disease or suspect having some serious disease).

Now about half of Moscow municipal clinical hospitals are participants of the voluntary health insurance system, but the share of revenues from this type of insurance in total revenues is insignificant. First, only a small share of voluntary health insurance policies (about 30% of market offers) cover inpatient treatment, therefore the total number of inpatients under voluntary health insurance is insignificant. Second, inpatient treatment is covered only by most expensive and full range voluntary health insurance policies, and holders of such policies prefer inpatient treatment in private hospitals with a relatively high level of service. Third, an average bed occupancy rate in Moscow municipal clinical hospitals is rather high (over 90%), therefore there are no beds for patients with voluntary health insurance policies.

In the future insurers will be interested in offering new forms for voluntary health insurance policies with lower prices to drive further growth of the VHI market. It is likely to be a combination of compulsory and voluntary health insurance, under which insured people will be provided standard medical treatment under compulsory health insurance with some guarantees of extra services in case of need (for example, additional tests, extra consultations with specialists, stay in extra comfort wards). Such business model will actively attract state-financed hospitals to the voluntary health insurance system. This cooperation will certainly increase the inflow of additional funding sources to the state-financed health care system (if municipal clinical hospitals are able to reduce the bed occupancy rate maintaining the number of patients under voluntary health insurance). The increased cooperation between VHI insurers and state-financed hospitals will result in greater control over hospital operations by insurers that might improve efficiency of state-financed municipal clinical hospitals. Insurers striving for continuous reduction of treatment costs while maintaining the quality of treatment will be involved in hospital operational processes promoting efficient and effective practices in hospitals of their networks.

WHAT ARE THE MAIN BARRIERS THAT PREVENT STATE-FINANCED CLINICS FROM INCREASING THEIR EXTRABUDGETARY FUNDING?

Exhibit 3 shows some figures to compare the Russian health care system with the health care systems in developed (USA, Germany) and developing (China) countries.

The RF dynamics since 2008 shows an increase in the average life expectancy (the main indicator of the national health care system quality) and convergence of some figures (number of physicians and bed-population ratio) to those of Europe and the USA. However, further improvements are very unlikely unless cardinal changes are introduced to the hospital management system.

Exhibit 3.
Russian health care sector is developing, but its efficiency has not reached the western standards

	Russia		USA	Germany	China
	2008	2013	2012	2012	2012
Share of insured people in the country, %	~ 100	~ 100	80-85	~ 90	~ 95
Voluntary insurance coverage, % of working-age population	10-12	10-15	~ 60	~ 10	~ 10
Hospital beds per 1,000 people	10,7	9,5	3,0	6,2	3,8
Physicians per 1,000 people	4,3	3,9	2,4	3,5	1,8
Average health care expenses , $/person per annum	399	671	8 500	5 600	261
Average life expectancy, years	65	69	79	81	72

- Statistics on health care in Russia speaks for inefficiency of used treatment methods (high bed/population ratio, high physicians/population ratio, low life expectancy) ...
- ... however its efficiency is gradually growing (growth of life expectancy, absolute growth of expenditures on health care)
- Further growth of efficiency and quality of health care in Russia may be driven by industry management practices tested and approved in developing countries (for example, transition to the compulsory health insurance (insurance from contributions made by working population), introduction of general practitioners, focus on disease prevention, popularization of visiting nurse care, improved self-reliance of health care institutions)

Source: World Bank, OCED, Statistic Centers by countries

The Russian health care system is changing and transforming, and the management practices of today do not cope with tasks imposed on hospitals. It means that new and up-to-date hospital management practices should be actively implemented.

According to the rules of providing commercial medical services updated in 2012, pubic and state-financed hospitals have no limitations for providing commercial medical services. Chief Physicians only have to obtain approvals for prices from founders (municipalities are founders of municipal clinical hospitals).

The Government keep saying that they are interested in improved self-reliance of state-financed hospitals in allocation of funds, active use of alternative sources of financing and focus on efficiency and better quality of treatment and reduced costs.

According to our estimates, in 2011 and 2012, average financing of Moscow municipal clinical hospitals from extra-budgetary sources (i.e. commercial services and voluntary health insurance) did not exceed 10-15% of the total hospital budget. The situation has remained almost unchanged in 2013.

Besides, while an average stay in Moscow municipal clinical hospitals lasts for 10-15 days, there is no use for Chief Physicians to start thinking about possible ways to increase financing from alternative sources. All beds are occupied, and there is no possibility to accept commercial inpatients. For comparison, an average stay in American clinics is only 5-6 days. Assuming that on average, Americans have the same diseases and the US health care quality is not worse, and even better in some aspects, such difference may be explained by lack of skills and absence of Russian physicians' motivation in effective reducing of treatment costs.

What should Russian municipal clinical hospitals do to increase their extra-budgetary funding and improve efficiency of money allocation?

First, municipal clinical hospitals should review their organizational set-up and attract people with expertise in corporate management to move to a higher level of hospital management. In the West General Directors manage clinics, while Chief Physicians (who control medical personnel and are responsible for medical services and matters) and other managers responsible for auxiliary functions (finances and accounting, IT, procurement, legal, etc.) are subordinate to them. An example of such organizational set-up is given in Exhibit 4. People who have expertise in such business spheres that are new to Russian municipal hospitals shall manage some hospital services responsible for marketing, pricing and other functions.

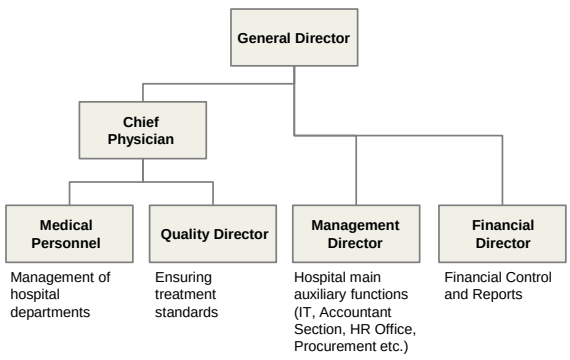
In Russian hospitals, all management functions are usually imposed on Chief Physicians. Such structure with the Chief Physician managing all aspects of hospital operations was justified in the period when Russian municipal hospitals had minimum autonomy in planning and allocation of budget funds and expenses, personnel motivation, procurement management and internal processes. Now, when the target is to improve autonomy and self-reliance of hospitals, hospital heads should pay more attention to auxiliary functions, other than medical services. Therefore, the municipal clinical hospital heads shall delegate to other heads (Chief Physicians) all functions of control and decision-taking concerning the hospital main function - treatment of patients.

Second, we think that adaptation to the new clinic management conditions may be more successful with attraction of external consultants, who can support managers of municipal clinical hospitals in planning and successive implementation of transformations.

Exhibit 4.
Comparison of the organizational set-up of Russian and foreign hospitals

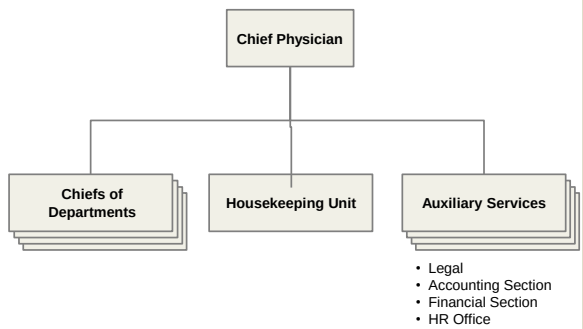
Key differences of Western hospitals:
- Medical functions are separated from hospital operational management
- There are bodies responsible for strategy development, marketing policy and sales
- Chief Physician is responsible only for treatment results

Example of Strong Memorial Hospital (USA)



Key indicators in 2011
- **739 beds**
- **40** different areas of medical services
- Inpatients per annum: **59,339**
- Average stay in hospital: **5,6 days**
- Bed occupancy rate: **87.2%**
- Outpatients: **26,616**
- Revenues: **$2,229 mln**
- Costs: **$2,163 mln**
- Profit: **$66 mln**

Example of the Central Clinical Hospital No.6 of JSC Russian Railways (Russia)



Key indicators in 2012
- **130 beds**
- **20** different areas of medical services
- Inpatients per annum: **5,000**
- Average stay in hospital: **11-13 days**
- Bed occupancy rate: **90%**
- Outpatients: **15,000**
- Revenues: **RUR157 mln**
- Costs: **RUR150 mln**
- Profit: **RUR7.1 mln**

Sources: public data, hospital Web-sites, MCG analysis

All over the world, health care facilities actively use consultants for various purposes - for example, to determine new areas in clinic specialization, to develop motivation systems, to set indicators for physicians' operational performance, to identify most prospective levers for cost reduction or pricing analysis and setting optimal prices for servicing. Advice and recommendations from insurers of voluntary health insurance who often have own effective clinic network may be perceived by state-financed hospitals as intrusion of partners in the sphere of other party's interests. Hiring of specialists who have expertise and competence in setting up of certain business functions is not worthwhile as efforts are required only for a very limited time period (about 4-9 months); and after processes are adopted hospitals will no longer need such expertise. Engaging a team of consultants who know how to set up business operations and have experience in working with Russian state-financed institutions is the most effective approach to timely transition of municipal clinical hospitals to operation under new rules.

Third and the most important, municipal hospital managers should be aware of irreversibility of changes in the health care system. The state is clear that the budget expenditures on the health care system will be gradually reduced to 3-5% of GDP. In such conditions municipal clinical hospitals with either have to go back to the 1990s when hospitals could not provide medical services to public because of lack of financing (i.e. for purchasing of health care products and consumables and payment of utility bills) or they will have to learn how to spend budget funds effectively (for example, to reduce an average duration of stay per patient, to hold tenders for purchasing of consumables and associated goods) and to increase financial flows from alternative sources (not only from commercial services, but also from grants and fund-raising).

New conditions will require significant efforts from Chief Physicians and change of mindsets from all hospital personnel. However, only such fundamental changes can bring the Russian health care system to a qualitatively new level of development and open up opportunities for successful treatment of patients.

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