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PATIENT CHOICE IN THE POST-SEMASHKO HEALTH CARE SYSTEM

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PATIENT CHOICE IN THE POST-SEMASHKO HEALTH CARE SYSTEM[4]

The opportunity for patient choice in the health care system in CIS countries was created by the partial destruction of the referral system and the development of paid medical services. The data of two population surveys conducted in Russia in 2009 and 2011 show that patient choice of medical facility and physician is taking place in the post-Semashko health care system, and it is not restricted to the area of paid medical services. However for the majority of population the choice of medical facility and physician is not a necessity.

Part of reason for patient choice is caused by the failure of the patient referral system to ensure the necessary treatment. For some Russian citizens, the choice of health care provider is a means to obtain better quality care, and in this respect the enhancement of patient choice is leading to the improved efficiency of the emerging health care system.

JEL Classification: I10, I11

Keywords: health care, Semashko system, patient choice, Russia

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Introduction

In most OECD countries patients have the right to choose their health care provider in the health care system financed from public funds (Paris et al., 2010). In health care systems with limited patient choice more attention is being paid to its extension. This is expected to promote competition among health care providers, to shorten waiting lists, to enhance the quality of services and access to care (Or et al., 2010). There are governmental programs to strengthen the right of choice in health care system in some countries, such as Denmark, Netherlands, Sweden, and UK (Department of Health, 2008; Bevan and Van de Ven, 2010; Dixon et al., 2010; Victoor et al., 2012; Vrangbaek et al. 2012). The experience of the English National Health System to ensure patient choice of specialist or hospital with a referral from a general practitioner for specialized medical care has attracted a lot of attention. The data from the monitoring of this program show that at the beginning of its implementation, in May 2006, 30% of patients were offered a choice of hospital for consulting a specialist, while in February 2010 49% had such an opportunity (Dixon, 2010).

Although the dominant trend is to ensure the choice of health care provider, there is a strand in the literature which argues that such choice is not necessarily good for the health care system. It can lead to a less efficient allocation of resources, aggravate the fragmentation of service delivery, and increase costs (Enthoven and Tollen, 2005; Thomson and Dixon, 2004; Sheiman et al., 2013). The policy of enhancing patient choice may have an ambivalent impact on access to health care and on equity in the utilization of medical services (Dixon and Le Grand, 2006). More educated people are choosing more often, less well-off families often respond that they are satisfied with the nearest hospital, and do not look for alternatives (Fotaki et al, 2006).

Ensuring the right of the patient to choose is particularly important for countries where the health care system was previously based on the Semashko model. This model included a rigid referral system that did not give any opportunity for a patient to choose the physician or medical facility (Davis, 2010). New EU members from central and eastern Europe have granted their citizens the right to choose their health care provider (Dimova et al., 2012; Murauskiene et al., 2013; Lai et al., 2013; Paris et al . 2010; Mitenbergs et al., 2012; Vlădescu et al., 2008).

In CIS countries, the right of citizen to choose medical facility and physician was decreed by law, but its implementation was much more difficult (Lekhan et al., 2010; Richardson et al., 2013). This right turned out to be incompatible with a public health financing system that was changed little in some countries since the Soviet period, or was being reformed in others. It failed to ensure consistent implementation of the principle “the money follows the patient” (Kutzin, Cashin, Jakab, 2010). However private practitioners and private health care facilities, as

well as the provision of paid medical services in public health facilities, were allowed to operate everywhere in all CIS countries, except Ukraine (Lekhan et al., 2010). Citizens of post-Soviet countries got the opportunity to choose providers of paid medical care.

Studies of existing practices of patient choice and the prospects for its expansion in post-Soviet countries provide new evidence for the ongoing debate about the role of patient choice in health care systems. This paper presents a study of the situation in Russia.

The Russian health care system changed dramatically during the transition from a planned economy to a market one, including the decentralization of public administration, the introduction of compulsory health insurance, allowing public health facilities to provide paid services, and the emergence of private health care providers (Popovich et al., 2011). The deficit in public health funding had a destructive impact on the referral system connecting different levels of health care services. A referral system has survived but is impaired in most administrative areas of Russia (Sheiman et al., 2013). The availability of a referral from a public outpatient facility for examination and treatment in a diagnostic center or a hospital ceased to be a guarantee of free access to the required care. Conversely, access to specialized outpatient care and inpatient care in non-emergency cases has been possible without referral from a general practitioner or outpatient facility if patient pays for these services.

The changes in the health care system during the transition created some opportunities for patient choice. However, these opportunities arose from paid services, while the choice of free health care was more limited. In recent years the attitude of the government towards the right to choose a health care provider has begun to change. Ensuring this right has been considered a way to increase the accessibility to health care facilities providing better quality medical care, and to develop competition among providers of health care services, which will contribute to enhancing the efficiency of the whole health care system.

The right of citizens to choose the health facility and physician that was previously only announced, received some specification in the Federal Law "On the Fundamentals of Health Protection of the Citizens in the Russian Federation" (Federal Law, 2011)[5].

More emphasis on the empowerment of patient choice raises the question of the analysis of the real practice of this choice. What is the prevalence of the practice of patient choice in the Russian healthcare system, that is, how often do patients chose between health care providers? Such a question is rarely put in other countries. Rules and restrictions of patient choice are usually defined quite clearly and the estimation the prevalence of patient choice arises only in

[5] The Law stipulates that a citizen has the right to choose a medical facility and a catchment therapist/pediatrician, or general practitioner working in the facility for free primary health care, but not more often than once a year (except for changing the place of residence or permanent stay of the citizen). Provision of non-emergency specialized free medical care should be by referral of the attending physician, who is obliged to inform the patient about the possibility of choosing a medical facility to get the necessary treatment.

evaluating the effectiveness of programs for their expansion, as was the case in the above mentioned English program. In Russia, where the rules of access to health care are not clear enough, this analysis is particularly relevant.

An important task is to assess the extent to which consumer choice is possible for paid medical treatment. And how prevalent are situations of choice for free medical care? Finally, it is important to understand why patients find themselves in situations of choice, and what choices they made.

Practices of consumer choice in the Russian health care system have not until recently been studied, and only limited aspects have been addressed within broader research. Fotaki (2006) shows there was low demand for choice of health care provider. In a survey of the population of Moscow, the Moscow Region, and two regional centers, conducted in 1999-2000 to assess the changes in health care, it was found that only 5.9 % of the population would change their primary care physician and 5.7 % would change medical facility where they were treated, if they were given the opportunity (, 2006). Choice is generally made using information from friends and family, rather than looking up medical facilities and doctors (Manning & Tikhonova, 2009 ; Rusinova & Brown, 2003).

The first attempt to provide answers to the questions raised above was a study based on a survey on the issues of the implementation of the right to choose a doctor and medical facility conducted in April 2009 by the HSE and the Levada Center. The sample size was 1600 respondents, representing the adult population of the country.

The findings showed that the right to choose had a high value for Russian citizens, but the numbers of patients who chose was quite small: 5-18% of the patients seeking different types of medical care did so in two to three previous years (Sheiman & Shishkin, 2012).

Another survey on these issues, which is now a part of the Russian Longitudinal Monitoring Survey (RLMS) was carried out to check the previously obtained estimates against a wider sample of respondents, and to do a more detailed analysis of the differences of patient choice in practice between different socio-demographic groups (which was difficult for the 2009 survey because of the small number of respondents who made a choice in that sample) and to identify possible changes in these assessments taking place under the influence of the increasing value of choice in society. For the purposes of this survey, the 20th wave of RLMS was supplemented by a cluster of questions in order to study the choice of medical facilities and physicians, which was based on questions used in the 2009 study. The survey held in autumn 2011 had a sample size of 6,385 households, consisting of 13,850 adult respondents.

This paper answers these questions using the results of two surveys mentioned above. The paper includes two main parts devoted to the choice of provider of outpatient and inpatient

care. For each of these areas, we consider first of all the prevalence of patient choice, including the choice of free medical services and of paid ones. Then we discuss the reasons why patients do not choose medical facility or a doctor. For those who had choice, we consider the main reasons for which patients had to choose between health care providers. The sources of information when making choice are also considered. The last section includes the conclusions arising from the findings on the functional role of patient choice in the post-Semashko health care system.

Patient choice of outpatient facilities and physicians

General assessment of the prevalence of choosing an outpatient care provider

The concept of patient choice is used in a broad sense, encompassing self-facilitated change and choice by the patient between two or more (1) medical institutions, (2) general practitioners in the medical facility where the respondent usually goes, (3) specialists, or (4) specialist medical institutions. Cases of a change of physician or medical institution independent from the respondent's circumstances are not taken into account, for example, change of residence area, as well as closure of the medical facility, illness of a physician. Choice of dental care providers was also not considered.

In 2009 and 2011 surveys respondents were asked about whether they chose a provider of outpatient care in the two years preceding the survey, and whether they chose a hospital in the three preceding years.

It is rational to begin the analysis of consumer choice in health care with a study of the choice of outpatient facilities and general practitioners.

The share of adult citizens who changed their outpatient care facility was 5% according to 2009 survey, and was only 1.7% according to 2011 survey (Figure 1). In addition, 0.8% of respondents reported that in the last two years they changed general practitioner, and in 2009 this figure was 3%. Thus, in 2009-2011, there was less change of the primary health care facility or general practitioner.

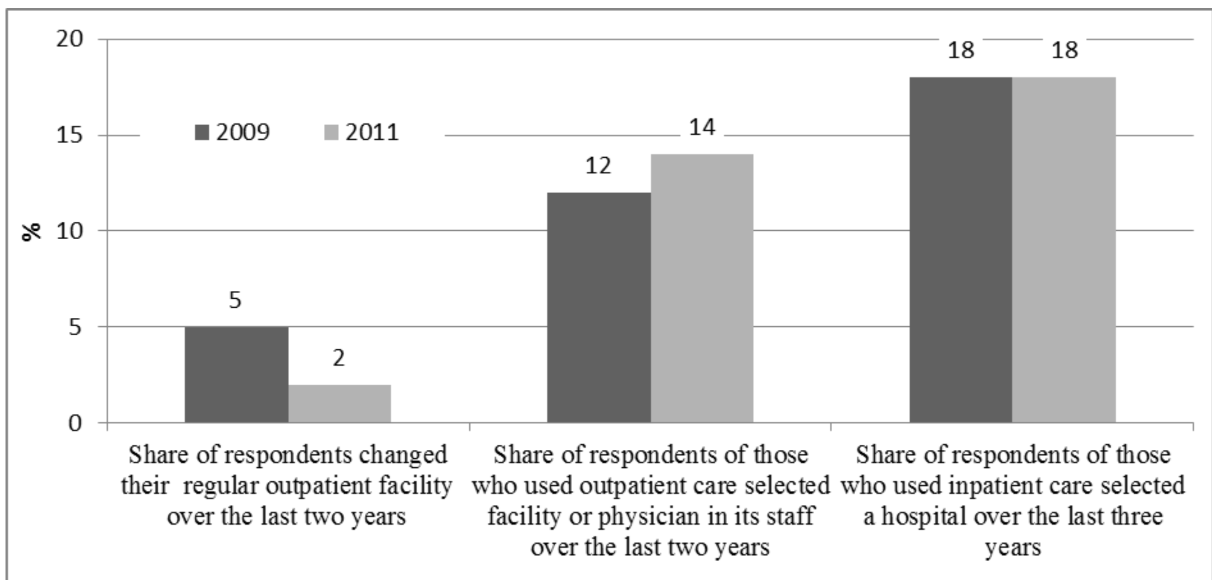

Fig. 1 The incidence of patient choice in Russia, percent

The vast majority of respondents (82% in both surveys) reported that the regular outpatient facility they use is near their place of residence or registration. Among respondents who chose between outpatient institutions, in 2011 71% of patients used local outpatient facilities, in 2009 it was 76% (Figure 2).

In 2009 the facilities to which respondents were assigned under the contract of voluntary health insurance (VHI) were used by 7% of respondents, and 3% of respondents who made a choice, reported that they use such facilities. In 2011 the corresponding figures were considerably lower, 0.9% among all respondents and respondents who made a choice. The use of other outpatient facilities were approximately equal according to both surveys. However in the 2011 survey the share of those who were not able to identify their regular facility for outpatient services, increased from 4% to 9%.

Respondents are least likely to be served on a regular basis by private facilities, or by a general practitioner. In 2009 and 2011 only about 1% of respondents used these outpatient care providers as their regular health care facilities.

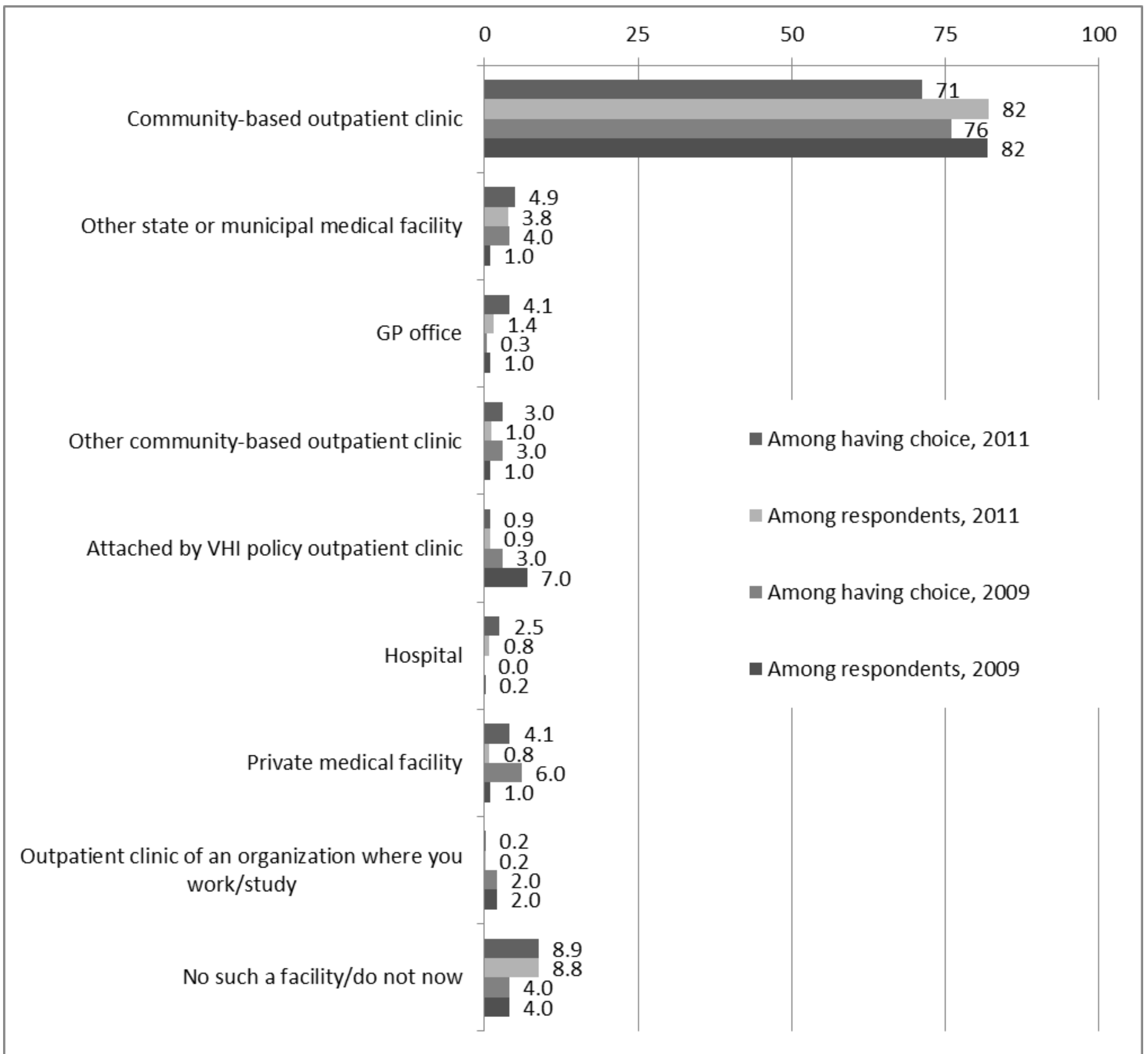

Fig. 2 Types of medical facilities which adults used and those who chose the outpatient facility

The prevalence of choosing free and paid outpatient care

The data of both surveys provide similar estimates of the share of citizens who chose a medical facility or doctor for outpatient care for the past two years: 12% in 2009 and 14% in 2011.

The share of patients who chose based on the free service provision was 21% in 2009 and 27% in 2011. The proportion of those using free treatment, but at the same time willing to pay if necessary, was approximately 44% and 46% respectively. The proportion of the respondents

who immediately was ready to pay for medical services decreased from 16% to 10% suggesting there is a tendency for patients to choose free access to outpatient care.

Payment (for a fee officially and under-the-table) occurred in 53% of cases of choosing an outpatient facility or physician, according to the 2009 survey, and in 42% according to the 2011 survey (Table 1). This allows us to conclude that most cases of patient choice for outpatient care occurred within the system of free health care.

Tab. 1 Paying for health care when choosing outpatient facility or physician, percent

	Free of charge	For a fee, officially	For a fee, under-the-table	For a fee, officially, and under-the-table	Getting medical care is not yet complete
2009	42.5	36.2	10.6	6.4	4.3
2011	57.0	33.1	6.0	2.5	1.4

The attitude to payment when choosing an outpatient facility or a physician varies significantly depending on whose services (primary care physician or a specialist) people need.

When choosing a general practitioner and a provider of outpatient care, a much stronger emphasis on receiving free medical care was observed. In the 2009 survey 24% of respondents, who chose a general practitioner, were looking for free medical care, while in 2011 it was 46% (Figure 3). The proportion of those who focused mainly on free care, but who were ready to pay, reduced from 60% to 39%, and the share of respondents who were initially willing to pay fell from 7% to 4%.

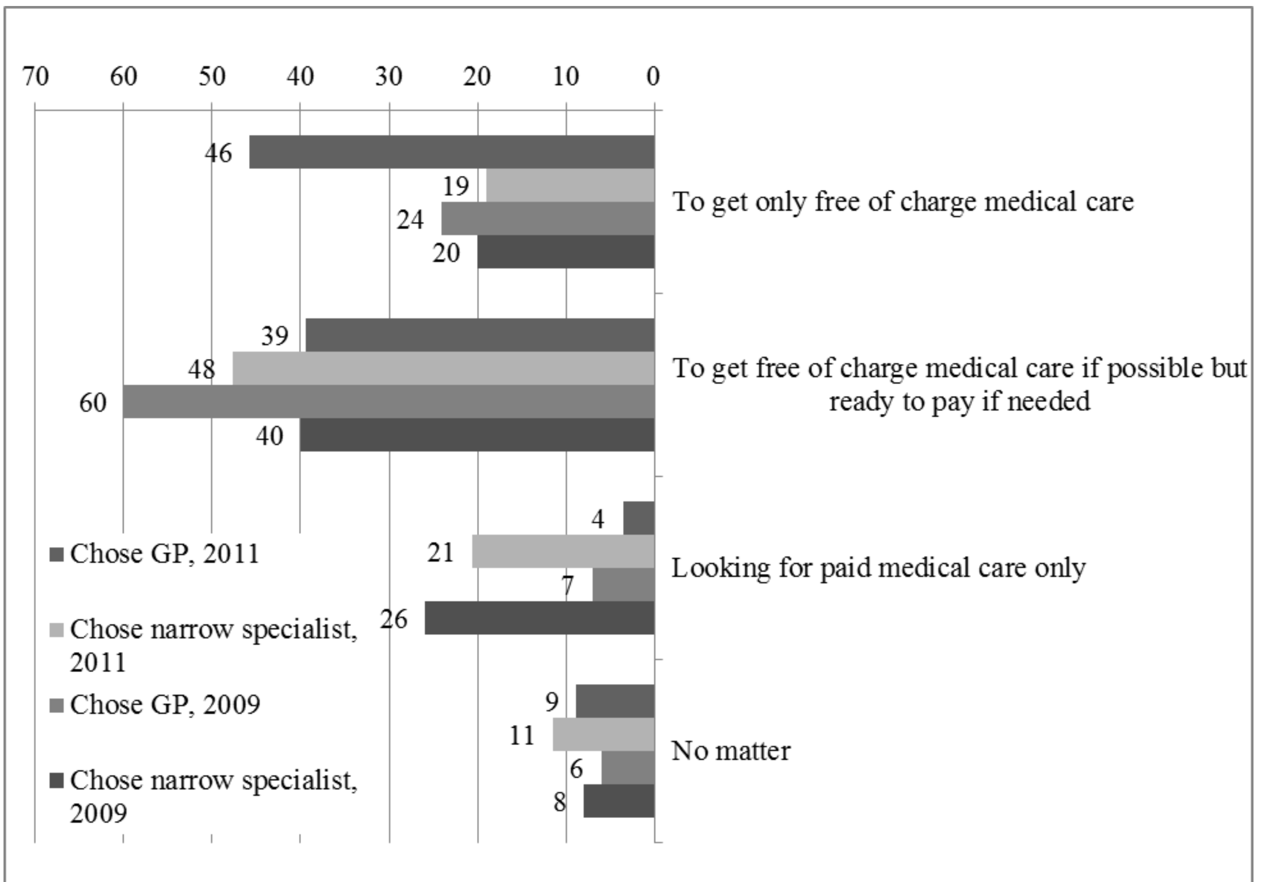

Fig. 3 Patient attitude to payment when choosing a GP or specialist as a percentage of those who made choice

Patient choice when choosing a specialist was slightly different. 20% looked for free care in both surveys. In 2011 48%, and in 2009 40% of respondents were willing if necessary to pay for the services of a specialist. The proportion looking for paid specialists fell from 26% in 2009 to 21% in 2011.

The attitudes in different socio-demographic groups towards paid or free medical care when choosing a provider of outpatient services vary considerably. As might be expected, retirement age respondents more often than others looked for only free medical care. More than a third of respondents in this group chose this answer, compared to 20-24% in other age groups. 21.2% of respondents aged 25-39 years searched for paid medical care compared to 12-18% in other age groups. 54% of respondents aged 18-24 were willing to pay if necessary (Table 2).

Tab. 2 Orientation toward payment for medical services by age and sex group of respondents, 2011, per cent

	Age groups				Total
	18-24	25-39	40-54	55 +	
When you were choosing where and who to go to, you were looking for …					
only free medical care	20.5	20.7	24.2	37.4	26.8
free medical care if possible but ready to pay if needed	53.8	45.8	48.7	40.8	45.9
paid medical care only	18.2	21.2	14.1	12.5	16.3
No matter	7.6	12.3	13.0	9.3	11.0
Total	100.0	100.0	100.0	100.0	100.0
Number of respondents	132	358	277	353	1120

Throughout the period, the poorest respondents more than any other group relied only on free services (33%). The wealthiest respondents were more likely to look for paid outpatient care (24%) (Table 3).

Tab. 3 Payment for medical services by income level of respondents, 2011, percent

	Quintile groups by per capita income					Total
	First (lowest)	Second	Third	Fourth	Fifth (highest)	
When you were choosing where and to whom to go, you were looking for …						
Only free medical care	33.3	26.9	26.5	29.6	22.5	26.7
Free medical care if possible but ready to pay if needed	42.3	48.4	46.1	50.0	42.9	45.9
Paid medical care only	12.2	8.6	15.7	14.2	24.3	16.4
No matter	12.2	16.1	11.7	6.2	10.4	11.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of respondents	123	186	230	226	338	1103
Actually received medical care						
Free	64.8	63.3	57.6	59.4	48.2	56.9
Paid, officially	28.0	24.5	33.8	32.3	39.1	32.9
Paid, under-the-table	4.8	5.9	5.2	4.4	8.5	6.1
Paid, officially and under-the-table	2.4	3.7	2.2	1.7	2.9	2.6
Getting medical care is not yet complete	0.0	2.7	1.3	2.2	1.2	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of respondents	125	188	231	229	340	1113

The prevalence of payment for medical services when choosing outpatient care increases with income; the better off paying more often than those with lower incomes (Table 3). Wealthier people more often choose an outpatient provider and rely more on paid medical services.

Reasons for the lack of choice of outpatient service provider

Some patients did not choose a doctor or a medical facility when receiving outpatient care. Did they lack the opportunity, or they did not have the need to choose a clinic or doctor?

In both surveys, most respondents replied that they had no need to change the provider of outpatient care, as they were satisfied with the existing one. In 2011, the share of respondents who were satisfied with the work of their regular doctor was higher (53%) than in 2009 (43%) (Figure 4).

Fig. 4 Reasons for the lack of choice of medical facility or physician, percent, (respondents could indicate not more than 2 answers)

Other reasons were significantly less important. In 2009 and 2011 respectively 10% and 13% lacked alternatives; 9% and 8% lacked time to find other facilities; and 6% and 3% had transport restrictions. The aggregate share of respondents reporting these reasons was very close in both surveys, 25% and 24%. For 9% of respondents in 2011 and 7% in 2009 the choice was not important.

The importance of payment for medical care as barrier to patient choice decreased in 2011 (7%) compared to 2009 (13%). This corresponds to the decrease in the proportion of respondents paying for services (Table 1).

Over the period under review the reasons for the lack of choice shifted from inability to make the choice to reluctance to do so.

Reasons for choosing outpatient facility for regular care

Why did people change their outpatient care providers? According to both surveys the most common reason why patients decided to change outpatient facility for regular care was the lack of skills of the medical personnel. However, the significance of this reason decreased from 57% in 2009 to 35% in 2011 (Figure 5).

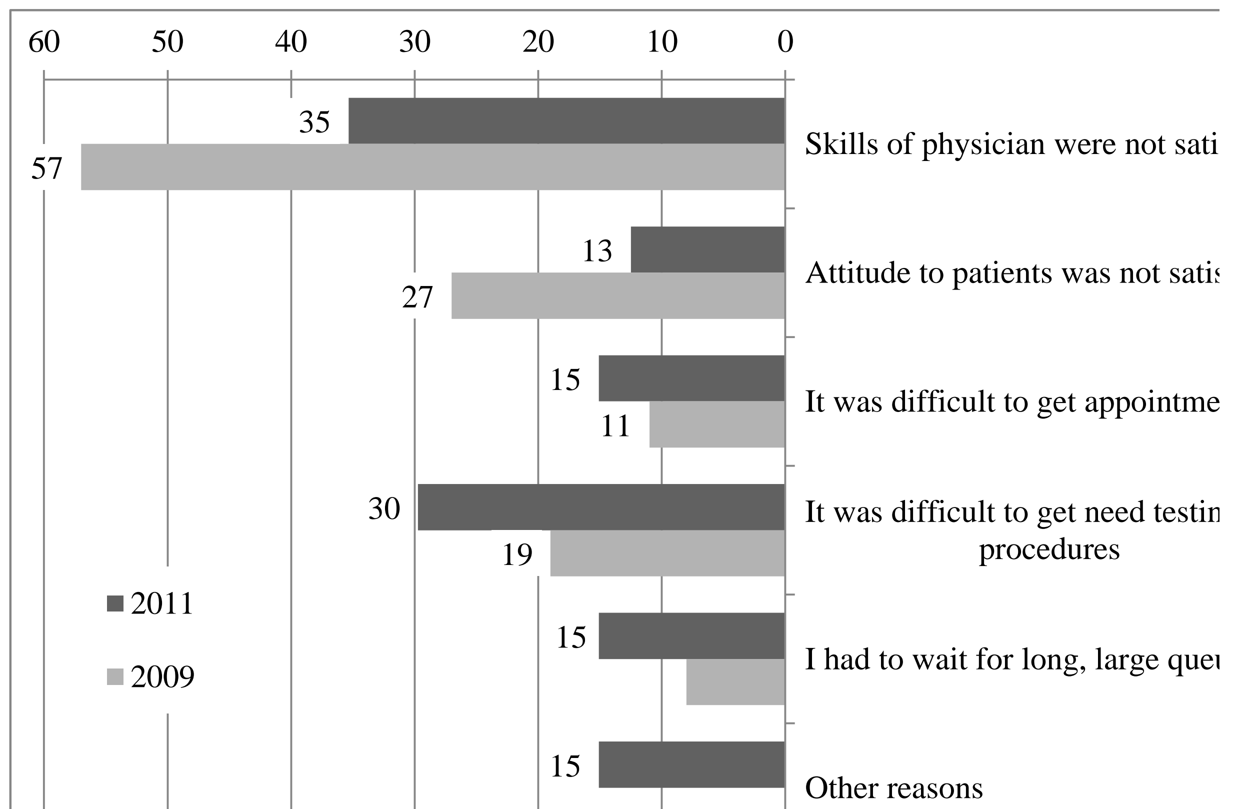

Fig. 5 Main reasons for changing outpatient facility of his/her catchment area, percent (respondents could indicate not more than 2 answers)

In contrast the share of respondents who changed their regular out-patient provider due to unsatisfactory care or service (the difficulty of making an appointment, difficulty in conducting necessary tests and diagnostics, waiting time, disrespectful attitude of medical staff) increased from 13% in 2009 to 27% in 2011.

The reasons for choosing a medical care provider differ considerably for different groups of the population. The higher the level of education of the patient, the more likely the reason for the change is insufficiently qualified staff. Respondents with higher education are more likely to change because of difficulties in carrying out the necessary tests and procedures.

The reasons for choosing polyclinic differ also for people living in different types of settlements. The accessibility of tests and procedure is the main reason for choice for citizens of rural settlements and small towns. 40% of them indicated this reason in comparison with 17-23% of respondents from other cities. And a lack of qualifications of the medical personnel is the leading reason for choice for the latter.

The findings of two surveys suggest a slight improvement in the quality of outpatient care in recent years, which has led to a reduction in the number of people changing of outpatient clinics.

Main reasons for choosing a physician

The cases when patients choose a specialist or a clinic for a specialized medical care account for 75-80% cases of outpatient care provider choice. Considerably less frequently patients choose general practitioners. In 2009 the choice of doctor occurred in 20% of cases, in 2011 this figure was 25%.

In 2009 a third of respondents indicated that the main reason for changing practitioner was dissatisfaction with the care provided, only a little over a fifth said it was the inaccessibility of a physician. In 2011 the main cause was inaccessibility of a previously selected doctor, more than a third of respondents indicated this cause, while 17% cited dissatisfaction with the quality of care provided as a reason for the change of doctor (Figure 6).

These estimates are for the sample as a whole. The significance of the reasons for choosing is noticeably different for residents of different types of settlements (Table 4). Patient dissatisfaction with medical care dominates as the reason for choosing health care provider in Moscow, while in all other types of settlements the choice is made mainly due to problems with access to care, and the proportion of respondents who reported these reasons, increases with the size of settlements.

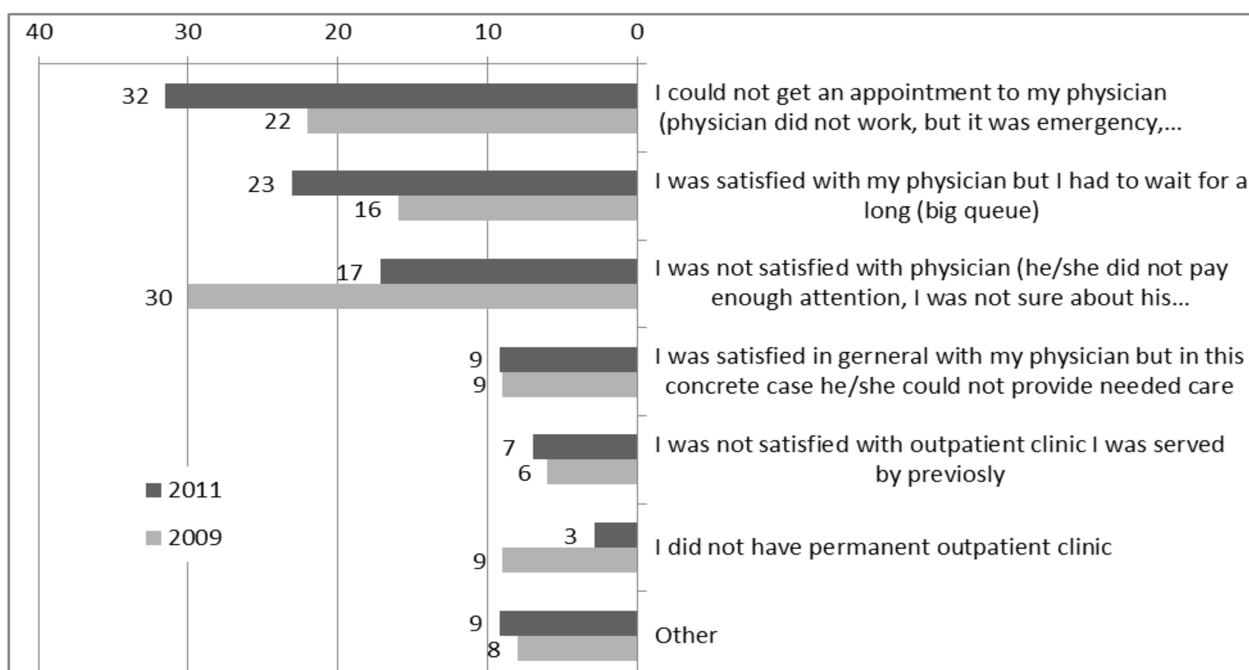

Fig. 6 Main reason for choosing a primary care provider, percent of those who made a choice

Tab. 4 Reasons for choosing a physician by inhabitants of different types of settlements in 2011, percent of those who made a choice

	Moscow	City with a population over 500,000	City with a population of 100,000 to 500,000	Town with a population to 100,000	Rural area	Total
Reasons for choice of doctor						
Dissatisfaction with medical care provided *	40.0	22.4	30.8	25.8	15.1	24.6
Inaccessibility of medical care**	43.4	65.7	53.9	72.6	80.3	66.6
Other	16.7	11.8	15.4	1.6	4.5	8.8
Number of respondents	30	76	39	62	66	273
Reasons for choice of specialist						
Dissatisfaction with medical care provided ***	26.6	17.1	25	22	18.4	20.5
Inaccessibility of medical care ****	25.7	28.7	26.1	30.5	28.1	28.3
There was a referral to specialist but specific physician was not mentioned	13.8	21.7	8.3	16.8	25.4	18.6
Self diagnosis that a specialist consultation is	31.2	29.7	32.3	28.9	25.4	29.4

needed but did not have referral						
Other	2.8	2.8	8.3	1.7	2.6	3.2
Number of respondents	109	327	96	173	114	819

* - the share of respondents who answered: "I was not satisfied with the physician", and "I was not satisfied with the outpatient clinic I was served by previously".

** - the share of respondents who answered: "I was satisfied with my physician but I had to wait for too long", "I was satisfied in gerneral with my physician but in this concrete case he/she could not provide care needed", "I could not get an appointment with my physician", "I did not have a permanent outpatient clinic".

*** - the share of respondents who answered: "I was not satisfied with the specialist I was referred to", "I was not satisfied with the physician I had been served by with the same health problem".

**** - the share of respondents who chose answers: "I had to wait for too long for an appointment, it was difficult to get an appointment with the specialist who I was referred to", "I could not get an appointment with the specialist I had been served by with the same health problem".

The reasons for choosing to get primary care and to get specialist care diverge. For the former the main reasons are dissatisfaction with the quality of care or with the availability of medical services. While selecting specialist care these reasons were given by less than half of those who made that choice. The main reasons were problems with the organization of care; self diagnosis without referral, access to a doctor and a referral to a non-specific specialist (Table 4).

Comparing the reasons for making a choice when receiving care from a specialist shows that the share of cases significantly increased when the patient made an independent decision on the need to see a specialist without a referral from a general practitioner and the patients themselves were looking for the right professional. In 2009 the percentage of such cases was 19%, in 2011 this figure rose to 29% (Figure 7). In 2009 in 52% cases[6] respondents chose a specialist with a referral from another physician, in 2011 it was 39%.

The data provide evidence of the intensification of the spontaneous formation of patient flows to suppliers of specialized outpatient care. The possibility of direct access of patients to specialists without a referral from a general practitioner appeared in the Russian healthcare system in 90s as a consequence of the development of the practice of paid services in public health care facilities, and the increasing scarcity of catchment primary care physicians. However, unregulated demand for specialized medical care leads to a growth in the volume of this more expensive type of care. That is why the Federal Law "On Fundamentals of Health Protection of the Citizens in the Russian Federation" (Federal Law, 2011) specified the right to choose medical specialists with a referral from a general practitioner, to obtain such assistance, and for

[6]This is a total percentage of patients who responded that (1) they had a referral to a specialist, but were not offered a specific doctor, so they had to choose themselves, (2) they had to wait for too long for admission, it was difficult to make an appointment with the specialist they were referred to or (3) they were not satisfied with specialist who they were referred to.

the general practitioner to provide information to the patient about the possibility of choosing a provider of specialized care.

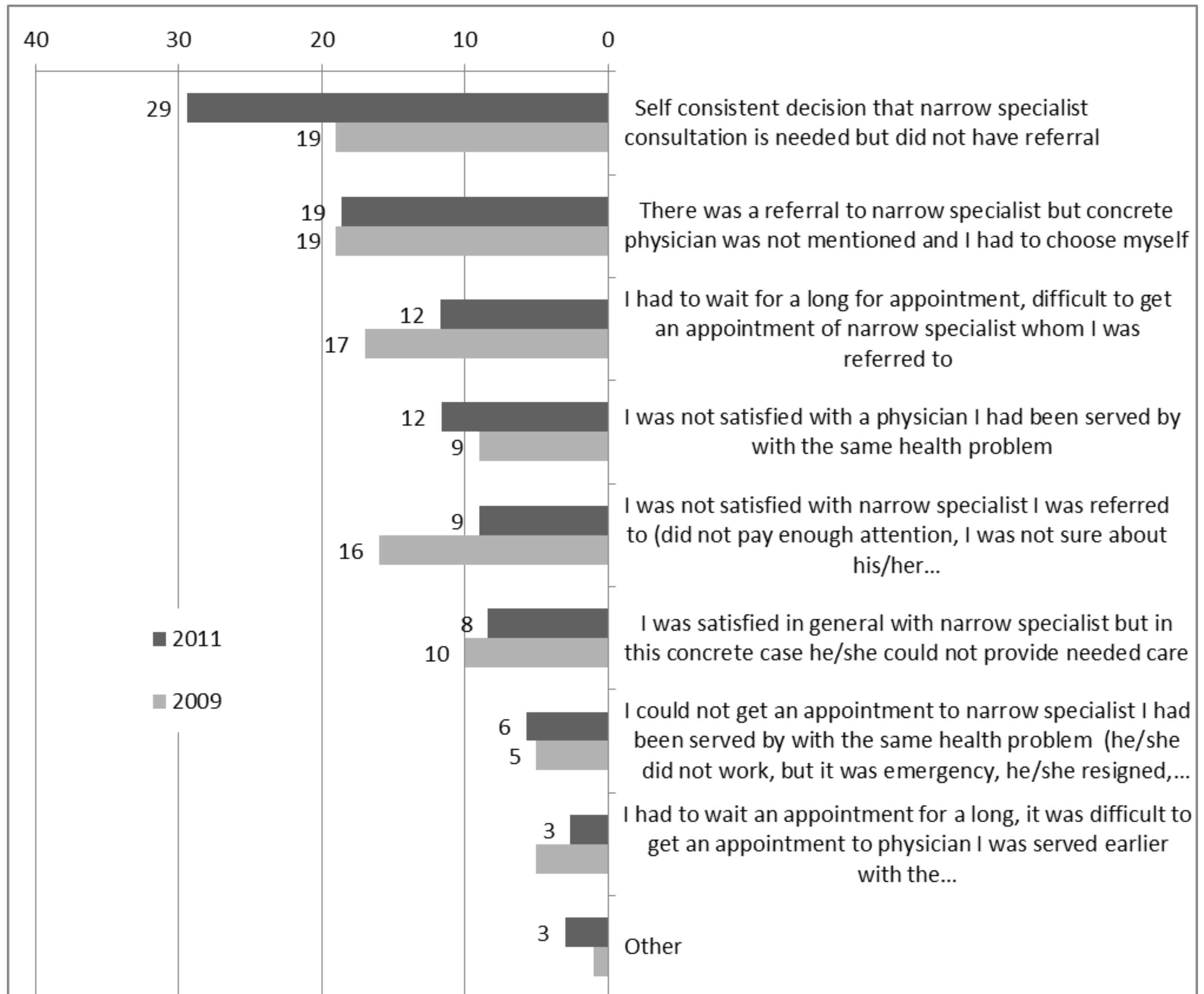

Fig. 7 The main reason for choosing a specialist, percent of those who made a choice, percent

The increase of the sample size in 2011 allows the detection differences in the reasons for choosing a specialist by the respondents from different socio-demographic groups. These reasons vary significantly for different age groups, levels of education, and place of residence. Among older age groups the main reason for choice is lack of guidance from the doctor who treated them earlier on who exactly they can seek assistance from. Respondents under 24 report more commonly that the reasons for choosing a specialist are dissatisfaction with the services received previously, independent referral for specialized care treatment without prior consultation and

referrals by a primary care physician. For respondents with secondary and higher education independent reference to a specialist is more frequent than for less educated citizens.

Differences between the citizens living in different types of settlements in their reasons for choosing a specialist are not as great as in the case of choice of a general practioner (Table 4). In Moscow dissatisfaction with medical care and its accessibility were almost equivalent, while in other types of settlements inaccessibility of medical care the main reason for patient choice. Residents of rural areas are much more often faced with the situation where they are given a referral, but are not offered a specific doctor.

Sources of information when making a choice

An analysis of the sources of information when choosing outpatient facilities and physicians was conducted within the research. The frequency of use of different sources of information turned out to be significantly different between the two surveys.

In 2009, Russian citizens more often used information from relatives, friends, and acquaintances (in two-thirds of cases when choosing a specialist and a general practitioner, 67% and 64%, respectively) (Figure 8). When choosing a general practitioner, patients often approached relatives, friends, and acquaintances who were medical workers (38%). Recommendations of those who were not medical workers were 26%. When choosing a specialist, on the contrary, respondents relied on the recommendation of friends who were doctors in 27% of cases, whereas the advice of relatives and friends who are not medical professionals was 40%.

The survey in 2011 showed a decline of importance of personal relationships and the opinions of friends and relatives in choosing a doctor; such sources of information were used in 44% of cases to select a general practitioner and in 55% to choose a specialist.

The growth of patient confidence in doctors’ recommendations and a small increase (of 1%) of the proportion of patients who benefited from recommendations of other medical professionals is seen.

The rarest source of information is different kinds of advertisements, information in the media or online promotions. These sources of information have the least credibility among respondents. However, in 2011 this source was more common than in 2009.

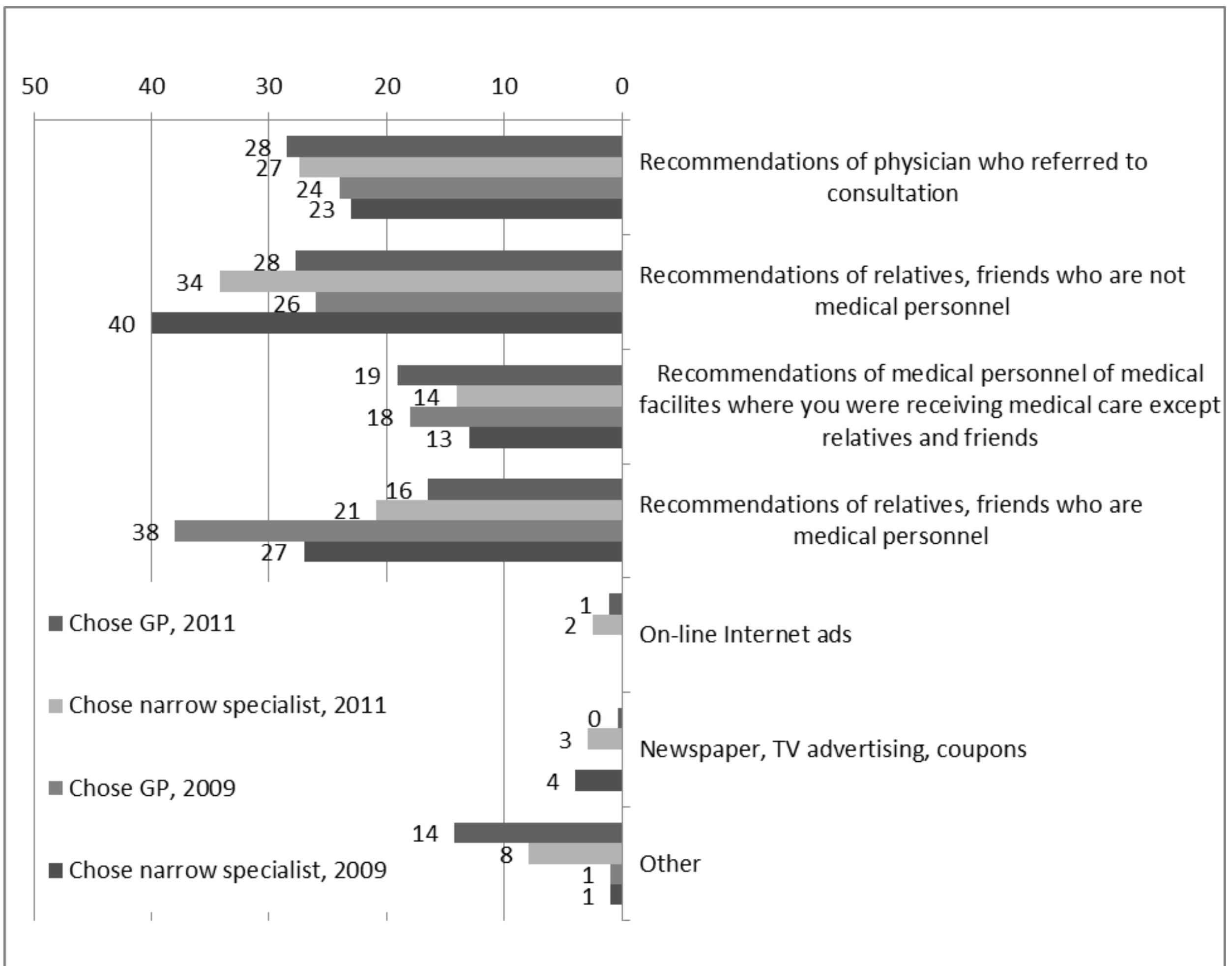

Fig. 8 Information sources used to choose a physician or outpatient facility, percent of those who chose the indicated sources

When choosing a doctor for outpatient care the leading source of information was and still is "word of mouth", but its role is reducing (40 % in 2009 and in 32% in 2011). The role of doctors' recommendations is growing.

Choice of inpatient facilities

A general assessment of the prevalence of choosing an inpatient care provider

According to the data of both surveys, the share of respondents who chose the hospital within the previous three years was 18%. More often the hospital was chosen during planned hospitalization (about two thirds of cases of hospital choice), during emergency hospitalization the choice of a hospital was less frequent (about one-third of cases). In 2011 during a planned

hospitalization 16% of cases patients did not have referral. However, the proportion of such cases in 2011 significantly decreased compared to 2009 (30%).

The choice of where to receive inpatient care is directly dependent on the level of education, income, and place of residence; people with higher education choose twice as often, and representatives of the richest quintile choose 1.6 times more than the poorest; residents of Moscow choose 1.5 times more than residents of other large cities (with a population of over 500,000), and 2.7 times more than residents of medium-sized cities and rural areas.

Payment as a factor in choosing a hospital

When choosing a hospital, and a provider of outpatient care, patients were often were expecting to receive medical care for free. In one third of cases, patients wanted to receive only free care, and in the case of emergency hospitalization this attitude was more common. Nearly half of the respondents had a more pragmatic attitude: “to receive free of charge medical care if possible, but ready to pay if it is needed”. Only 9% of respondents when choosing a hospital immediately focused on receiving paid medical care. It is important to note that there is a very stable distribution of patient preferences, and it has not changed much since 2009 (Figure 10).

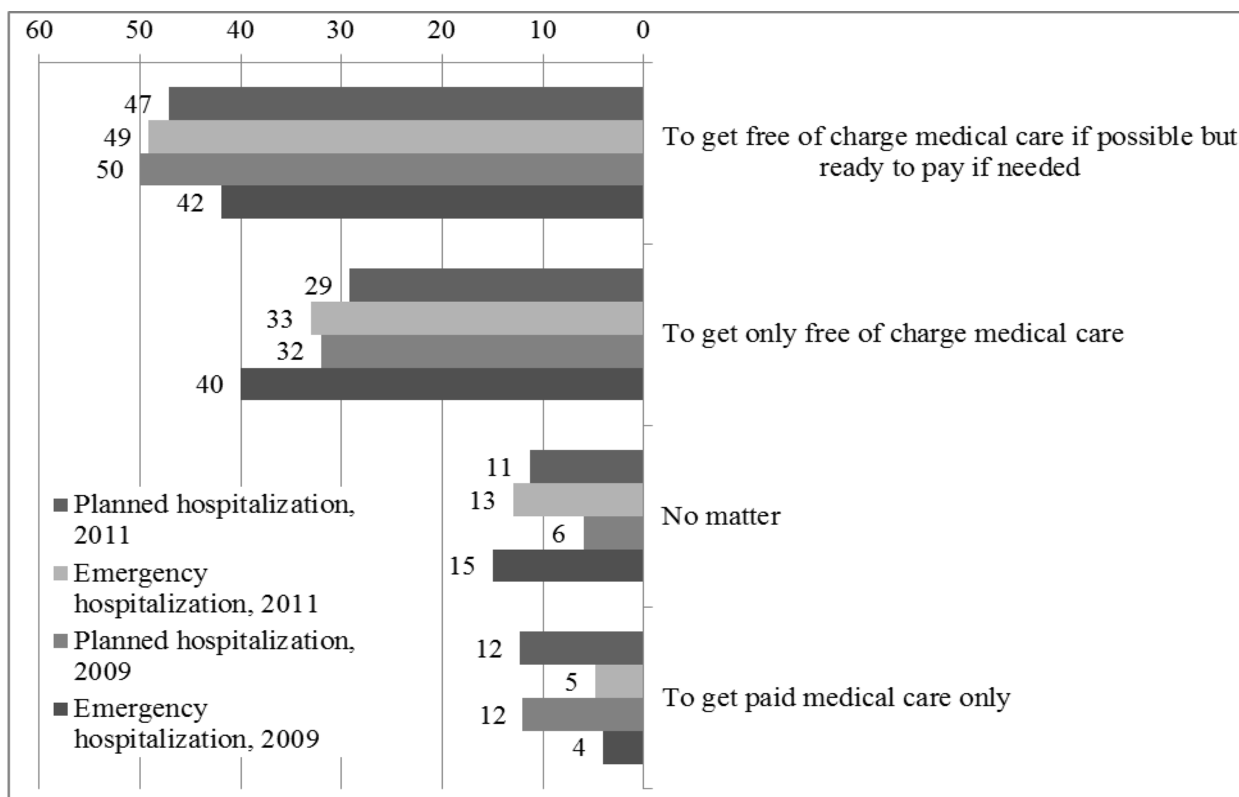

Fig. 9 The attitude of patients to the payment for medical care when choosing hospital, percent of those who chose the inpatient facility

59% of those who chose a hospital received free medical care. This proportion was 41% in 2009. As in the case of outpatient care most inpatient care provider choice was made without any payment. Among the patients who made a choice and expected to get free inpatient care, in 9 cases out of 10 they did not pay anything (in 2009 the level was 65%).

Among the cases when respondents sought free care if possible, but were willing to pay, half managed to get free care (in 2009, 33%), in other cases, patients paid, including informally in 24% of cases (in 2009, 26%).

Reasons for absence of choice of an inpatient facility

Throughout the period in review, the main reasons for not exercising a choice when receiving hospital care were hospitalization by referral, the availability of an inpatient facility that provides satisfactory care, and lack of choice.

The main reasons for the inability to choose when receiving hospital care varies notably in the two surveys. In 2011 patients generally did not choose the hospital while being admitted by referral (primary care or ambulance care), while in 2009 the main reason for not choosing was the availability of a satisfactory hospital (Figure 10). The inability to make a choice because of lack of other hospitals remains the third most common reason. There was a reduction in the proportion of responses involving restricted choice of hospital due to lack of money. In 2011 the proportion of these responses was almost half of the 2009 figures; 16.0% and 8.1% respectively.

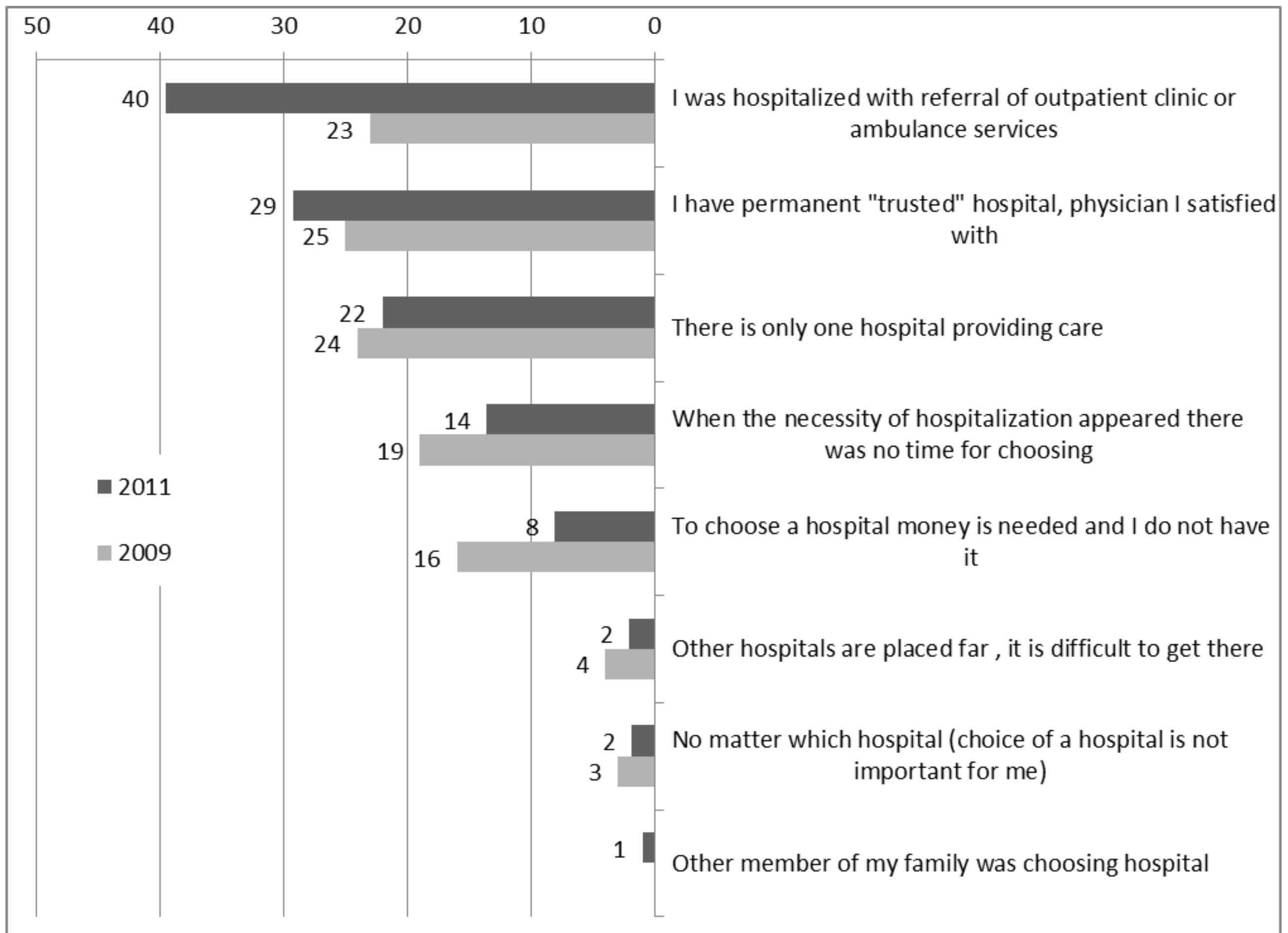

Fig. 10 The main reason for choosing a hospital, percent of respondents who did make a choice, respondents could indicate no more than 2 answers

Sources of information when making a choice of a hospital

The sources of information used when choosing an inpatient care provider were significantly different than in the case of outpatient care. Most often, when choosing a hospital, patients were guided by the opinion of medical professionals (Figure 11), rather than friends as in the case of outpatient care (Figure 8). The most common source of information was the primary physician or ambulance doctor; in 2011 57.5% of cases, in 2009 55%. Information from other health care workers who are not relatives, or friends of the patient, was 7% in 2009, and 12% in 2011.

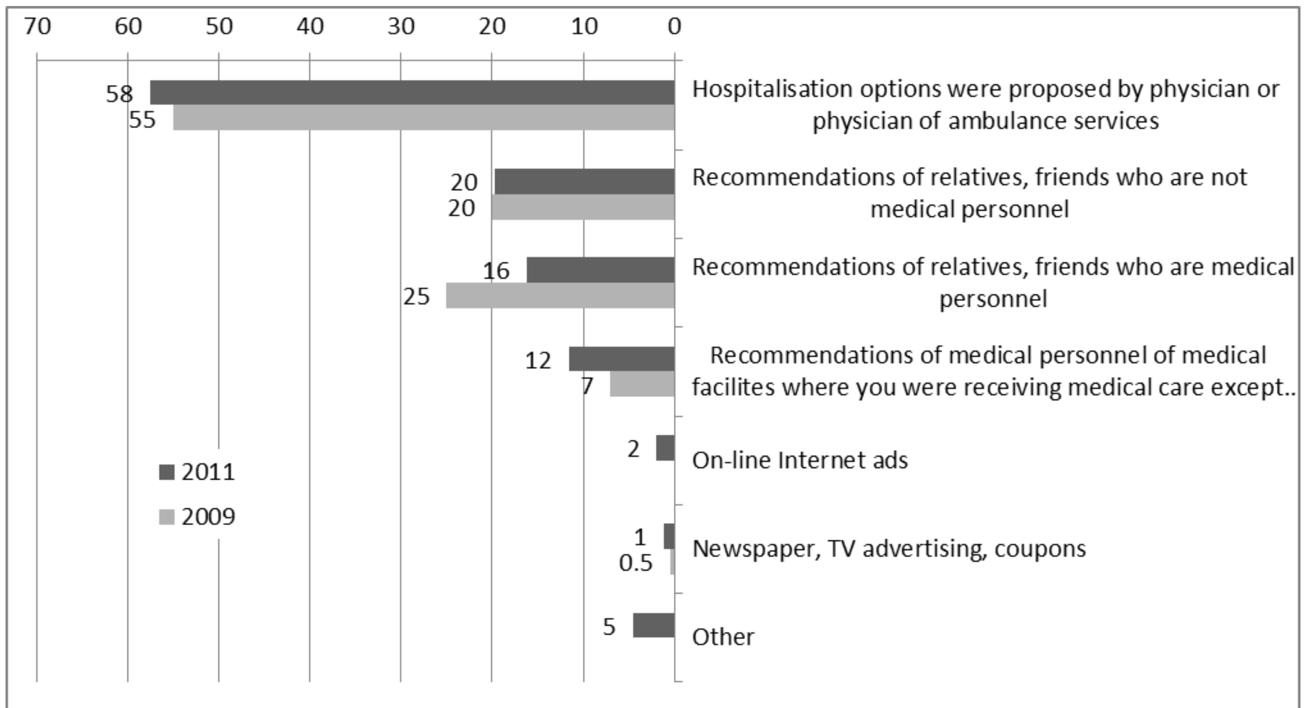

Fig. 11 Information sources which respondents used to choose inpatient facilities, percent of those who chose the indicated sources

Recommendations of relatives or friends were used in 36% of cases of the hospital choice (in 2009, 45%), among them 16% of cases were the recommendations of close friends who are health care workers. The smaller role of "word of mouth" as a source of information when choosing a hospital and a greater credibility in the professionals' information can be explained by the fact that hospitalization is a rarer event and fewer among people close to the patient have the relevant knowledge.

As with choosing outpatient care, when choosing a hospital, the patients less often used the media as a source of information (3.2% in 2011). It is worth comparing this figure with the responses of British patients to a similar question in 2010: when choosing a hospital, 43% of those surveyed used the recommendation of their general practitioner, 29% used the recommendations of friends or family members, or were guided by their own experience, 6% use information from NHS brochures, and 5% use information from the Internet (Dixon, 2010). In the Russian survey however respondents could choose two options. With this in mind, we can say that differences in the sources of information for patient choice in the two countries are not very large, but there is less information from the media, internet and health facilities booklets for Russian patients.

Conclusions

The data of two surveys conducted in Russia in 2009 and 2011 show that patient choice of medical facility and physician is occurring in the post-Semashko health care system, but it is not widespread. The findings of these surveys conducted using different samples, are quite close, and this suggests that the findings are reliable. As of 2011, less than 2% of respondents had changed their regular outpatient facility over the last two years; 14% of those who used outpatient care chose the facility or the physician; 18% of those who used inpatient care over the last three year chose a hospital.

The opportunity of patient choice in the Russian health care system was the outcome of the partial destruction of the Semashko system and the growth in the supply of paid medical services, which was during the transitional period of the 90s and was due to the reduction of public health funding. Paid services continued expanding during the period of economic growth and increased public spending on health that followed (Shishkin, 2013). However, consumer choice in the Russian health care is not restricted to the area of paid medical services. The latest survey data show that the incidence of choice for free medical care is higher than the frequency of choice for paid medical services: in 2011 the choice of free outpatient care was 57%, and the choice of free inpatient care was 59%.

Barriers to choice, related to the lack of alternatives or the money to pay for the necessary treatment, were not as significant as one might think; the percentages of respondents who did not have the opportunity to choose for the above reasons, were 19% for outpatient care and 25% for inpatient care.

Part of patient choice in the post-Semashko health care system is caused by the failure of the referral system to ensure the required treatment. Patient choice becomes a forced search for a provider of treatment by the patients themselves. Clear evidence of such failure are the findings of the surveys that among those patients who chose a specialist, 29% of patients themselves were doing so without a referral from a general practitioner, and 19% had a referral, but it did not specify who the consultation was with. Rural residents and people of retirement age were the most disadvantaged by the referral failure; the proportion of patients in these groups who had a non-specified referral was the highest (25% for each group).

For some Russian citizens, the choice of health care provider is a means to obtain a better quality of care. Such patient choice contributes to the development of competition between providers and increases the efficiency of the health care system. This is a familiar function of consumer choice for Western countries, but the share of patients making such choice in Russia is small. Among those who chose, the proportion of patients made this choice because of

dissatisfaction with health care was 25% for general practitioners and 21% for specialists. This choice is most demanded by the residents of Moscow where the share of patients indicated dissatisfaction was 40% and 27% respectively. For the majority of Russian citizens a choice of medical facility and physician is not a real necessity. 53% of patients who visited a doctor in the last 2 years were satisfied with their regular doctor's services and referrals to other physicians. Another 10% of respondents indicated that choice is not important for them.

In the post-Soviet health care system patient choice is the outcome of the partial dismantling of the Semashko system, and the attempt to improve the efficiency of the emerging health care system. The government policy towards patient choice therefore should be differentiated according to these different functions.

The first priority is to recover the referral system for patients to obtain the necessary medical care. And on this basis, the tasks of the development of opportunities for patient choice might be solved. In particularly this includes the development of information for patients about existing options for choosing a provider.

At the same time the priority of health care policy in the largest cities should be the reduction of the remaining barriers to choice, including the lack of information, and an increase in its impact on competition between health care providers. However, unlimited, and unregulated patient choice leads to a misallocation of resources in the health care system (Sheiman, et al., 2013). Due to information asymmetry between consumers and providers of health services, the latter have the opportunity to provide redundant services. A self diagnosed patient choice of specialists stimulates increased demand for secondary health care and increases the fragmentation of the medical care system. Non-emergency hospitalization without a referral often leads to the provision of inpatient care at an unnecessary level of complexity. Therefore, the enhancement of patient choice is not an absolute imperative for health care systems where patient choice is restricted. A balance must be found between the expansion of choice, thereby increasing the availability and quality of health care and the additional costs that this might entail for the health care system.

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