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The Budgetary and Insurance Model of Healthcare Funding in Russia

E.A. Soboleva
Baikal State University, Irkutsk, Russia
https://orcid.org/0000-0003-4755-103X

ABSTRACT

This paper **aims** to investigate the essence and method of building a financial model of healthcare in Russia. The author applies **methods** such as analysis and synthesis, statistical data processing, systemic and structural approaches. This article is an analysis of the basics of building a budgetary and insurance model: cost allocation (various types of medical care, individual costs) by funding sources; system of inter-budgetary relations; the structure of expenditures of the budgetary system of the Russian Federation on healthcare in 2019. The study presents the financial model of the compulsory medical insurance (CMI) system and defines the role of insurance and private medical organizations in the CMI system. The mechanism of financing state (public) healthcare institutions is shown. The procedure for financing medical organizations according to the territorial program is considered (as illustrated by the example of the Irkutsk region). The article analyzes the methodology for calculating the cost of the territorial program and identifies the problems associated with it. The author pays special attention to organizations that do not carry out activities in the field of compulsory medical insurance, outlining the specifics of financing and legal regulation, and arguing the reasons for excluding a number of diseases from the compulsory medical insurance program. The paper examines the content of the new law on the CHI reform, which provides for direct financing from the budget of the Federal CHI Fund of federal institutions providing specialized medical care. The author highlights the main problems of the building of the budgetary and insurance healthcare funding model such as congestion, inconsistency, cost intensity. The author **concluded** that it is necessary to revise the organization of the healthcare system and mechanisms for its financial support. The outstripping growth in healthcare costs, on the one hand, and inadequate funding of medical institutions, on the other, lead to a constant search for a compromise between equity and cost-effectiveness. Based on this, the author substantiated the goals and determined the **directions** for further research, such as reducing transaction costs, changing the motivation of participants, identifying cost growth factors and the possibility of eliminating them.
Keywords: healthcare financing; inter-budgetary transfers; state guarantees program; free healthcare; compulsory medical insurance; predominantly single-channel financing; fragmented funding

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INTRODUCTION

The national health care system ensures the implementation of the right of citizens to free health care. There are numerous scientific publications devoted to financing health care in Russia: this topic is versatile, controversial, and socially significant, the discussed range of problems affects the wider society.

At present, the Russian Federation (hereinafter referred to as the "RF") operates a mixed model of financing public health care based on the compulsory medical insurance system (hereinafter referred to as "CMI"), which is conventionally called budgetary insurance.

Over the past 30 years, scientists, doctors, politicians, and officials have been arguing about the most effective model for financing health care: from returning to the state budget to improving insurance. In 2020, a law on the reform of compulsory medical insurance was adopted, which determines the relevance of the topic.

Scientific publications, as a rule, consider one or another aspect of health care financing with authors setting out their vision of the situation and proposing possible transformations, criticizing the issues that are in their field of their vision. But this does not allow compiling a holistic picture of the financing of the industry, which makes it difficult to have a meaningful and productive public discussion in this area.

The paper aims to study the essence and method of constructing a financial model of public health in the Russian Federation. The objectives are to form a comprehensive understanding of the mechanisms for the formation and distribution of financial resources of public health; identify the problems of financing the industry; determine the goals and directions of further research. The "routine" period 2015–2019 is considered (before exacerbation of the epidemiological situation).

Such studies are necessary to find ways of further (post-crisis) development of Russian healthcare. When analyzing the effectiveness of the health care system, it is important to have a clear understanding of the logic of the origin of the system, its development, generic qualities, factors of influence, the response of the system [1].

CHI SYSTEM INTEGRATED INTO PUBLIC HEALTH SYSTEM

According to the legislation of the RF[1] everyone has the right to receive health care in accordance with the program of state's guarantees for the provision of free medical care to citizens (hereinafter referred to as "State Guarantee Programs").

The program of state guarantees establishes a list of types of medical care (diseases and conditions), the provision of which is carried out free of charge and is formed based on medical statistics characterizing the level and structure of morbidity of the population in Russia, considering the characteristics of the sex and age composition.

In accordance with this, territorial programs of state guarantees are adopted in the constituent entities of the Russian Federation, which are developed considering the structure of morbidity in a given region (hereinafter referred to as "Territorial Programs TP").

The key point (in understanding the way of building a budget insurance model) is the difference between the State Guarantee Program and the basic CMI program as its component (*Fig. 1*). Accordingly, the territorial compulsory health insurance program (hereinafter referred to as "TPCMI") is an integral part of the territorial program.

Insured persons are entitled to free health care[2]:

- in the "home" region (in which the compulsory medical insurance policy was issued) — in the amount established by TPCMI;
- in another region of the Russian Federation — in the amount established by the basic CMI program.

[1] Federal Law No. 323-FZ of November 21, 2011 (as amended on December 8, 2020) "On the basics of protecting the health of citizens in the Russian Federation", Art. 19.

[2] Federal Law No. 326-FZ of November 29, 2010, (as amended on December 8, 2020) "On Compulsory Medical Insurance in the Russian Federation", Art. 16.

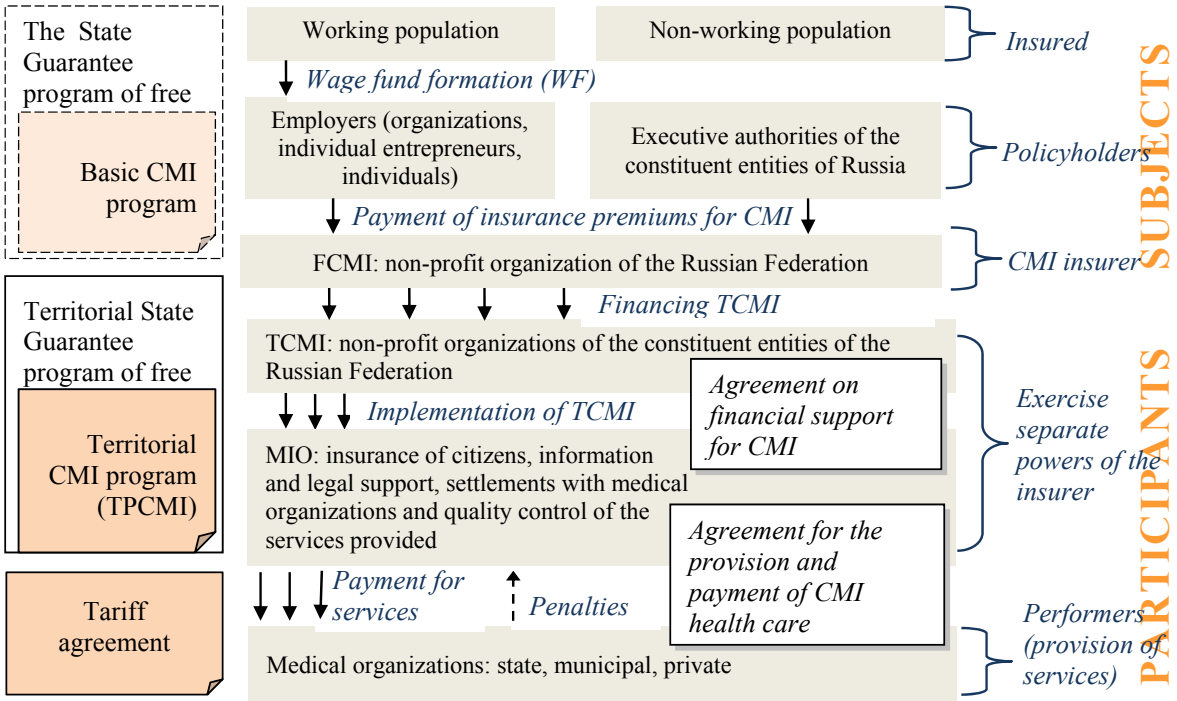

Fig. 1. **Financial model of the compulsory medical insurance (CMI) system**

Source: developed and compiled by the author based on the Federal Law of November 29, 2010 No. 326-FZ "On compulsory medical insurance in the Russian Federation" (latest version). URL: http://www.consultant.ru/document/cons_doc_LAW_107289/ (accessed on 25.01.2021).

In this case, the insured persons are (326-FZ, art. 10): citizens of the Russian Federation, foreign citizens, stateless persons, refugees, i.e. the entire population of the country. This is the essence of compulsory medical insurance.

However, the State Guarantee Program is a broader document than the basic CMI program: this is the meaning of the definition used, which defines the public health financing model as budgetary and insurance (not just insurance).

An essential characteristic of the CMI system, as part of the state health care system, is the participation in it of non-governmental (commercial) organizations: medical insurance organizations (hereinafter referred to as "MIO") permanently and medical organizations (hereinafter referred to as "MO") on a contractual basis (*Fig. 1*).

The basic difference between state (social) insurance and commercial insurance is that the insurer (which initiates the conclusion of an insurance contract, bears financial risks, and provides insurance compensation) is a state non-budgetary fund (Federal fund of CMI, hereinafter referred to as "FCMI"), and not an insurance company (*Fig. 1*).

Health insurance organizations make settlements with MOs (for payment for medical care provided to insured persons) on the basis of earmarked funds (*Fig. 2*) provided by the budgets of territorial CMI funds (hereinafter referred to as "TCMI").

The main trend in the CMI sector is the reduction in the number of insurance organizations: the largest companies remain on the market. Since 2010, the number of health care organizations has decreased by almost 3 times: from 98 to 34 organizations.[3]

For example, during 2016, 6 organizations ceased their activities: one of them had its license revoked, the rest were reorganized by joining other MIOs.[4]

[3] CMI system in the Russian Federation. URL: http://www.ffoms.gov.ru/system-oms/ (accessed on 25.01.2021).

[4] Bulletin of the Accounts Chamber of the Russian Federation. No. 3 (231) 2017. URL: https://ach.gov.ru/statements/byulleten-schetnoj-palaty-3-mart-2017-g-892 (accessed on 05.03.2021).

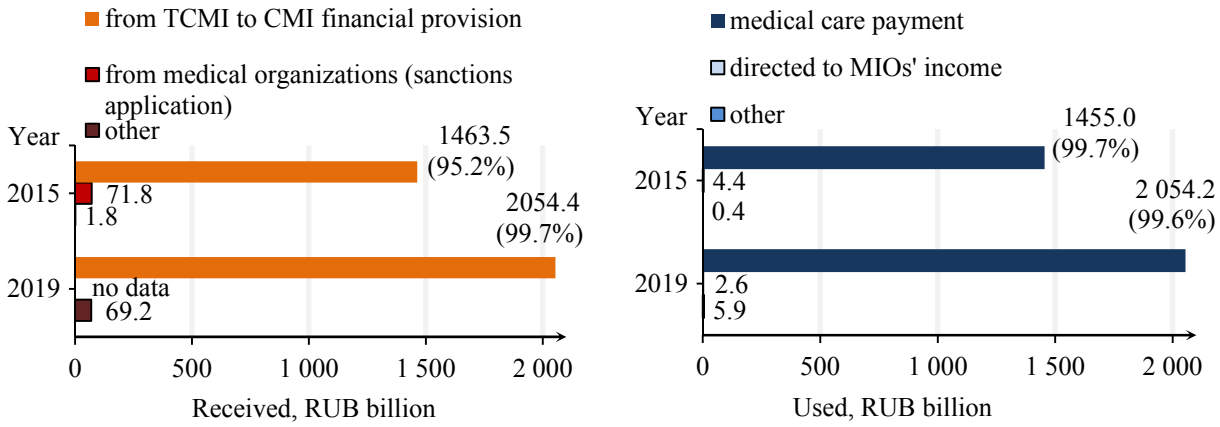

Fig. 2. **Main indicators of MIOs in terms of CMI in 2015 and 2019**

Source: Russian Statistical Yearbook 2018. Moscow: Rosstat; 2018. 694 p.; Russian Statistical Yearbook 2020. Moscow: Rosstat; 2020. 700 p.

According to the FCMI, since 2010, the legislative requirements for the activities of the medical insurance organizations, including financial ones, have been constantly tightened.[5] Since 2017, the requirements for the minimum size of the authorized capital of MIOs have been increased by 2 times (up to 120 million rubles).[6] As a result, the most financially stable insurance companies remain in the CMI sector, capable of performing all the functions assigned to them.

Private MOs are included in the unified CMI register based on a notification sent to the TCMI. At the same time, the TCMI does not have the right to refuse an organization (individual entrepreneur) to be included in the register (326-FZ, art. 15, p. 2).

According to FCMI,[7] the share of private medical organizations in the CMI system in Russia increased from 2.2% (253 organizations) in 2007 to 35.9% (3309 organizations) in 2020. According to practitioners, the involvement of private medical organizations contributes to the improvement of the quality of health care, since it allows the treatment process to be provided with modern equipment and medical technologies [2]. But in this regard, the question arises: will the CMI system have enough financial resources for all?

SOURCES OF FUNDING

Sources of funding are one of the main factors in the formation and development of the health care system [3]. If public health care in Russia is provided to the extent established by the State Guarantee Program, then the sources of funding for the Program must be considered.

The distribution of costs (various types of medical care, individual costs, etc.) by funding sources underlies the construction of a budgetary and insurance model of health care funding (*Fig. 3*).

At the same time, by "funding health care" we mean financing medical institutions that provide free medical care to the population of the country.

The sources of funding for the State Guarantee Program are:

- CMI funds: FCMI budget (TCMI budgets);
- federal budget funds;
- funds from the budgets of the constituent entities of the Russian Federation (local bud-

[5] Insurance medical organizations will inform insured citizens about the need to undergo a medical examination in 2018. URL: www.ffoms.gov.ru/news/ffoms/strakhovye-meditsinskie-organizatsii-proinformiruyut-zastrakhovannykh-grazhdan-o-neobkhodimosti-proy/ (accessed on 05.03.2021).

[6] Law of the Russian Federation of November 27, 1992, No. 4015–1 (as amended on December 30, 2020) "On the organization of insurance business in the Russian Federation", Art. 25.

[7] The FCMI assessed the level of private medicine. URL: https://ria.ru/20200724/1574843699.html (accessed on 25.01.2021).

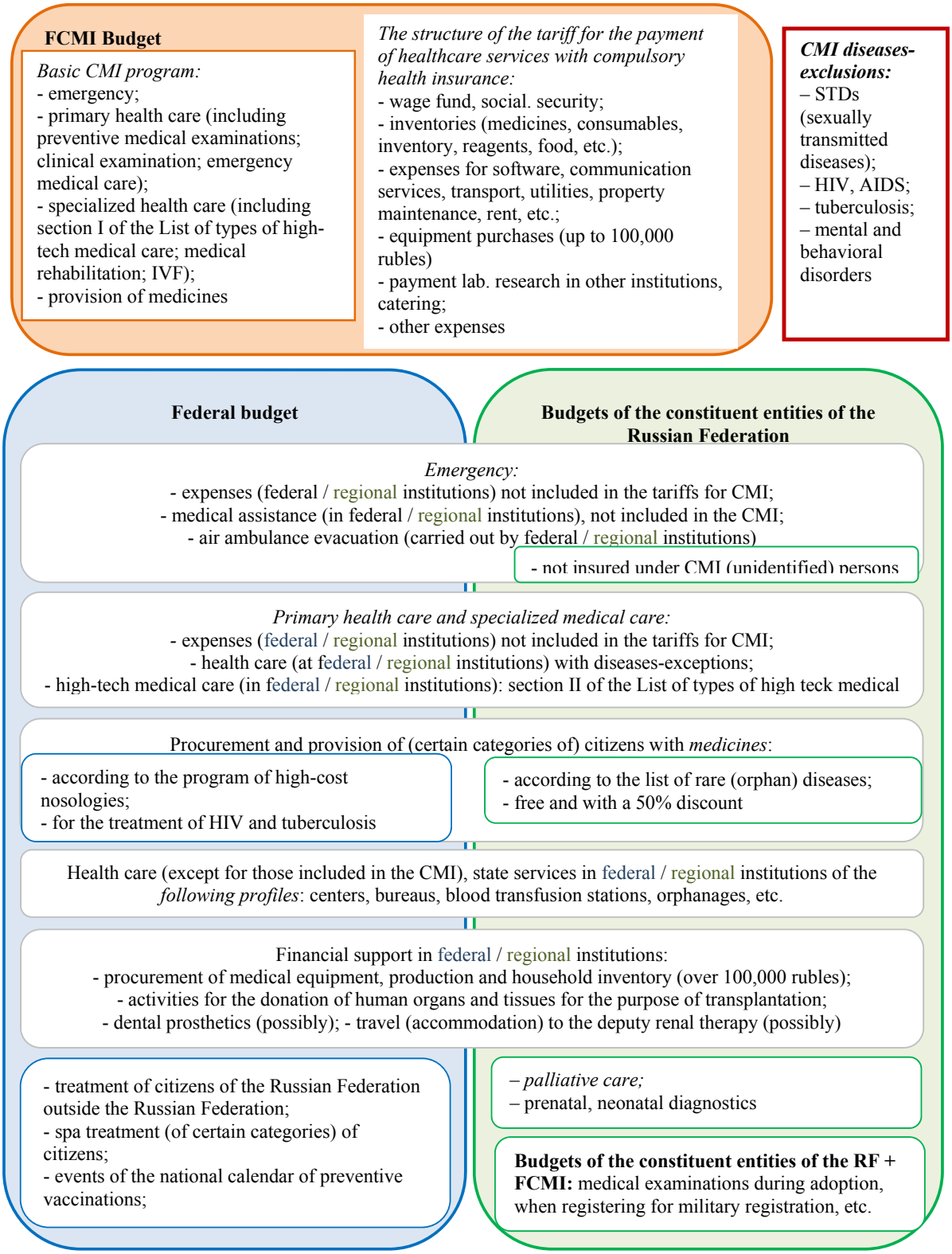

Fig. 3. **Budgetary and insurance model: cost allocation (types of medical care, individual costs) by funding sources**

Source: developed and compiled by the author based on the Resolution of the Government of the Russian Federation of December 10, 2018, No. 1506 "The Program of state guarantees for access to free-of-charge medical aid for Russian citizens for 2019 and for the planned period 2020–2021" (latest version). URL: http://www.consultant.ru/document/cons_doc_LAW_313205/ (accessed on 25.01.2021).

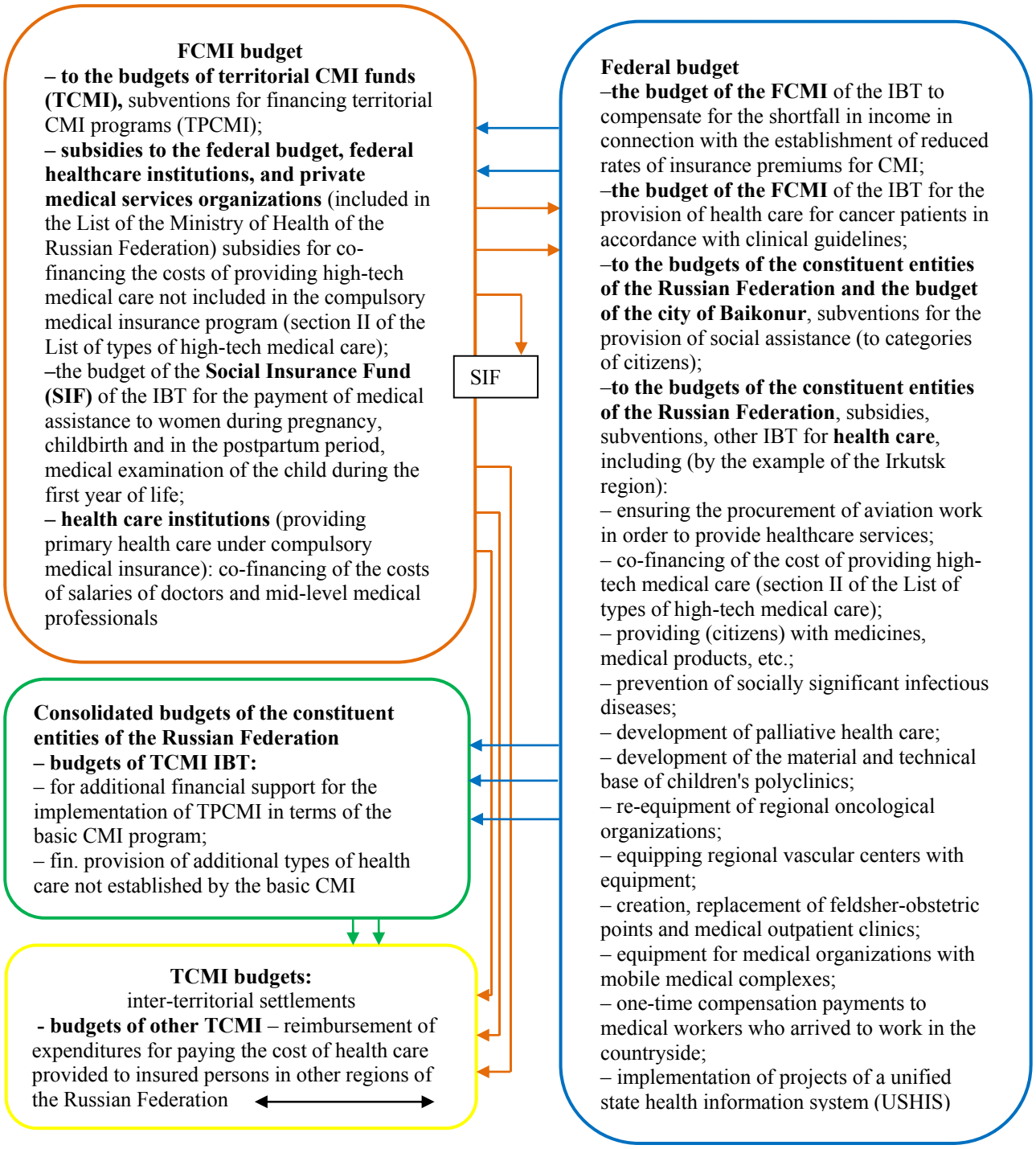

Fig. 4. **Budgetary and insurance model: inter-budget relations system**

Source: developed and compiled by the author based on the Reporting on budget execution (2019) of Federal Treasury of the Russian Federation. URL: https://roskazna.gov.ru/ispolnenie-byudzhetov/ (accessed on 25.01.2021).

gets — in the event of the transfer of appropriate powers).

Thus, the budgetary and insurance model of healthcare funding in the Russian Federation includes:

1. Budget financing (in whole or in part of certain expenses):

- certain types of medical care, drug provision;
- certain types of activities, events.

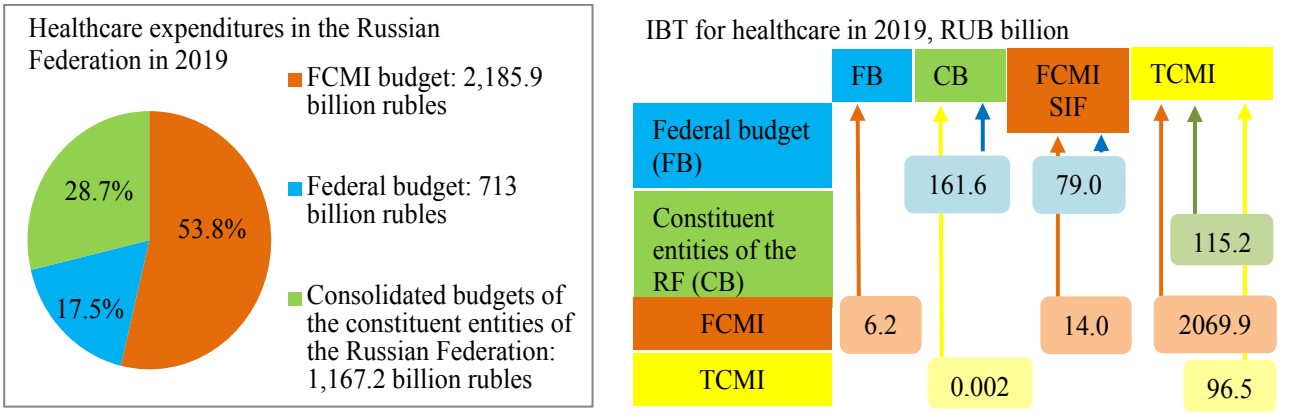

Fig. 5. **Healthcare expenditures, inter-governmental transfers in 2019**

Source: developed and compiled by the author based on the Reporting on budget execution (2019) data of Federal Treasury of the Russian Federation. URL: https://roskazna.gov.ru/ispolnenie-byudzhetov/ (accessed on 25.01.2021).

2. Extrabudgetary funding:

- according to the compulsory medical insurance system;
- the possibility of receiving income from the provision of paid services (from property, other business activities).

The allocation of MOs expenditures to the respective budgets is a complex system. On its basis, a no less complex system of inter-budgetary relations has been built (*Fig. 4*), in which a lot of inter-budgetary transfers (hereinafter referred to as "IBT") are carried out.

With the introduction in 2013 of predominantly single-channel financing of health care at the expense of compulsory medical insurance funds [4], the budget of the compulsory medical insurance fund is currently the main source of funding health care in the Russian Federation (*Fig. 5*).

Revenues budgeting of the FCMI (see *Fig. 1*) is mainly due to insurance contributions for the CMI of the working population (65% in 2019): employers deduct 5.1% of the wage fund (hereinafter referred to as "WF").

Payers of insurance premiums for the non-working population are (authorized) executive authorities of the constituent entities of the Russian Federation (see *Fig. 1*): in fact, these are calculations within the budgetary system of the Russian Federation.

We elaborate on the issue of the obligation to pay insurance premiums for the compulsory medical insurance of the working population in more detail. Formally, it is entrusted to employers (acting as insurers of working citizens), who, in turn, in one way or another transfer it to employees. In fact, according to the author, we discuss the targeted taxation of the working population.

As you know, insurance contributions have replaced the unified social tax (hereinafter referred to as "UST"), i.e. they also have a tax origin. Since 2010, "compulsory payments intended to mobilize funds for the realization of the right of citizens to state pension and social security (insurance) and medical care" (Tax Code of the Russian Federation, Art. 234, repealed), were transformed into "compulsory payments for compulsory pension, social, medical insurance in order to financially ensure the implementation of the rights of insured persons" (Tax Code of the Russian Federation, Art. 8), which allows us to say that their essence has not changed from this. Until now, many accountants use the term "UST", implying insurance premiums.[8]

It is indicative that since 2017, the administration of insurance premiums has come under the jurisdiction of the Federal Tax Service of Russia (with the exception of contributions from industrial accidents and occupational diseases paid to the SIF). Moreover, at the

[8] Insurance premiums in 2021. URL: https://www.kontur-extern.ru/info/esn-strahovye-vznosy (accessed on 25.03.2021).

Table 1

Main characteristics of the autonomous, budgetary and governmental institutions (AI, BI, GI)

Feature	Characteristic	Application		
		AI	BI	GI
Type of organization	A non-profit organization created by the founder	+	+	–
	Government agency	–	–	+
Purpose	Provision of public services (performance of work, performance of government functions)	+	+	+
Normative legal regulation	"On Autonomous Institutions" dated 03.11.2006 No. 174-FZ	+	–	–
	"On non-profit organizations" dated 12.01.1996 No. 7-FZ, art. 9.2	–	+	–
	Budget Code of the Russian Federation of July 31, 1998, No. 145-FZ, Art. 161	–	–	+
Management	Presence of the supervisory board as a supervisory authority	+	–	–
State assignment for the provision of services	The founder forms and approves	+	+	–
	Can be formed, but not required	–	–	+
Financial support of activities	Compulsory medical insurance funds (in the field of health care)	+	+/–	–
	Regional budget funds: subsidies	+	+	–
	Regional budget funds: budget estimates	–	–	+
	Income from the provision of paid services (the possibility of obtaining)	+	+	+
Income generating activities	Self-management of the received income	+	+	–
	Crediting the income received to the (corresponding) budget	–	–	+
Disposal of property without the consent of the owner	Real estate: at the expense of the owner / own funds	–/+	–	–
	Particularly valuable movable property: at the expense of the owner / own funds	–/+	–/+	–
	The rest of the property (on the basis of operational management)	+	+	–
Control	Control over the activities is carried out by the founder	+	+	+
Reporting	Since 2012 it has been placed in the public domain (on the website bus.gov.ru)	+	+	+

Source: compiled by the author based on the Federal Laws (listed in the *Table*).

same time, initiatives were discussed to abolish insurance premiums and return the UST,[9] which remained at the development stage.

Employers were also payers of the UST (as well as insurance contributions), but in essence, they performed, rather, the functions of tax agents (i.e., intermediaries). When certain authors in their works propose to establish differentiated rates of insurance premiums for compulsory medical insurance —

[9] The government is thinking about returning the unified social tax. URL: https://www.forbes.ru/news/310791-pravitelstvo-zadumalos-o-vozvrashchenii-edinogo-sotsnaloga (accessed on 25.03.2021).

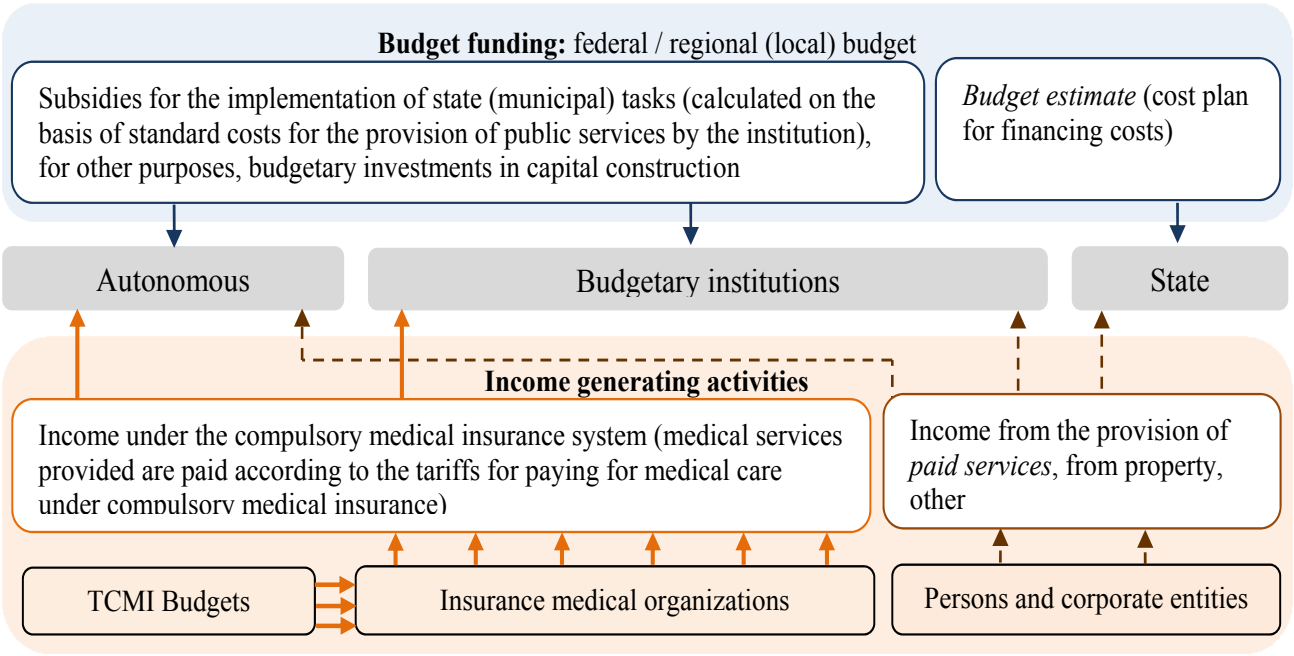

Fig. 6. **Financing mechanism of governmental (public) medical organizations**

Source: developed and compiled by the author based on the Federal Law of November 3, 2006, No. 174-FZ "On autonomous institutions" (latest version). URL: http://www.consultant.ru/document/cons_doc_LAW_63635/ (accessed on 25.01.2021); Federal Law of January 12, 1996, No. 7-FZ "On non-profit organizations" (latest version). URL: http://www.consultant.ru/document/cons_doc_LAW_8824/ (accessed on 25.01.2021); Federal Law of July 31, 1998, No. 145-FZ "Budgetary Code of the Russian Federation" (latest version). URL: http://www.consultant.ru/document/cons_doc_LAW_19702/ (accessed on 25.01.2021).

depending on the level of income [5], they mean the income of employees (not employers), the degree of solvency of the population (and not business entities). According to the author, individuals (and not legal entities) should be recognized as payers of insurance premiums, similar to the rules for levying personal income tax (PIT).

Thus, the author shares the opinion that the real (actual) source of funding for health care is the able-bodied, working population, those who create these funds by their own labor [6]. All kinds of budgets are just channels that transmit funds from consumers of medical services (population) to providers (MO), thus forming a very ramified structure.

FINANCING MECHANISM OF STATE (MUNICIPAL) MOs

The focus of attention is the state (municipal) MOs since they act as guarantors of the constitutional right of Russian citizens to free medical care.[10]

According to their organizational and legal form, all the state (municipal) MOs are subdivided into three types: autonomous, budgetary, and state institutions (*Table 1*).

Based on this, within the framework of the budgetary and insurance model, there are three possible ways of financing (*Fig. 6*) state (municipal) municipalities:

1. Compulsory health insurance funds + budget subsidies (+ paid services).
2. Budget subsidies (+ paid services).
3. Budget estimate (+ paid services).

As a result of the budget reform[11] the rights of autonomous and budgetary institutions for

[10] The Constitution of the Russian Federation, adopted on 12.12.1993 (as amended on 01.07.2020), Art. 41.

[11] Federal Law of 08.05.2010 No. 83-FZ (as amended on 15.10.2020) "On Amendments to Certain Legislative Acts of the Russian Federation in Connection with the Improvement of the Legal Status of State (Municipal) Institutions", Art. 5.

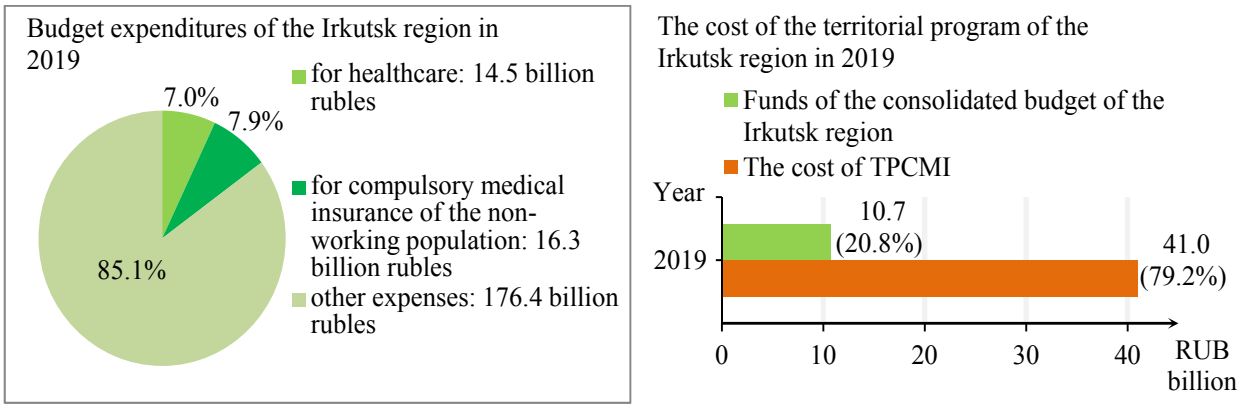

Fig. 7. **Healthcare expenditures of the Irkutsk region in 2019**

Source: Law of the Irkutsk region of October 12, 2020, No. 83-OZ "On execution of the regional budget in 2019" (latest version). URL: http://www.openbudget.gfu.ru/ispolnenie-budgeta/law/ (accessed on 25.01.2021); Resolution of the Government of the Irkutsk region of December 26, 2018, No. 965-pp "The territorial program of state guarantees for access to free-of-charge medical aid for citizens in Irkutsk region for 2019 and for the planned period 2020–2021" (latest version). URL: http://www.irkoms.ru/mo/cat/normativnyie-pravovyie-dokumienty-irkutskoi-oblasti-i-inyie-dokumienty (accessed on 25.01.2021).

financial management have been expanded: extra-budgetary revenues are transferred to the independent disposal of institutions.[12] At the same time, in the health sector, extra-budgetary revenues include both compulsory medical insurance funds and revenues from the provision of paid services.

The presence of three different channels for the receipt of funds distinguishes the healthcare sector (from other industries) and determines the uniqueness of the system of its financing.

Consider the composition of the participants in the territorial program. As an example (hereinafter), the territorial program of the Irkutsk region for 2019 is considered.

The budget expenditures of the Irkutsk region in 2019 on health care and insurance of the non-working population amounted to almost 15% of all expenditures (*Fig. 7*).

The cost of the territorial program of the Irkutsk region in 2019 was almost 80% formed at the expense of the compulsory medical insurance funds (*Fig. 7*).

The per capita funding standard is 20,768.7 rubles, of which:

- 4481.0 rubles — at the expense of the budget (per 1 resident);
- 16 287.7 rubles — at the expense of compulsory medical insurance (for 1 insured person).

In the territorial program of the Irkutsk region in 2019, 160 organizations participated, of which 76.9% are state-owned and 23.1% are private (*Table 2*). At the same time, 85.4% of state MOs are financed under the compulsory medical insurance system: they carry out activities in accordance with obligations to the insurer under compulsory medical insurance and state order.

In the context of predominantly single-channel financing, most of the state MOs working in the CMI system are financed according to a mixed model, but with a predominance of CMI funds (*Fig. 6*).

At the same time, the ratio of funding sources can vary — from full-fledged two-channel financing (if the income from paid services is not considered) to one-channel in its pure form or almost so. We consider these cases and the procedure for financing the MO under the territorial program as a whole (*Table 3*).

Due to the change in the forms of the territorial program annexes in 2019, the data are given for 2018 (*Table 3*).

[12] Federal Law of 30.11.1994 No. 51-FZ (as amended on 08.12.2020) "Civil Code of the Russian Federation (Part One)", Art. 298.

Table 2

List of participants in the territorial program of the Irkutsk region in 2019

Organizational and legal forms	Types of organizations
Participants of the territorial compulsory medical insurance program of the state health care system: 105 organizations	
FSBHI (federal state budgetary healthcare institution); FSHI (federal state healthcare institution); FSBSI (federal state budgetary scientific institution); FSBEI HE (federal state budgetary educational institution of higher education); FSBEI APE (additional professional education), FSAI (federal state autonomous institution); RSBHI (regional state budgetary healthcare institution); RSAHI (regional state autonomous healthcare institution); RSBISS (regional state budgetary institution of social services)	Outpatient clinic, medical unit, hospital, dispensary, ambulance, hospital, health center, center, bureau, university, institute, academy
Participants of the territorial compulsory medical insurance program of the private health care system: 37 organizations	
OOO (limited liability company); AO (joint-stock company), ZAO (closed AO); ANO (autonomous non-profit organization); Private institution, private healthcare institution	Outpatient clinic, medical unit, clinic, hospital, health center, resort, center, airport
Medical organizations that do not carry out activities in the field of compulsory medical insurance: 18 organizations	
RSBHIZ (regional state budgetary healthcare institution); RSGHI (regional state government health institution)	Hospital, dispensary, hospice, blood transfusion station, center, office, orphanage

Source: compiled by the author based on the Resolution of the Government of the Irkutsk region of December 26, 2018, No. 965-pp " The territorial program of state guarantees for access to free-of-charge medical aid for citizens in Irkutsk region for 2019 and for the planned period 2020–2021" (latest version). URL: http://www.irkoms.ru/mo/cat/normativnyie-pravovyie-dokumienty-irkutskoi-oblasti-i-inyie-dokumienty (accessed on 25.01.2021).

An example of two-channel financing is the activity of an institution of such a profile as a dermatovenerologic dispensary (*Table 3*), which provides medical care for dermatological diseases and sexually transmitted diseases (exclusions from the compulsory medical insurance, *Fig. 3*).

Among the participants in the territorial program of the Irkutsk region in 2018, the state health care system, the geriatric center, and the medical-sanitary unit (*Table 3*) provided services only at the expense of the compulsory medical insurance funds (like all private municipalities, which, by definition, are not financed from the budget).

Table 3 shows the cases where the degree of state participation in the financing of the services provided is minimized.

At the expense of the budget, 1 type of medical care is co-financed [outpatient clinics, perinatal centers, hospital (1), children's hospital], 2 types [hospital (2), city hospital], 3 types (district hospital), while the share of budget funds does not exceed 1–2%. In physical terms, these are very small volumes of medical care: from several tens, hundreds to 1.4 thousand units (*Table 3*).

UNDER STATE CONTROL: BUDGET SEGMENT

The segment of institutions that do not carry out activities in the field of compulsory medical insurance occupies a special place in the budgetary and insurance model of health care financing.

Table 3

Planned volumes of medical care in 2018 (some examples)

Type (profile) of activity (all RSBHI, RSAHI)	Hospitalizationcases (share, %)		Outpatient care (calls, visits): (share, %)					Patients treated in day hospitals (share, %)	
			call	visit	call	visit	Emergency		
	Budget	CMI	Budget-funded		CMI-funded			Budget	CMI
Regional dermatovenerologic dispensary	1950 (59.0)	1354 (41.0)	50032 (59.3)	50260 (61.9)	34400 (40.7)	30900 (38.1)	–	116 (6.3)	1713 (93.7)
Regional senior centre	–	980	–	–	10380	5500	1735	–	84
Medical and sanitary part	–	–	–	–	45050	36895	11765	–	3200
City clinic (1)	–	–	130 (0.2)	995 (1.6)	72614 (99.8)	61740 (98.4)	12233	–	2871
City clinic (2)	–	–	334 (0.4)	1358 (0.9)	78138 (99.6)	142451 (99.1)	22004	–	3137
Perinatal center (1)	30 (0.5)	6535 (99.5)	–	–	10400	37348	–	–	1234
Perinatal center (2)	98 (0.7)	14004 (99.3)	–	–	8476	24900	2600	–	1255
City hospital (1)	240 (1.3)	18508 (98.7)	–	–	109313	193900	55095	–	3763
City hospital (2)	37 (0.6)	6167 (99.4)	–	120 (0.1)	68702	90053 (99.9)	20832	–	1700
City children's hospital	311 (1.5)	19900 (98.5)	–	–	3250	–	59000	–	1750
City hospital	89 (1.9)	4677 (98.1)	1254 (1.3)	242 (0.3)	97654 (98.7)	91405 (99.7)	26911	–	3238
District hospital	12 (1.6)	747 (98.4)	40 (0.9)	132 (1.4)	4279 (99.1)	9540 (98.6)	800	Ambulance calls	
								20 (2.1)	920 (97.9)

Source: compiled and calculated by the author based on the Resolution of the Government of the Irkutsk region of December 28, 2017, No. 882-pp "The territorial program of state guarantees for access to free-of-charge medical aid for citizens in Irkutsk region for 2018 and for the planned period 2019–2020" (latest version). URL: http://www.irkoms.ru/mo/cat/normativnyie-pravovyie-dokumienty-irkutskoi-oblasti-i-inyie-dokumienty (accessed on 25.01.2021).

Table 4

Characteristics of health care institutions that do not work in the CMI sector

Type of medical organization	Activity	Organizational and legal form
Hospital, dispensary: 3 org.	Psychiatric and drug addiction medical care	RSGHI, RSBHIZ
Hospital, dispensary: 3 org.	Medical care for tuberculosis patients	RSBHIZ
Hospital, hospice: 2 org.	Palliative medical care	RSBHIZ
Center: 2 org.	AIDS prevention and control; preventive measures	RSBHIZ
Bureau: 1 org.	Forensic medical examination	RSBHIZ
Blood transfusion station:1 org.	Procurement of donor blood and its components	RSBHIZ
Children's home: 5 org.	Child care (children without parental care)	RSGHI
Dispensary (medical and physical education): 1 org.	Medical care in sports, physical culture, rehabilitation	RSBHIZ

Source: see *Table 2*.

We consider their composition using the example of participants in the territorial program of the Irkutsk region in 2019 (*Table 4*).

In accordance with the State Guarantee Program (*Fig. 3*), the regional budget funds are financed (*Table 4*):

- medical care for diseases-exclusions from the compulsory medical insurance program;
- palliative care;
- medical care, public services in AIDS prevention and control centers, medical prevention centers, forensic medical examination bureaus, blood transfusion stations, children's homes, medical and physical dispensaries, etc. (with the exception of types of medical care provided at the expense of compulsory medical insurance).

By their organizational and legal form, most of the institutions are budget-funded (*Table. 4*).

Clinical psychiatric hospitals and orphanages were transformed into state-owned hospitals in accordance with the requirements of the legislation of the Russian Federation.[13]

We consider the procedure for financing these institutions (*Table 5*).

All types of medical care provided by these institutions in 2018 were financed from the regional budget (*Table 5*).

An exception is an activity of a medical and physical dispensary (*Table 5*), where 0.03% of the volume of medical care (in terms of the types included in the basic CMI program) is planned at the expense of CMI funds (considering that treatment is a complete case treatment with a frequency of visits of at least 2).

Let us consider what caused the exclusion of certain diseases from the CMI program (*Fig. 3*).

Diseases not included in the compulsory medical insurance program are included in the List of socially significant diseases and diseases that pose a danger to others,[14] due to the high level of disability and mortality of the population, a decrease in the life expectancy of patients

[13] Federal Law of 08.05.2010 No. 83-FZ (as amended on 15.10.2020) "On Amendments to Certain Legislative Acts of the Russian Federation in Connection with the Improvement of the Legal Status of State (Municipal) Institutions", Art. 31.

[14] Resolution of the Government of the Russian Federation of 01.12.2004 No. 715 (as amended on 31.01.2020) "On approval of the list of socially significant diseases and the list of diseases that pose a danger to others".

Table 5

Planned volumes of medical care in 2018 (non-CMI)

Type (profile) of activity	Impatient days	Hospitalization cases	Outpatient care:			Treated in a day hospital, budget-funded
			call	visit	call	
	budget-funded		budget-funded		CMI-funded	
Mental hospital	–	4102	–	–	–	646
Mental hospital	–	974	–	–	–	–
Psychoneurological dispensary	–	7020	35 233	109 331	–	2783
Tuberculosis hospital	–	3484	39 934	163 965	–	326
Tuberculosis hospital	–	330	–	–	–	–
Tuberculosis dispensary	–	542	1706	2854	–	61
Hospital (hospice)	31 500	–	–	1343	–	–
Hospice	5331	–	–	284	–	–
AIDS Center	–	–	–	84 576	–	–
Medical exercises dispensary.	–	–	–	78 871	10	–

Source: compiled by the author based on *Table 3*.

(along with hypertension, diabetes mellitus, cancer, etc.)

The provision of medical care for these diseases is regulated by separate federal laws (*Table 6*).

In addition, in 2020, an inter-sectoral Federal Law "On Biological Safety" was adopted, according to which the main biological threats include: tuberculosis, HIV infection, viral hepatitis.[15]

Thus, the exclusion of certain types of medical care from the CMI program is dictated by the need to implement the following measures:

1. Implementation of the most complete state control over the system of medical care to prevent the critical level of the spread of dangerous pathologies in society.

2. Ensuring compliance with the legality of certain types of medical activities in the form of establishing a state monopoly on them.

3. Reducing the risks associated with the activities of medical institutions in the compulsory health insurance system.

What these risks are is a separate question. However, the non-inclusion of socially significant diseases in the compulsory health insurance program directly indicates the presence of such risks.

As for the provision of palliative care, this is an important issue that has not only a medical, but also a social, social, moral dimension.[16]

The need to create a new direction in medicine — palliative care — was announced by the World Health Organization (hereinafter referred to as "WHO") in 1982 [7].

[15] Federal Law dated 30.12.2020 No. 492-FZ "On biological safety".

[16] Message of the President of the Russian Federation to the Federal Assembly of 02.20.2019.

Table 6

Government regulation of certain types of medical care

Type of medical care	Federal Law	Funding / Organization Information
Medical care for HIV-infected, AIDS patients	From 30.03.1995 No. 38-FZ "On the prevention of the spread in the Russian Federation of a disease caused by the human immunodeficiency virus (HIV infection)", Art. 4	Events (in subordinate MOs) are financed from the federal budget, the budgets of the constituent entities of the Russian Federation, municipal entities (Art. 6)
Medical care for patients with tuberculosis	From 18.06.2001, No. 77-FZ "On the prevention of the spread of tuberculosis in the Russian Federation", Art. 7	Assistance is provided by licensed anti-tuberculosis medical institutions (Article 8); a system for aiding in specialized federal and regional MOs has been organized (Articles 4, 5)
Psychiatric care	Law of the Russian Federation of 02.07.1992 No. 3185–1 "On psychiatric care and guarantees of the rights of citizens during its provision", Art. 16	Assistance (in subordinate MOs) is financed from the federal budget, the budgets of the constituent entities of the Russian Federation (Art. 17)
Drug treatment	From 08.01.1998 No. 3-FZ "On drugs and psychotropic substances", Art. 54	Treatment of patients (treatment of mental and behavioral disorders caused by the use of psychoactive substances) is carried out only in the state (municipal) MOs (Art. 55)
Donation of human organs and tissues and their transplantation (new bill published)	From 21.11.2011 No. 323-FZ "On the basics of protecting the health of citizens in the Russian Federation", Art. 47; Law of the Russian Federation of December 22, 1992, No. 4180–1 "On transplantation of human organs and tissues."	Fence, procurement, organ, and tissue transplantation are carried out in the state and municipal MOs (Law of the Russian Federation No. 4180–1, Art. 4), the list of which is approved by order of the Ministry of Health of Russia and the Russian Academy of Sciences
Palliative care	From 21.11.2011 No. 323-FZ "On the basics of protecting the health of citizens in the Russian Federation", Art. 36	MO sends a request to the constituent entity of the Russian Federation for the provision of social services. service to the patient (regulation on the organization of the provision of palliative medical care, clause 18, approved by orders of the Ministry of Health of Russia No. 345n, Ministry of Labor of Russia No. 372n of 05.31.2019)

Source: compiled by the author.

CALCULATING THE COST OF THE TERRITORIAL PROGRAM

The cost of the territorial program (and the cost of TPCMI) is calculated as the sum of the products of the volumes (of various types) of medical care and the financial costs of their provision (this is how the per capita funding standard is approved) with subsequent multiplication by the number of permanent/insured population of the constituent entity of the Russian Federation.

The key powers in the formation of the territorial program are the distribution of the volume of medical care between the MO; setting tariffs for paying for medical care under compulsory medical insurance.

The main problem in the formation of territorial programs is balancing:

- the financial capabilities of the constituent entity of the Russian Federation (which are limited by the size of the subvention provided to the TCMI budget from the FCMI budget, and by the level of regional budget revenues);
- the financial needs of the territorial network of MOs (which includes both state organizations, by default, and private, upon notification).

Based on the total amount of subventions (set in the budget), the FCMI calculates the subventions for each region based on indicators[17] such as:

- standard of financial support for the main compulsory medical insurance program;
- the number of the insured population;
- the coefficient of differentiation (for a given constituent entity of the Russian Federation), the coefficient of adjustment for the share of participation of federal MOs (innovations).

First of all, based on the size of the subvention from the budget of the FCMI, the regions calculate the amount of funding for the MO. In this case, the formula for calculating the cost of the territorial program can be represented in the form of the equation:

$$Sub + B = \sum_{i=1}^{n} (Vol_{ai} * Exp_a + Vol_{bi} * Exp_b + Vol_{ci} * Exp_c),$$

where $Sub + B$ — subvention and the approved amount of budgetary funds, rubles;

a, b, c — types of medical care;

Exp_a, Exp_b, Exp_c — standards of financial expenses per unit volume of medical care, rubles;

Vol_{ai}, Vol_{bi}, Vol_{ci} — volumes of medical care for the i-th MO, unit;

n — number of MOs.

The program of state guarantees sets average standards (volumes of medical care and financial costs). According to this, but considering regional characteristics, territorial (differentiated) standards are established in territorial programs: for 1 resident, for 1 insured per year.

When multiplying the volume standards by the population of the region, the total (planned) volumes of medical care are obtained, which are then distributed among medical institutions.

Therefore, the only variable in this formula that can be changed (while maintaining the overall value) isVol_i, that is, the volume of medical care for each specific MO.

The basis for the formation of the territorial program[18] is the population's need for medical care (determined according to medical statistics). Thus, in TPCMI, the volumes of medical services are distributed between medical institutions, based on the needs of the insured for medical care and the population attached to outpatient medical institutions.[19] At the same time, exceeding the established volumes entails the application of sanctions to MOs.

However, the payment for medical care under compulsory medical insurance — the calculation of the cost of medical services and the setting of tariffs — involves the use of coefficients that allow taking into account the differences in the amount of expenses of the medical organization.[20] These include (except for the coefficients reflecting the cost intensity of treatment cases): the coefficient of differentiation, established for individual territories at the federal level, and correction coefficients established at the regional level, including the coefficient of the level (sublevel) of medical services and the coefficient of the specificity of medical care.

There is a three-level system for organizing medical care in Russia, in addition to this,

[17] Resolution of the Government of the Russian Federation of 05.05.2012 No. 462 (as revised on 08.10.2020) "On the procedure for the distribution, provision, and spending of subventions from the FCMI budget to the TCMI budgets for the implementation of the powers of the Russian Federation in the field of CMI transferred to the state authorities of the constituent entities of the Russian Federation.".

[18] Letter of the Ministry of Health of Russia dated December 31, 2020, No. 11–7 / I / 2–20700 "On the direction of clarifications on the formation and economic justification of territorial programs of state guarantees of free provision of medical care to citizens for 2021 and the planning period of 2022 and 2023".

[19] Tariff agreement for payment of medical care for compulsory medical insurance in the Irkutsk region. 30.12.2020.

[20] Letter of the Ministry of Health of Russia dated 12.30.2020 No. 11–7 / I / 2–20691, MHIF No. 00–10–26–2–04 / 11–51 "On methodological recommendations on methods of paying for medical care at the expense of compulsory health insurance funds".

sublevels (no more than 5) can be allocated for each level, also with the establishment of coefficients.

Specificity coefficients (the management coefficient was previously used) can be applied to specific diagnosis-related groups of diseases (DRG) or set considering such criteria as population density, transport accessibility, climatic and geographical features of regions, achievement of target indicators, etc. When calculating the coefficients of specificity for medical organizations that provide outpatient care and have an attached population, age and gender differentiation coefficients (set depending on the structure of the population) are considered.

Thus, the tariffs for the provision of medical care under compulsory medical insurance are differentiated depending on the characteristics of the medical organization.

While the distribution of the volume of medical care in the territorial program does not take into account the specifics of MO (see *the formula for calculating the cost of the program*), which can only be adjusted by redistributing the volume of services.

However, firstly, as a result of such an adjustment, the needs of the population in medical care are distorted; secondly, such a method (of establishing volumes) cannot be considered economically justified at all.

Therefore, the adopted method of distributing the volume of medical care (i.e., the amount of funding for medical organizations) is not accurate, since it does not take into account the difference in the cost of providing medical services by different medical organizations.

In addition, other factors, such as the need for personnel, the state of the material and technical base, buildings and structures, etc., can influence the real size of the expenses of the MOs.

The method used for calculating the amount of funding for medical organizations is focused on "results management" (payment for the number of services rendered), and not on "cost management" (financing the costs of maintaining a network of institutions). However, given the fact that health outcomes management is a complex non-linear process [8], this approach does not always work correctly. It seems that in order to calculate the amount of financing for medical organizations, the cost accounting method should also be used (if not as the main one, then as a complementary one).

Thus, in order to develop measures to ensure the financial balance of the territorial program, at least several conditions are necessary.

First, it is required to accurately establish the size of the deficit (surplus) of funds. To do this, it is necessary to define the "financial needs of the territorial network of MOs" as the amount of funds sufficient for the proper functioning of each MO that is part of the network.

Second, the territorial network itself should be formed. The Ministry of Health of Russia recommends, within the framework of the territorial program, the distribution of medical facilities by levels. Also, according to the author, it is advisable to separate state (municipal) and private municipalities. The FCMI has already announced plans to change the principle of including private medical organizations in the CMI system from notification to declarative.[21]

CMI REFORM: AMENDMENTS TO THE BASIC LAW

The main legislative innovation in 2020 was the introduction of amendments to the law on compulsory medical insurance,[22] which modify the financing mechanism of federal municipalities.

From 2021, the activities of federal medical organizations providing specialized medical care (including high-tech) under the CMI program will be financed directly from the Compulsory Medical Insurance Fund, bypassing both the TCMI and the MIO.

[21] FFCMI: In 2020, 148.5 billion rubles are planned for the operation of private clinics in the CMI. URL: https://vademec.ru/news/2020/07/24/ffoms-v-2020-godu-na-rabotu-chastnykh-klinik-v-oms-zaplanirovano-148–5-mlrd-rubley/ (accessed on 26.02.2020).

[22] Federal Law No. 430-FZ of 08.12.2020. "On Amendments to the Federal Law "On Compulsory Medical Insurance in the Russian Federation".

At the same time, the procedure for distributing the volume of medical care and determining tariffs is established by the Government of the Russian Federation as part of the basic compulsory medical insurance program. The responsibility for monitoring medical care is transferred to the FCMI.

Payment for medical care will be carried out on the basis of a new form of contract: for the provision and payment of medical care within the framework of the basic compulsory medical insurance program (concluded between the federal MOs and the Compulsory Medical Insurance Fund).

At the same time, the federal MOs has the right to provide medical assistance under TPCMI — if the volume of health care is established for it.

Certain changes affect the activities of TCMI and MIO.

In particular, medical care provided to an insured person in another region of the Russian Federation will be paid for (and controlled) by the TCMI, and not by the medical insurance company.

The MIO retains the responsibility for monitoring medical care (including the conduct of a medical and economic examination, examination of the quality of medical care), while the obligation to conduct medical and economic control is assigned to the TCMI (it has the right to carry out any control measures, including repeatedly).

In addition, the new law provides for a reduction in the amount of funds allocated for the management of cases under compulsory medical insurance: from 1–2 to 0.8–1.1% of the amount of funds received by the health insurance organization (according to differentiated per capita standards). Initially, it was planned to cut the amount of remuneration of the insurance company by half, but due to the basic disagreement with the ongoing reform on the part of insurance companies, the value of the standard was adjusted.

During the discussion of the draft law, representatives of the Accounts Chamber of the Russian Federation, the Ministry of Finance of Russia, and the Bank of Russia also expressed concern about the departure from insurance principles in the CMI system [9].

As noted by the auditors of the Accounts Chamber of the Russian Federation,[23] the new law will require the adoption of a significant number of bylaws, including due to the heterogeneity of the changes introduced.

Today in Russia there are several dozen federal MOs providing specialized assistance. The adopted amendments are intended to solve the problem of underfunding of their activities within the framework of TPCMI. Due to a lack of funds, federal institutions were allocated insufficient volumes of medical care at tariffs that did not reimburse their actual costs [10]. According to experts, a change in the funding mechanism will be able to guarantee the stability of medical organizations and confidence that their capacities will work for the benefit of patients [11].

FINANCIAL MODEL DESIGN AND THE PROBLEMS OF ITS FUNCTIONING

The dual nature of the financial model of public health is manifested in the presence of external (income) and internal (expenditure) parties [12].

The subject of this study was the "external block", which includes mechanisms for the formation and distribution of financial resources by the state intended to ensure the protection of public health.

Mechanisms for the use of financial resources ("internal block"), including the organization of the health care system as a whole and the activities of the health care system in it (formation of reports for the provision of medical services and methods of payment, disposal of income, accounting and justification of costs), as well as methods of establishing tariffs for compulsory medical insurance, the calculation of subsidies and the amount of estimated financing are outside the scope of this article.

[23] The Accounts Chamber has prepared an opinion on amendments to the law on CMI. URL: https://ach.gov.ru/expertise/schetnaya-palata-podgotovila-zaklyuchenie-na-popravki-v-zakon-ob-oms (accessed on 25.01.2021).

The existing model of health care financing has developed as a result of gradual transformations, primarily due to the development of the CMI system [13]. The nature of the construction of the budgetary insurance model rather testifies to the empirical path of its formation, to the absence of scientific support for the process of reforming financial relations [12].

At the heart of building a budgetary insurance model, if we briefly summarize the results of the study, is the compulsory medical insurance program as the core and a long list of exceptions in the periphery: certain types of medical care and drug provision, activities, activities, and individual costs [14].

Diseases (from the list of socially significant and posing a danger to others) and activities (requiring state supervision) that are not included in the CMI program stand apart.

At its core, the CMI system, which is responsible for the insurance component of the combined model [15], is not insurance in the generally accepted sense. Commercial insurance involves the insurer's assessment of the insurance risk, probable losses, and profits, as well as the possibility of establishing individual insurance conditions (volumes of insurance obligations, amounts of premiums, and payments) depending on the characteristics of the insured and the solvency of the policyholder.

The CMI does not pursue the goal of making a profit (FCMI is a non-profit organization), it provides uniform rules for the provision of (free) medical care and uniform insurance premium rates for the entire population. Payment of insurance premiums for the non-working population is carried out at the expense of budget funds [16]. This makes it possible to ensure the universality and free of charge of Russian health care, since compulsory medical insurance, by definition, is a type of social insurance.

For the period 2015–2019 healthcare expenditures of the consolidated budget of the Russian Federation and the budgets of the State non-budgetary fund[24] increased by almost 1/3, or by 32.5% (from 2861.0 to 3789.7 billion rubles).

At the same time, the problem of underfunding the activities of health care institutions persists. Thus, the report of the specialists of the Higher School of Economics points to the difficult economic situation of many municipalities, the growing financial problems of the industry. The authors see the main reasons for this in the declining volume of financing for health care and the rise in prices for medicines, medical equipment, and consumables caused by the weakening of the ruble [10].

The problems of funding health care are concentrated not so much in the formation of funds but their distribution and use. Even an increase in the volume of financing for the industry — without changing its organizational and economic system — may not provide the expected results.

In order to increase the volume of financing for the industry, it would be necessary to increase the rate of the insurance premium. However, an increase in the social burden on the payroll in the Russian economy is undesirable, since this may entail an underestimation of the official size of wages and the number of employed [17].

What is causing the rise in costs? Is it only inflationary processes?

According to American authors, the provision of medical services on a free basis leads to excess demand for them and, as a consequence, an increase in health care costs [18]. However, there is reason to believe that in Russia most of the population still does not go to a doctor unnecessarily. Considering the fact that accounting is carried out in electronic form [19], it is possible to conduct an appropriate study.

[24] Reporting of the Treasury of Russia on budget execution. URL: https://roskazna.gov.ru/ispolnenie-byudzhetov/ (accessed on 25.01.2021).

If there "medical care for all" is a dream unattainable for many [20], here it is a tradition, a custom. And it should not be forgotten that the "free" of Russian health care is provided at the expense of the payers of insurance premiums, which are not subject to repayment [21].

At the same time, in Russia, neither the state, nor business, nor society shows the proper interest in investing in the quality of life of the population [22]. Therefore, the most acceptable way for Russia is to reform the health care system in its traditional way. Copying foreign experience in the social sphere, at best, only leads to imitation of forms and methods of work [23].

Thus, the introduction of the principles of commercial insurance in the CMI can lead to a decrease in the volume of social guarantees, discrimination of patients in relation to medical care, and a weakening of the country's ability to withstand global challenges. Strategic risks to the health of the population require mandatory state control of key processes in the medical industry [3].

The growing demand for healthcare services in Russia is largely determined by objective factors such as demographic changes and the associated burden of disease [3].

However, it is more appropriate to speak not about excess demand, but about limited volumes of medical care. When forming the cost of territorial programs, the volumes of medical services are balanced with the available financial resources, which, on the one hand, causes the "queuing phenomenon" [3], and on the other hand, the underfunding of (part of) healthcare institutions.

The CMI system is based on a fee payment method, i.e. proclaimed the transition from providing health care institutions with financial resources to earning them, depending on the volume and quality of services provided [6]. The problem of distribution of financial resources (volumes of medical care) within the framework of territorial programs is directly related to the concept of equity. The question is: on what grounds should the "search for compromise solutions" [12] between equity and economic efficiency be carried out?

But in addition to the objective reasons for the growth of health care costs (such as the state of health of the population, inflationary component), there are others. The problem with Russian healthcare is that expenditures are growing at a faster pace (compared to income). One gets the impression that no matter how much money is added, there will still be little, which levels the FCMI's achievements in collecting insurance premiums [1]. Obviously, the reasons for this phenomenon lie in the system itself.

CONCLUSIONS

The problems of funding health care are concentrated not so much in the formation of funds but their distribution and use. Even an increase in the volume of financing for the industry — without changing its organizational and economic system — may not provide the expected results.

Based on the foregoing, three main problems can be identified when building a budgetary and insurance model for financing health care and, in accordance with this, determine the goals and directions of further research:

1. Congestion. A polystructural and asymmetric financial model unnecessarily complicates financial flows. This includes both settlements in the CMI system and between budgets of all levels in the process of co-financing health care costs. All this creates significant non-production costs (transaction costs).

Among the reasons for the global financial crisis of 2007–2008 is called the "burden" of transaction costs, which fell primarily on the financial sector of the economy [24]. To reduce transaction costs, which tend to increase in the presence of a "gray" economy, corruption, and other illegitimate relations in the country [25], the organization of the health care system and the mechanism of its financial support must be considered. Among the many factors

causing problems in the health care system, the organization is critical [26].

According to the author, at the first stage, it would be necessary to abandon the excessive fragmentation of the financing of the MOs. In particular, it is irrational to finance 1–2% of the (homogeneous) services provided by the institution at the expense of budget funds (*Table 3*) or, conversely, at the expense of compulsory medical insurance funds (*Table 5*). It is necessary to delimit the powers of financing a medical organization so that from one source not 95–99% of medical services within one institution are financed, but 100%.

Fragmented funding and administration have been identified by WHO as one of the main reasons for the inefficient use of health system resources.[25]

According to the author, the prospects for ensuring the consolidation of funding sources for the state (municipal) MOs lie in the structuring of the territorial network of MOs: the allocation of subsystems of institutions. In principle, the reform of the health financing mechanism in accordance with the changes introduced by the new law is being carried out in this direction.

2. Inconsistency. We are discussing a potential conflict between the main goal of public health (ensuring the provision of medical care to the population in terms of free, accessibility, and quality) and its commercial component (financial incentives for activities).

To minimize the existing contradictions, it is necessary to analyze the motivation of all participants in the health care system and, based on this, adjust their functional roles and financial relations. It is necessary to consider the following principles: the unity of the goal of health care; economy, fairness and transparency in the use of resources; accountability of actors and governing bodies of the health system at different levels.

One of the most illustrative examples of distorted motivation is that MIOs (for detecting violations) receive a certain percentage of the amounts paid by the MOs as a result of the application of sanctions to them (326-FZ, Art. 28). In fact, there is a "monetization of violations" (MIOs are interested in the presence of violations, and not in the absence).

Moreover, from the point of view of motivation, it is doubtful not only the method of remuneration for the performance of functions to control the quality of medical care, but also this measure itself (application of penalties) as such.

One cannot but agree that the goal of health care reform should be the continuous improvement of the quality of medical care.[26] But the mechanism of applying sanctions against the MOs does not, in itself, contribute to qualitative transformations; it is necessary to envisage other measures stimulating real changes in this area.

Rather, control is a discipline tool. And if the use of monetary fines is still necessary, then again, one should use the coefficients of differentiation, which are set depending on the level of income of the medical organization (including from paid services).

3. Cost intensity. In the health care system, incomes "do not keep pace" with expenditures. It is necessary to identify the intra-system factors of the outstripping growth of costs and the possibility of their elimination. To solve this most important problem, it seems that joint efforts of the professional and scientific community are needed.

Neither the ministries and departments nor the chambers of control and accountability set the goals (objectives, subject) of their monitoring and expert and analytical activities in relation to state (municipal) MOs, in a context that assumes a non-standard approach without being limited by any framework. Science not only fixes the connections and dependencies of economic processes but also reveals their deep, "invisible" unscientific view of nature [27].

[25] World health report. Financing of health systems. The road to universal health coverage. WHO, 2010. URL: https://www.un.org/ru/development/surveys/docs/whr2010.pdf (accessed on 28.02.2021).

[26] The Ljubljana Charter on Reforming Health Care in Europe. URL: https://www.euro.who.int/ru/publications/policy-documents/the-ljubljana-charter-on-reforming-health-care,-1996 (accessed on 28.02.2021).

At present, a methodological basis has not been formed for conducting a comprehensive analysis of the financial and economic activities of health care institutions, which would fully consider the industry specifics in modern conditions (and the set research task is even more multifaceted). Therefore, despite the steps taken in this direction, there remains a high need for conducting such studies based on healthcare institutions of various types and levels.

Health systems are losing money, according to the WHO report. At the same time, most countries do not use the available resources to the full due to irrational or inappropriate spending of funds, poor management of factors of production.

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ABOUT THE AUTHOR

Elizaveta A. Soboleva — Master's Degree (Banking and Finance), Baikal State University, Irkutsk, Russia
econo2017@yandex.ru

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