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Human Rights and Health Care Reform: Lessons for the Former Soviet Union

David F. Chavkin

American University Washington College of Law

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BRIEF

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International Legal Community Makes Strides in Developing International Norms for Protecting and Assisting Internally Displaced Persons

by Ellen B. Zeisler

While world attention has focused on the problems of refugees, forced to flee their countries to escape persecution or armed conflict, an even greater number of individuals facing such crises remain in their own countries, uprooted from their homes or places of habitual residence. These internally displaced persons (IDPs) are like refugees in that they are vulnerable to discrimination and violations of their basic human rights. Unlike refugees who are protected in large part by major international conventions, however, international law frequently fails to protect the special needs of the internally displaced.

The United Nations High Commissioner for Refugees (UNHCR) estimates that there are approximately 13.2 million refugees in the world today. The Washington-based foreign policy think tank, the Brookings Institution, estimates that IDPs number between 20-25 million. Refugee law obliges states which are parties to the major refugee conventions to afford bonafide refugees certain rights. Internally displaced persons who do not cross international boundaries often have the same protection and assistance needs as refugees but are not covered by international

refugee instruments since they do not qualify as refugees.

Appointment of a UN Representative on Internally Displaced Persons

In response to the growing phenomenon of IDPs worldwide, the international community has in recent years focused on formally promoting the rights and needs of the internally displaced. In 1992, the UN Secretary-General, at the request of the UN Commission on Human Rights, appointed Dr. Francis M. Deng as the Representative on Internally Displaced Persons. Dr. Deng, a former Sudanese diplomat and Minister of State, was assigned the task of examining the problem of IDPs by undertaking missions to countries with large displaced populations. With some 35-40 countries facing acute problems of internal displacement, the Secretary General's Representative has already visited the former Yugoslavia, the Russian Federation, Somalia, the Sudan, El Salvador, Sri Lanka, Colombia, Burundi, Rwanda, Peru, Tajikistan and Mozambique. On the ground, Deng assesses the protection and assistance needs of IDPs and dialogues with governments and other relevant actors regarding the treatment of IDPs.

Deng is also addressing the problem of creating an effective institutional framework within the United Nations for dealing with internal displacement. No UN agency currently has an express mandate to protect and assist IDPs. The

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Human Rights and Health Care Reform: Lessons for the former Soviet Union

by David F. Chavkin*

For the past several years, since the dissolution of the Soviet Union, the United States has been working with such allied institutions as the World Bank to convert the economic systems of the former Soviet Union (FSU) countries from state socialism to free market economies. One of the areas in which the United States has been encouraging reform is in the health care financing and delivery systems of these newly independent states.

While the United States has much to teach Eastern Europe in the delivery of high technology health care services, there is good reason for the United States to proceed slowly in urging the

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FSU countries to embrace America's free market health care model. Both political stability and basic health status hang in the balance as these newly independent countries decide on the course of health care reform.

Health Care as a Human Right

Although the term "human right" conjures up images of freedom of speech and freedom from torture, there is strong support for including health care within the constellation of fundamental human rights that should be protected in civilized societies. Article 25, section 1 of the United Nations Universal Declaration of Human Rights provides that, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and *medical care* and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." (Emphasis added.) The Constitution of the World Health

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Organization (WHO) similarly provides that, "Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures." The WHO Constitution defines "health" broadly to encompass "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Defining health care as a basic human right only takes this discussion so far, however. If health care is a human right, who has the duty to ensure its availability—government or individual health care providers? If health care is a human right, how much health care is someone entitled to—all medically necessary care or something less

than that? If health care is a human right, how do we finance a system to ensure its availability—through general tax revenues or through some other system?

The Special Status of Health Care

In thinking about reform of a health care financing and delivery system, it is important to first think about the special status of health care in most societies. For a variety of reasons, citizens perceive health care as different from most other commodities or services. It is the weight given these reasons that helps explain why health reform must be given special attention.

First, every citizen is a potential or current patient and, therefore, recipient of health care services. Second, health care is a commodity cherished by every citizen. Because of the relationship between health care and life itself, citizens regard health care in a special way. Third, health care is a commodity whose availability is assumed by every citizen. This is especially true in the countries of the FSU where the Soviet system was designed to guarantee a basic level of health care for all citizens.

There are at least two other reasons why reform of the health care financing and delivery systems deserves special attention. First, from a *budgetary* perspective, we need to give health reform special attention because the health care system has the capacity to drain dollars from national economies that need to be used for roads, education, defense, and other priorities. Only so much money is available to meet the responsibilities taken on by governments. Monies spent on health care necessarily must be taken away from meeting other needs.

While health reform may be appropriate, it does no good to design and implement thoughtful and creative reforms if the impact will be to make the government susceptible to political demagogues.

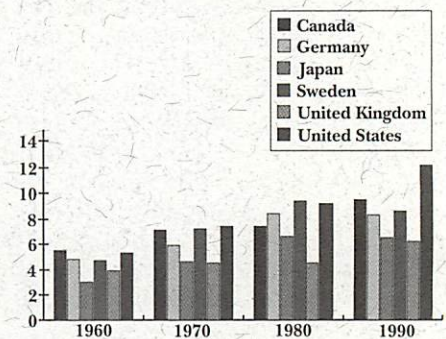
Second, from a *political* perspective, we need to give health reform special attention because access to health care can rouse such strong feelings among the citizenry. For example, the Conservative government in Great Britain

under Margaret Thatcher was nearly brought down by its abortive attempt to dismantle the National Health Service. While health reform may be appropriate, it does no good to design and implement thoughtful and creative reforms if the impact will be to make the government susceptible to political demagogues. Plans for reform must therefore necessarily recognize these powerful political realities and the potential for political mischief in this area.

How much spending is enough?

There are no clear guidelines for deciding how much money a country needs to spend on health care. However, comparisons by percentages of gross domestic product are frequently used by entities like the Organization for Economic Cooperation and Development (OECD) to provide some guidance.

This chart compares health expenditures for selected industrialized coun-

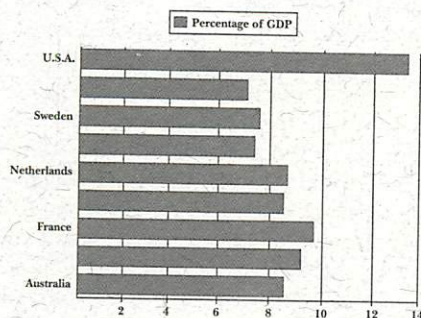


tries over the 30 years from 1960-1990. As the chart indicates, most industrialized countries were spending relatively similar percentages of their gross domestic products on health care in 1960. Over the next thirty years, however, while all countries experienced a growth in their health care expenditures, expenditures in the United States increased faster than any other country. This occurred despite the fact that the United States does not guarantee universal health insurance coverage for its citizens and does relatively poorly on many health indicators. This reminds us that spending a lot of money is not the same as having a quality health care financing and delivery system.

The following chart compares the health expenditures for selected countries by percentage of gross domestic product in 1993. By 1993, the United States was spending approximately 14.3 percent of its gross domestic product on health care. By contrast, other industrialized countries were ensuring uni-

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versal coverage to essential health care services at between approximately 7 to 10 percent of gross domestic product. More is not always better and countries other than the United States can provide important lessons about models for financing and delivering health care services.

While a budget percentage model appears to be very simple and straightforward to administer, there are also a number of limitations inherent in such a model. First, health care needs are not directly related to status of the economy. In several recent years the gross national products of countries in the FSU actually decreased. During that same period the health care needs of those populations did not decrease and may have actually increased. Second, a rapidly developing economy may mask high health care costs. So long as the economy is increasing at a faster rate than health care costs, the percentage of gross domestic product spent on health care will actually decrease.

In fact, health care needs in developing countries are often inversely related to the status of their economies. Citizens in countries with smaller gross domestic products often have poorer living conditions and poorer health status. They may, therefore, require more intensive (and often expensive) health interventions than will citizens in more highly developed countries. This means that a developing country may have to spend a relatively higher percentage of its revenues on health care.

Evaluating the Health of a Health System

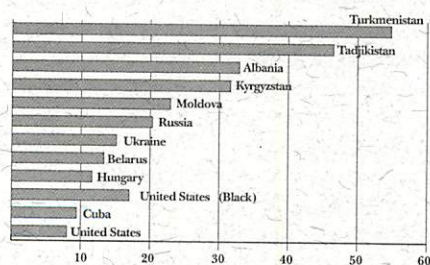
While budget percentages are often useful guides to health expenditures, they are by no means the only indicators used in guiding decisions about health reform. Public health researchers more frequently use process and outcomes measures to evaluate the "health" of a health system. Through process mea-

sures we look at the kinds of services being provided in a country; through outcomes measures we look at the results of that care. Immunization rates are an example of a process measure; life expectancy is an example of an outcomes measure.

Among the outcomes indicators commonly used are such composite indicators as the Human Development Index utilized in the UN Report on Human Development. This composite index is based on infant mortality rates, life expectancy rates, birth rates, and literacy rates. The UN Human Development Index for 1994 placed nearly all of the FSU countries at or slightly above the international average for developing countries. While there is ample room for improvement in the rates in each of the areas that makes up the composite index, there is also a strong foundation upon which future improvements can be built. It is therefore essential not to throw out the healthy babies with any health reform bath waters.

Unfortunately, in many statistical areas, reliable data are not available from many of the FSU countries. This highlights the importance of developing statistical capabilities to guide financial allocation decisions. Where statistics are available, they remind us that health outcomes are not necessarily a matter of resources. Often more important is how those health resources are used. Moreover, it is important to keep in mind that many low-cost interventions are available that can yield high rewards for society. For example, the estimates in the United States are that a dollar spent on prenatal care saves three dollars during the first year of life and nine dollars over the lifetime of the child.

Another common outcomes indicator is infant mortality rates. The figures in this chart are based on deaths per 1,000 live births in 1994. Especially in the poorer FSU countries, much needs to be done to bring infant mortality rates down. However, it is important to note the relatively low infant mortality rate for Cuba in contrast to the relatively high black infant mortality rate in



the United States. This disparity and a number of public health studies emphasize the dividends that can be achieved through low-cost interventions.

Issues to Resolve

With what these indicators can tell us about the "health" of the health care financing and delivery system, we must also decide the urgency of reform of that system. Because significant questions have been raised about the costs of maintaining the current system in the FSU and the quality and quantity of services provided through that system, it appears that there is a consensus that health care reform is essential in the FSU countries in the near future. Once a decision is made to undertake health care reform, there are a number of issues that must be resolved.

All of these issues flow from what appears to be a consensus in the FSU about the goal of a health system—to provide all citizens with dignified access to an adequate level of medical care at a socially acceptable cost. As is evident from this formulation, there are four pillars of health care reform that any model for reform must address: ready access to care, reasonable costs for care, high quality of care, and respect for the personhood of patients. With these four pillars in mind, a coherent model for health reform can be developed.

Four Models of Health Reform

There are four basic models of health care reform that reflect very different approaches to these issues. The most significant differentiating factor among these models is the degree to which they rely on government or private mechanisms to finance and provide care.

The four models of health reform are the "Health Service" model (most exemplified by Great Britain), the "Single Payer" model (most exemplified by Canada), the "Social Insurance" model (most exemplified by Germany and Japan), and the "Private-Sector" model (most exemplified by the United States). No country's health system is a perfect example of a single model of health reform. All deviate from the theoretical model to some degree. However, it is useful to compare the theoretical model to its implementation in particular countries.

National Health Service

Advocates of a national health service view the problem of health reform as

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one that requires extensive government involvement. They believe that extending health insurance to all persons will address only part of the problem. Access to health care for many persons will still not be assured. Profits will continue to be elevated in importance over basic human needs. Insurance and other administrative costs will siphon off needed funds.

National health service advocates, therefore, support the creation of a national health service. Most hospitals, nursing homes, and other health care institutions would be owned by the government. Most individual health care providers would be employees of the government.

The United Kingdom is one of the nations relying in large part on a national health service. The Service is financed largely through the national government and provides universal and comprehensive coverage. Individual health care providers are employees of the National Health Service, but may have limited private practices. Wealthy individuals can purchase private insurance but still can receive coverage under the national system. Global budgeting controls costs, but at the patients' expense. Hospitals and other facilities tend to be older than in other industrialized nations, technology is less cutting-edge, and there are waiting lists for many elective services.

Single Payer System

Advocates of a single payer model perceive the problem of health reform as one requiring a smaller, but still significant, role for government. They believe that private health insurance is one of the major villains within the health system that adds to the complexity of the health care system. Multiple forms and benefit coverages add to administrative costs. Insurance company profits siphon off funds that could be used for services. Overall limits on expenditures need to be imposed.

Advocates of a single payer system therefore believe that the federal government should administer a national health insurance system for all persons. This insurance system would be funded through general tax revenues and would be based on a national health budget. The agency administering the system would contract with hospitals and would negotiate rates with other providers.

The Canadian system (Medicare) utilizes a single payer model financed through general revenues. In Canada,

there is universal and comprehensive coverage with minor variations in services in each province. Health care providers are primarily private and are prohibited from engaging in private practices if they participate in the government program. Costs are controlled through fee schedules negotiated between medical associations and provincial governments. There are waiting lists for many elective procedures, especially

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those involving high-cost technologies. Wealthy individuals are not permitted to opt out from the national system, but may purchase private insurance for certain optional benefits.

Social Insurance Model

Advocates for a social insurance model for health reform believe that universal health care coverage should be a responsibility of society. Cost sharing should not impede access to necessary health care. Government has an important role to play in controlling costs.

Advocates of a social insurance model believe that employers should be required to provide health insurance for all employees through contributions to health funds. This system would be supplemented by a government-funded program of subsidized insurance for all other persons. Government would keep down costs by controlling fees and capital expenditures.

Germany and Japan are examples of countries with national health insurance systems based on a social insurance model. In Germany, there is comprehensive coverage administered predominantly through a network of non-profit "sickness" funds with payments made to outpatient physicians through regional associations. The system is financed through a mix of sources. Taxes on employers and employees help cover the employed and their dependents. The unemployed, disabled, elderly and poor are covered under social security provisions. Capital costs of hospitals come mostly from state and local governments. Patients have free choice of primary care physicians, specialists and hospitals at least each quarter. Sickness fund associ-

ations negotiate with state associations of panel physicians to set fee schedules. There are caps on annual incomes of physicians. Wealthy individuals may opt out for private insurance but then can never return to the national system.

The system in Japan was modeled after the German (Bismarck) system and is quite similar today. Again, coverage is universal, comprehensive, and compulsory. Instead of the German "sickness" funds, the system is administered primarily through not-for-profit *kenpos* (health insurance societies). Each major employer has a *kenpo* and smaller firms and the unemployed participate in a pooled fund administered by the government. Again, the system is financed through several sources. Employers and employees split the cost of premiums. The self-employed and the unemployed are covered by a national health insurance system financed through the local income-based household tax. The elderly are funded through the national government and health insurance societies. Most health care providers are non-governmental and private hospitals and clinics are owned and controlled by physicians. Costs are controlled through fee schedules for hospitals, salaries for hospital-based doctors, and fee schedules (point-fee system) for outpatient practitioners. However, there are no caps on physicians' income. Wealthy individuals cannot opt out of the system, but they can make gifts to attending physicians for special treatment.

Free Market System

Advocates for a private sector model of health reform believe that the health care system is best dealt with by a model that minimizes government involvement. They believe that it is acceptable to sacrifice universal coverage to reflect this priority. Cost control is best left to the free market.

Advocates for a private sector model of health reform, therefore, would design a health system in which citizens would purchase private insurance to cover health care expenses. However, they believe this insurance system should encourage cost-conscious decisions on the part of consumers by requiring patients to share in the costs of care. This will help keep costs down within the system by allowing free market forces to operate.

The United States is usually identified with the private-sector model. The US system is neither universal in cover-

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age nor comprehensive in scope of services. The system is administered primarily through for-profit private insurance plans with government administration for the poor and elderly. Most health care insurance comes through voluntary employer and employee premiums for workers and their dependents. Care for the elderly is largely financed through a payroll tax (Medicare) and these funds are supplemented by general tax revenues. Care for the poor (Medicaid) is financed through general tax revenues. Funding for capital expenditures comes mostly from private investment. Freedom-of-choice of provider, a cornerstone of the American system, is now largely an historical artifact with the expansion of managed care. Care is provided through a mix of public, non-profit, and for-profit entities. There is limited control of costs in the American system. There is limited global budgeting for the elderly and the poor and managed care plans negotiate reimbursement levels with providers. Wealthy individuals are free to insure or self-insure.

Health Reform in the Former Soviet Union

In light of these considerations, what model of health care reform makes most sense at this time in the development of the countries of the FSU? If we evaluate health reform models in light of the present systems we can then decide which of those models best builds on the strengths and addresses the weaknesses of those systems.

The systems largely still in effect in the FSU countries are models inherited from the Soviet Union. The Soviet system was highly centralized and provided largely through clinics and other institutional settings. It was a three-tier system in terms of quality. The highest level was provided to political appointees; the next level was provided to the military; the third level was provided to the general population. Doctors were not accorded high status in the Soviet Union and earned on average only three-quarters of the mean non-farm wage. The system was also excessively bureaucratic and suffered from inefficiencies in administration and service delivery. There were far too many hospital beds, far too great a reliance on institutional services, and far too many employees in many settings. At the same time, there was a universal guarantee of

the availability of basic care. Primary care services were readily available and of fairly high quality.

The national health service model is the model most similar to the former Soviet system. It has the advantage of universal coverage, but suffers from problems in cost control and quality assurance. While the national health service model could be greatly improved on, the basic inadequacies of that system would not be addressed. Patients would still be treated by health professionals with no incentives, financial or otherwise, to work harder, to treat patients with greater dignity and self-respect, to utilize innovative techniques, or generally to compete for patient retention. Only fundamental changes would affect these factors.

The social insurance model depends on the presence of a network of large and small private employers that can be primarily responsible for financing health care for most of the country's population (workers and their dependents). At this stage of free market development, that employer network does not exist. The social insurance model, therefore, does not appear to be presently viable.

FSU countries could move to a private sector model in which the central governments would not guarantee health coverage for the citizenry. However, it does not appear that the governments are willing to leave a substantial percentage (perhaps a majority) of the citizenry without health coverage. Aside from the politically destabilizing effects of such an action, such a result appears to be morally unacceptable. Therefore, even if the governments were willing to accept the other aspects of the private sector model, that model does not appear to be presently viable.

That leaves us with the single payer model. The FSU countries could begin the transition from a centralized health service model to a system in which the government would guarantee health coverage but would permit privatization of health care providers. The present health care providers would be able to participate (and compete) in this system. However, private (not-for-profit and for-profit providers) would be able to compete for patients alongside the existing network of public providers. Private providers would permit the introduction of private capital to upgrade services through financing of new facilities and new technologies. At the same time, a single payer system

would permit the government to maintain control over costs through global budgeting between the finance and health ministries. There could also be some control over the exploitation of the system by organized crime and entrepreneurs interested only in profits.

Conclusion

This does not purport to be a comprehensive discussion of all the issues involved in reforming the health care financing and delivery systems of the FSU. However, it does provide a conceptual basis for thinking about reforming the health systems throughout the FSU and in other developing countries. At the same time, there are several important cautions that must be kept in mind.

It would do significant disservice to democratic principles to bring free-market economics to these new governments without softening some of the harshness associated with capitalism. A citizen deprived of access to basic health care, what in most countries is recognized as a fundamental human right,

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In thinking about reform, it is therefore critical that these governments move forward cautiously to incorporate free market principles that will address the weaknesses in their current health financing and delivery systems without losing sight of the substantial strengths within those systems. These strengths include a basic guarantee of access to comprehensive care, a fundamental human right that the United States cannot yet ensure for its citizenry. ☉

**David Chavkin is an Associate Professor of Law at American University, Washington College of Law where he teaches courses in health law and clinical education. He has served as a consultant to the U.S. Department of the Treasury and to the U.S. Agency for International Development on health care reform in the former Soviet Union. This article is informed by his work with these newly-independent countries.*