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АНАЛИЗ ВИДОВ ФИНАНСИРОВАНИЕ УЧРЕЖДЕНИЙ ЗДРАВООХРАНЕНИЯ

ANALYSIS OF TYPES FINANCING OF INSTITUTIONS HEALTH CARE

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Abstract. The article summarizes and analyzes the domestic and foreign experience of financing health care institutions. The author examined the financing options for medical and preventive institutions, the distribution of financial resources within various medical organizations, as well as the measures of material incentives for employees.

Also, further plans for the development of health care financing in the Republic of Uzbekistan were discussed.

Аннотация. В статье обобщен и проанализирован отечественный и зарубежный опыт финансирования здравоохранительных учреждений. Автором рассмотрены варианты финансирования лечебно–профилактических учреждений, распределения финансовых средств внутри различных медицинских организаций, а также меры материального стимулирования сотрудников.

Также, обсуждены дальнейшие планы развития финансирования здравоохранения в Республике Узбекистан.

Keywords: financing, healthcare, system, economics, insurance, medicine.

Ключевые слова: финансирование, здравоохранение, система, экономика, страхование, медицина.

Introduction

This year in Uzbekistan, the number of family polyclinics in rural areas has grown at times from 180 to 973, the number of substations and ambulance stations has increased from 806 to 2102, and 1269 ambulances have been purchased for the regions. In 2017, 6.7 trillion soums were allocated for health care, and in 2018 it is expected to increase funding to 10 trillion soums. Financing activities to improve the material and technical base will increase from 552 billion soums in 2017 to 803 billion soums (45%). Planned construction and reconstruction of 290 objects (this year - 180). In 2017, construction was carried out in the capital and regional centres. In 2018 it is planned to carry out construction and reconstruction in remote areas, in villages. There are 11 specialized centres and 23 branches in the regions, 126 polyclinics in the districts and 52 district medical associations. 915 billion soums will be allocated for the medical provision of medical institutions, 2.5 times more than this year (376 billion soums) and 4 times more than in 2016 (227 billion soums). This proves the state's great attention to financing health care in general.

Literature review

In each country, the health system is a product of its unique characteristics, history, political process and national character of the people. There is no universal model of health organization that is suitable for everyone. The history of the Russian state was a complex path of development, and the essence of the processes taking place in the state influenced the formation, functioning, content of its social institution health. As described in his writings, V. V. Prokhorov, O. P. Shchepin, V. A. Scientists have contributed to the study of modern problems of improving the organization of medical institutions: Lyasnikov N. V., Dudin M. N. [1], Komyagin A. V., N. B. Okushko [2], Pushkaryov O. V. [3], Chubarova T. V. [4]. Medic and other scientists forming the medical service originates from ancient times, with the opening of the first hospital hospitals, the formation of zemstvo medicine. The history of health development, as well as the history of the development of the state, is the historical experience of the people, its social memory circulating in the society in the form of monographs, brochures, articles that answer the question of the reasons for the ripening of crises and ways to overcome them. The problems of health management in the middle of the last century are reflected in domestic and foreign publications: Becker G. [5], Drummond M. [6-7], McGuire A. [11-13], Torrance G. W. [14]. They analyzed the formation and development of compulsory health insurance in foreign countries.

Analysis of existing health systems

Nowadays, all existing health systems can be described with the help of three main economic models. There are no single-valued, generally accepted names for these models, but the descriptions of their main parameters are given by specialists, in general, equally. (Figure) The first model is characterized by the provision of medical assistance mainly on a fee basis, at the expense of the consumer of medical services, the absence of a unified system of state medical insurance. The main tool for meeting the needs of medical services is the healthcare market. That part of the needs that are not satisfied by the market (low-income strata of the population, pensioners, unemployed) is borne by the state through the development and financing of public health care programs. Thus, the scale of the public sector is small. This model is usually called paid, market, American, and sometimes — a private insurance system.

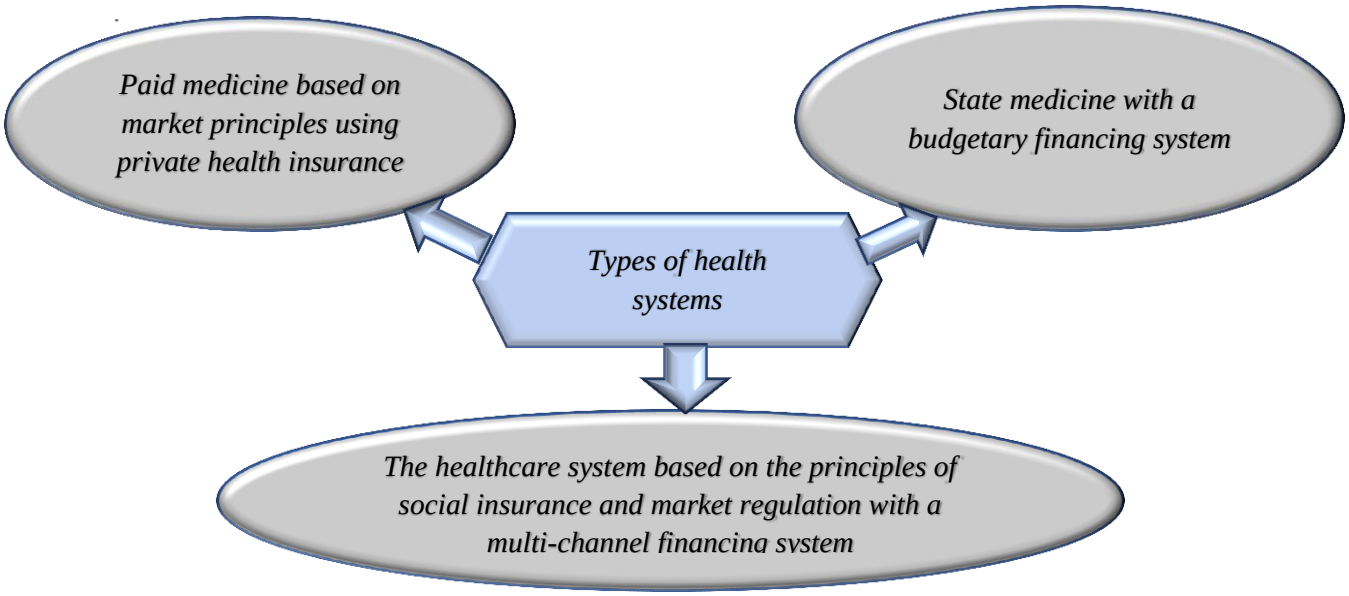

Figure. Existing health systems

The second model is characterized by a significant role of the state. All medical services are provided by the public sector, financing of which is carried out mainly from the state budget, at the expense of taxes from enterprises and the population. The population of the country receives medical assistance free of charge (except for a small set of medical services). Thus, the state is the main buyer and supplier of medical care, ensuring the satisfaction of most of the public need for health services. The market is assigned a secondary role, as a rule, under the control of the state. The state is the main guarantor of protection of incomes of medical workers from inflation (minimum wages, pensions, holidays, etc.). This model from the 1930s until recently was characteristic of the former CIS republics, the countries of Eastern Europe. It is called state, budgetary, state budget. The third model is defined as a social insurance or a system of regulated health insurance. This model of healthcare is based on the principles of a mixed economy, combining the medical services market with a developed system of state regulation and social guarantees, access to medical care for all segments of the population. It is characterized primarily by the availability of compulsory health insurance for all or almost the entire population of the country with a certain state participation in the financing of insurance funds. The state here plays the role of guarantor in meeting the socially necessary needs of all or most citizens for medical assistance regardless of the level of income, without violating the market principles of payment for medical services. The role of the market of medical services is reduced to meeting the needs of the population above the guaranteed level, providing freedom of choice and consumer sovereignty. Multichannel financing system (from a profit of insurance organizations, deductions from wages, state budget) creates the necessary flexibility and stability of the financial base of social insurance and the mechanism of social protection of its employees.

The third model includes the signs of both state and market models. Depending on which parameters prevail, the social-insurance model may be closer to either state or market.

The models of the organization of public health services described earlier take different account of the specifics of the medical service as a commodity. And this factor is no less important than the role of the state in distinguishing different types of organization of the health care system, moreover, it determines the scale of the public sector in each model.

Differences in the mechanism of functioning of these models are predetermined by an implicit contract. Let us dwell on it in more detail. In the case of pain medicine, the patient pays for a visit to the doctor. This circumstance puts the health care provider in a dual position — long unsuccessful treatment leads to an increase in his incomes, but at the same time undermines his reputation and causes a decline in incomes in the long term. The content of the contract, therefore, provides for "overpayment" by the client for additional services. The key routine that determines the functioning of paid medicine is the expansion of practice (in effect, the attraction of a new clientele, both sick and healthy people).The content of the contract presupposes network decentralized contacts between doctors (clinics), the Ministry of Health can only influence the medical corporation indirectly. Essential is the reputation of the doctor not only among patients, but also among colleagues — this is accompanied by increased incomes and status. The peculiarity of this system is the interaction between the medical corporation and the manufacturers of medicines and medical equipment — there are practically no methods of direct influence on doctors and clinics, therefore, seminars and conferences are constantly held here, where presentations of medicines, equipment and new methods of treatment are carried out. At the same time, quality control and treatment costs are carried out within the medical corporation by each manufacturer independently. In the case of insurance medicine, the service provider is paid the cost of treating the illness, while the patient

pays for the insurance against the case of getting sick. The "gap" between the cost of treatment and insurance is a conflict of interest between the clinic and the insurance company; thus there is a conflict of interests and within the medical corporation: some treat, others - experts of insurance firms — estimate the correctness of treatment (in terms of quality and cost).

The duality of interests inherent in the position of the producer of medical services in the market model is eliminated, and overpayments are reduced; in connection with which this model is recommended by the World Health Organization for dissemination. However, the role of the state, introducing standards for the activity of insurance organizations and clinics (especially with regard to compulsory medical insurance) is also increasing here. The mechanisms of motivation, introduction of innovations, high-quality services here are similar to paid medicine.

Finally, in the budgetary medicine, the cost of services is equated with some normative indicator (indicators). In domestic healthcare, this indicator — the key routine of financial planning — is a bed in a medical and preventive institution. On the basis of these indicators, the cost of maintaining the budget healthcare network is calculated, to which the number of doctors, the cost of medicines, and other cost items are tied. At the same time, the normative indicators are interrelated: for example, hospitals with N number of beds are built per 10,000 people according to construction norms and rules (SNiPs), so the replacement of one normative indicator (bed) by another indicator (per capita standard) affects the situation negligibly. There is a rigid corporate ethic that is close to the military, the colleagues do not give out their "own", the recognition of medical error is a rare exception. Innovations are carried out by long-term development and approbation in relevant specialized institutions of the Ministry (institutes and specialized clinics in oncology, cardiology, orthopaedics and traumatology, etc.). Such a system is quite effective in eliminating mass epidemiological diseases, however, in cases when it is required to apply individual, non-standard methods of treatment, it begins to give significant failures. With such a funding system, effective work of doctors is directly eliminated — the link directly providing medical care to the population, there is a lack of possibilities to cover all costs for medical care (for this, state financing should increase at least twice), the question arises of the forms of organizing personal payments of the population for medical care.

Paid services expand the possibilities of providing those services that budget institutions cannot provide at the expense of tax funds, and in this role, they are able to improve the quality of medical care. Paid services are a source of additional funds to strengthen the material and technical base of the institution, they are included in its budget and can be allocated for the implementation of the statutory objectives of the institution, as well as to stimulate the activities of staff. But in practice, the impact of paid services on local efficiency is determined by the level of tariffs and the order of distribution of funds received from paid services. If the tariff is understated, and the staff does not receive adequate compensation, then the motivation to provide paid services is reduced. And, consequently, there is no real increase in the return on the resources invested. The transition from one model to another requires changing both the key routines that determine the specificity of each model, as well as the appropriate methods of management, interaction with patients and the public, with public opinion, with manufacturers of medicines and medical equipment.

Modern forms of financing medical organizations

Until the beginning of the 1990s, the financing of treatment and prevention institutions was carried out according to the cost estimates. Funds were planned and allocated to institutions by the articles of economic classification of budget expenditures. The number of financial resources was calculated depending on the category and indicators of the capacity of the health facility (the

number of hospital beds, the maximum number of outpatient clinics, polyclinic visits of doctors for a shift), to which all the cost norms for individual items were attached (the norms of the staffing table, the costs of feeding patients and medicines, etc.). Institutions had to spend the funds received strictly for their intended purpose and did not have the right to independently reallocate them between different items of expenditure. In the event of cost savings for some article for the year, the financial authorities sought to reduce the planned expenditure of the institution for the following year under the said article for the amount of savings received. It is obvious that the method of budget financing is convenient for financial authorities, but does not create incentives for institutions to use resources more rationally and reproduces the cost-based type of management. The practice of foreign countries and the domestic experience of recent years have shown that the formation of the range of medical services provided by the very important motive is the economic interest of physicians. In turn, the economic interest of medical institutions and their employees is largely determined by the chosen system of financing medical care. For example, the number of visits per resident to general practitioners in the UK, where the payment for these doctors does not depend on the number of visits, is almost 2 times lower than in Germany and France, using the fee-based payment method, depending on the number of visits. According to foreign authors, about 20% of the studies and manipulations done in the US were unnecessary.

No strengthening of control on the part of insurers (which also has a lot of money) can not, in this case, limit the growth of the cost of medical care. According to modern ideas, the optimal system for financing medical care must meet the following criteria:

1. The financing system should be of an anti-cost nature;
2. The cost of medical care must be predictable in advance;
3. The expenses of the financing party (including the insurer) on the control functions related to the payment of medical services should be minimized;
4. Methods of payment for each type of medical care should encourage health facilities to perform their functions in the best way for patients in conditions of the most effective use of resources.

In addition, it is necessary to take into account that the calculation of the provision of medical care can be based on two approaches. The first is a retrospective payment of medical care. This approach involves reimbursement of the actual volume of medical care provided. The health facility independently determines the types and volumes of care provided. The role of the financing party is minimal: the health facility issues invoices for the services provided, and the insurer pays for them. Strictly speaking, in this case the financing party is not a purchaser of medical care, since the amount of services determined by their suppliers themselves is subject to payment. There is no major characteristic of a market transaction — the right to choose a certain volume and structure of goods and services. The second approach is the advance payment of medical care. This approach assumes compensation not for an actual but for a preliminarily agreed amount of assistance. The latter is determined on the basis of an agreement between the funding party and the health facility. Not all health facility accounts are subject to payment, but only those that correspond to the agreed amount of assistance. The most important difference between retrospective and prepayment is the degree to which planning tools are used. In the first case, the financing party does not manage the volumes and structure of medical assistance, in the second — it acts as an informed buyer, ordering and paying only what corresponds to its plans and financial possibilities. Calculations based on the decisions of the health facility itself on the volume and structure of work are giving way to planning and coordinating the economic interests of the funding party and the health facility. Polyclinics should have incentives to expand the scope of their work and contain referrals to hospitals. A

possible mechanism for optimizing the economic interests of a hospital and a polyclinic is the combination of payment for a completed case for a hospital and a method of fundholding for per capita financing for an outpatient unit.

It should be noted that it is necessary to establish a system for managing the method of payment for medical care. Its most important element is the constant monitoring of its implementation. It involves the development and use of a system of indicators that allow you to track the behaviour of a managed object and adjust the implementation of the selected payment method. This will reveal not them but the practical consequences of replacing the old method of payment for medical care with new ones.

Features of financing of public health institutions.

Financing refers to any provision of financial resources to economic entities — the country's spheres and areas of economy, regions, enterprises, entrepreneurs, the population and its individual groups, and the targeted allocation of such funds for the implementation of programs or economic and social activities. Speaking about financing, often tie him to the sources of financial resources:

– Budget financing refers to financing from the budgets of the state, regions, municipalities.

– Self-financing is the financing of economic activity from own sources.

In some cases, the financing of one organization, the firm may be carried out by another organization or firm, which is called a sponsor. The sponsor can provide monetary funds:

– on a free, beneficial basis,

– and in the form of a loan, subject to refund and also with interest.

Own funds are the number of monetary resources that are in the economic circulation and belong to medical and preventive institutions. Borrowed or attracted are money resources that are temporarily in possession along with their own means, but do not belong to a medical institution. Sources of borrowed funds — loans, own debt obligations.

Sources of own funds — authorized capital, added capital, reserve capital, retained earnings, targeted financing. In order to evenly include the pre-existing costs in the cost of production or circulation, organizations should create reserves. The health facility can create reserves for the forthcoming vacation pay for employees, payment of annual remuneration for long service, payment of remuneration based on the results of the work for the year, repair of fixed assets, covering other foreseen costs, and for other purposes stipulated by the legislation of the Republic of Uzbekistan. External sources of financing are current, periodic receipts of money or other types of monetary funds to the accounts of medical organizations in the form of payment for rendered services, various types of financial assistance, subsidies, loans, which serve as the main sources of replenishment of financial resources.

Internal sources of financing are accumulated own funds.

The main external sources of financing for a medical institution are:

1. funds of budgets of all levels,
2. OMS funds,
3. funds of legal entities,
4. funds of public organizations,
5. personal funds of citizens,
6. other sources not prohibited by law.

To own funds include:

1. money on accounts in banks and at the checkout,

2. securities (shares, bonds, promissory notes purchased in financial markets, and independently issued securities);

3. funds in circulation,

4. liquid assets in the form of natural values that can be easily converted into money by selling.

Sources of replenishment of own funds of health organizations:

1. deductions from the profit received by the institution from commercial activities (the difference between income from activities and expenses for it),

2. Amortization deductions (part of the organization's income allocated for the formation of depreciation of fixed assets).

It is necessary to strive to replenish own funds to compensate for their expenditure or even exceed it, since the value of own funds is an important criterion for the sustainability of the organization and institution.

Features of health financing in the state or budgetary financing system:

1. The cost of medical care is covered by taxes levied on the population;

2. The population receives medical assistance without payment of contributions, free of charge, or only partially paying for the services rendered;

3. The executive power is authorized by taxes, which is delegated the right to distribute funds under legislatively approved articles of budgets of different levels.

The advantage of budgetary health care is the availability of medical care in relation to all segments of the population. Negative signs of public health:

• lack of address;

• the formation of patients' rights in terms of not providing the possibility of choosing a doctor, a medical institution;

• deterioration of the quality of services due to the dictates of the representative (producer, seller) of health services and lack of control over the users and consumers of medical services. Budget financing can be implemented by:

1. direct government funding,

2. indirect state financing,

3. on the basis of special state programs.

State programs can be financed by:

–general tax revenue,

–and special target taxes and deductions.

Within the framework of targeted programs, budget financing can acquire targeted, targeted nature. Prevalence of the public health system:

–existed in the socialist countries, incl. in the former CIS;

–in some developed and developing countries;

–In the developed capitalist countries, it was implemented in the fullest extent in England in 1948, largely following the recommendations of the Report of Lord Beveridge, published in 1942. Currently, the group of countries with predominantly budgetary funding includes Great Britain, Italy, Norway. Budgetary health financing in a number of countries is quite effective. In public health care in Great Britain:

1. the independence of general practitioners from public health authorities is preserved;

2. private practice is allowed in accordance with the practice of medical specialists working in public medical institutions;

3. General practitioners are not in the state of municipal health institutions, they work under contract;

4. the entire population has the opportunity to use almost all types of medical care. The state system of financing public health services costs society cheaper than insurance systems.

The state health system of England by international standards is poor in comparison with countries with a similar level of economic development. In England, the share of expenditure on health in the GNP in 1992 was only 6,2%. For comparison: in the USA — 11,1%, Sweden — 9,1%, France and Canada — 8,5%, Germany — 8,1%, Japan — 6,7%. The cost of health care per capita in England is about 1/2 of the level of the US and Western Europe. At a certain stage of solving relatively simple tasks — treatment, mainly infectious diseases, the public health system demonstrated its advantages. Limited funding provided access to health care. In modern conditions, the structure of diseases has changed — the proportion of residential people, chronic diseases, diseases of the cardiovascular system, which require expensive high-tech medical care, has increased.

This led to the fact that:

–there were queues for hospitalization,

–there were cases of social inequality with the free distribution of services of different cost;

–lack of equipment with expensive equipment, the latest medical technologies;

–and, as a consequence, a decline in the quality of care.

Medical insurance occupies an intermediate position between budget financing and paid medicine.

According to the general recommendation of WHO, the state should allocate at least 6-7% of gross domestic product (GDP) for health as a sector providing national security of the country.

Conclusion

It should be noted that the system of budget financing and the system of compulsory medical insurance are alternative ways of organizing public health financing. In 2018 for the purpose of preferential financing of the private sector, 14 million dollars of interest-free loans will be allocated. 234 new private medical institutions should be opened. The issue of outsourcing is also being considered. The most important difference between these systems and the system of private health financing is the independence of the volume of medical care received by the sick person from his solvency. The following approaches can be used to assess the level of financing for health facilities and the use of funds received:

– • analysis of the quantitative indicators that form the income of the hospital;

– • characteristics of all sources of financing;

– • identification of factors affecting the income and expenses of the institution.

From the point of view of assessing the effectiveness of the use of financial resources, an economic analysis of expenditures by budget classification, cost of services, the ratio of costs for treatment and patient care is required. Carrying out of the financial analysis under the presented scheme allows to estimate resources of the establishment, to define strong and weaknesses of formation and use of money resources, to establish the reasons of an inappropriate use. In addition, the results of the study can serve as the basis for the development of a financial strategy aimed at strengthening the institution’s position in the market of medical services, improving the quality of service to the population.

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