Health Resort Intstitutions: the Financial Aspects of their Development in Kazakhstan

Saule Iskendirova, Gulmira Rakhimova, Guldinar Erzhanova, Aynur Bazylzhanova, Aliya Sultanova, Saltanat Iskakova

Kokshetau State University named after Sh. Ualikhanov, Abai str.,76, Kokshetau, Kazakhstan, 020000

Abstract. This article discusses the issues of financing of health resort institutions in Kazakhstan. Today the problems of financing the social sector are relevant not only due to the growing need for considerable financial resources, but also because the government needs to find the real ways to finance the system of health resort institutions.

[Iskendirova S., Rakhimova G., Erzhanova G., Bazylzhanova A., Sultanova A., Iskakova S. **Health Resort Intstitutions: the Financial Aspects of their Development in Kazakhstan.** *Life Sci J* 2014;11(10s):477-482] (ISSN:1097-8135). http://www.lifesciencesite.com. 91

Keywords: Health resort systems; Development & Reform; Health Economics & Finance; Kazakhstan.

Introduction

The operation of any sector or industry assumes provision of its resources, including human resources, facilities and financing.

The problem of financing the social sector of the country today features not only the growing demand for significant financial resources, but real opportunities for the state to finance the most critical social areas.

Up until now, limited financial resources impeded the improvement of budget financing of the healthcare system. To resolve this issue more favorable preconditions start to develop at the present time.

Within the continued commercialization of the social sector, the growth of fee health services and narrowing of healthcare for workers, health resorts represent a significant addition to medical network in diagnosis and treatment. Therefore, providing affordable health resort services and their expansion gain national importance.

The transition to a market economy resulted in privatization of the majority of health resort institutions and lack of the state budget financing. In contrast to the Western countries, all the services in health resort institutions were free of charge because Soviet government budget financed the whole health sector.

The Western European resorts differ from the Soviet resorts by their objectives and organizational structure. The operation and development of the European resorts is based on the principles attributable to any capitalistic enterprise. An indirect or direct profit is the main incentive for their development.

When a provider cannot refuse patients who require high treatment costs or discriminate patients by qualities, optimally designed prospective payments can implement the efficient quality and cost reduction efforts, but cost reimbursement cannot induce any cost incentive. When the provider can refuse expensive patients, implementation of the first best requires a piecewise linear reimbursement rule that can be interpreted as a mixture of pure prospective payment and pure cost reimbursement. Under appropriate conditions, prospective payment can implement the first best even when the provider can use qualities to discriminate patients. [1].

By the beginning of “perestroika” (rebuilding), resort operations in Kazakhstan introduced new progressive forms of resort therapies and increased their level of comfort. But the economic collapse of the end of 80ies negatively affected the development of resort and spa sector: service quality deteriorated, nutrition level decreased, and prices for resort vouchers rose. Sanatoriums left without the state financing could not shift to self-financing. The communal expenses became rackingly high, which resulted in higher ticket prices. Decrease of population income led to the lack of possibility to pay for resort vacations.

The sector of health resorts went into decline. Rich people preferred vacations abroad or in elite resorts of the former General administration of the Ministry of Health, which possessed a certain level of comfort and variety of health services. These institutions were held “afloat” with their “new Russian” clients and better developed facilities with the state budget.

Former labor unions’ health resorts, unable to adapt to a market economy, opted for "washout" low-cost medical services necessary for competent medical process, and their replacement with expensive fashionable services to increase prices. In these circumstances resorts facilities have largely lost their social significance. Losing to elite health resorts in the comfort, they started facing challenges in ensuring occupancy. Unprofitable resorts were

closed, while others, in the process of reforms, were transformed into joint stock companies of open and closed ownership (OJSC and CJSC), as well as limited liability partnerships (LLP). The number of resort institutions increased by 14% in the period from 2004 to 2010 mainly due to the increase of non-government institutions (Table 1).

A joint-stock company or a corporation is an enterprise or institution (organization), acting as a legal entity based on issue of shares to raise funds of their owners to carry out its activities, to produce and sell various goods and services on the markets.

Facilities financed through the state budget continue operations together with health resorts organized in new legal forms. At the present time they mainly include anti-phthisic resorts. The majority of authors consider it practical to maintain children's and anti-tuberculosis resorts in forms of budget institutions. A.T. Bykov in his research analyzes advantages of a state-owned health resort in comparison with other forms of ownership [2].

Other authors consider recreation as a cost-effective way of providing health resort services, as vacations at resorts not only serve medical purposes, but also offer entertainment programs rich with various animation cycles, which can raise the vital tone of vacationers, satisfy their spiritual and emotional needs. They also predict conversion of many resorts into recreational facilities.

Table 1 – Health resorts and recreation facilities in the Republic of Kazakhstan in 2004 – 2010.

Title	Years						
	2004	2005	2006	2007	2008	2009	2010
1. State-owned, total including:	50	50	52	53	53	50	53
- resorts, retreat centers with treatment, health and preventative resorts	47	47	48	50	50	48	50
- rest homes and centers, retreat centers	3	3	4	3	3	2	3
2. Non-state, including:	56	52	67	64	67	67	68
- resorts, retreat centers with treatment, health and preventative resorts	46	43	51	55	56	57	61
- rest homes and centers, retreat centers	10	9	16	9	11	10	7
Total	106	102	119	117	120	117	121
Annotation: Calculated and compiled by authors based on data of the Statistics Agency of the Republic of Kazakhstan;							

At the present time the interest for animation activities at resorts not only have not decreased, but also obtained high importance. Choosing a vacation spot people consider not only medical factors, but also sports and animation services, which are provided at a resort. This makes modern resorts pay more attention to leisure activities for vacationers in addition to enhancement of medical facilities.

Analysis of data in Table 2 shows that the number of people who used health resort services for treatment is higher in the regions including Akmolinskaya, Aktobe, Atyrau, Karaganda, South-Kazakhstan as well as the city of Almaty.

Consequently, changes in recreational needs of the population and its demands of quality vacations at resorts must lead to transformation of health resort sector into a resort and recreation system (RRS), with the main purpose of improving people's health, the quality and duration of life.

The state budget funds provide for maintenance of healthcare organizations, which help improve the health of population in the CIS countries. However, within the last decade most of the CIS states have had higher mortality rates and socially preconditioned morbidity of population with a sharp decrease in childbirth.

The main causes of death were diseases of the circulatory system, respiratory system and malignant neoplasms.

There is a growing incidence of respiratory, infectious and parasitic diseases, especially tuberculosis. The epidemiological situation with regard to infections caused by human immunodeficiency virus (HIV-AIDS) has been exacerbated.

The state also plays control and coordination roles. And funding is represented by sources of mandatory contributions by all business entities accumulated by the state in special extra-budgetary funds.

Health resort services consist of two elements: *dominant* and *recessive*. The dominant element is represented by initial set of services including those that are essential for organizing health resort treatment, specifically: accommodation, meals, as well as specific services determining distinction of a given trip, treatment and leisure. The cost of services of dominant part includes the price of a trip ticket.

The recessive part of health resort services includes supplemental set of optional paid services associated with health resort treatment or vacation. For instance, it may include hairdressing services, billiards, lawyers available for additional payment.

The ratio of dominant and recessive parts of recreation services in the world practice is 40:60, and 80:20 in Russia. Many of the health resorts in the Republic of Kazakhstan have an average ratio of 93:7.

It examines how the incentive structure of General Practitioners with respect to the interface between primary and secondary care changed with the introduction of GP fundholding, and how it might change further with the new Primary Care Groups. It concludes that the effectiveness of the internal incentive structure of the new groups will depend on the location of power within the PCGs, and that the external incentives involving the possibility of heavy central monitoring may affect the behaviour and motivation of GPs in potentially harmful ways. [3].

Consequently, a major portion of revenues received is generated from health resort treatment

service, while additional services represent a small portion of that. It is important to achieve two sources of revenue from paid services – recessive elements, and providing optional services, unrelated directly to health resort treatment of a patient. These could be rent of unoccupied spaces, sales of materials and waste and others.

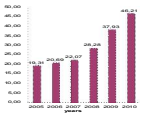
During the period of reforms in the Kazakhstan's economy the nature and sources of financing, specific forms and methods of attracting investments and their technologies have changed drastically. The experience shows that only health resorts providing high quality treatment can survive within the market economy, whereas profitability of health resorts depends on the culture of services. [4]

Price increases for energy resources, food and industrial goods, transport tariffs caused increased cost of vouchers to health resort facilities.

New social and economic conditions provide higher economic and organizational freedom to resorts, putting them, however, in more stringent existing conditions. These conditions are characterized by:

a) Termination of various types of donations, subsidies, subventions, health resort facilities shift to self-financing and self-sufficiency.

b) Introduction of independent sales of vouchers into practice.



Graph 1 – Average cost of one bed-day in resorts in the Republic of Kazakhstan during 2004 – 2010 years, USD

From 2004 to 2010 the cost of one bed-day increased by 2.4 times (Graph 1), while monetary income increased by 2.2 times in the same period excluding increase in other operating expenses.

This explains why most of the population is forced to spend their vacations at home (Table 2).

According to the Statistics Agency of the Republic of Kazakhstan, from 2004 to 2010 the number of resorts, recreation centers with treatment, preventative resorts increased from 93 to 111, that is by 1.2 times, while the number of patients in them increased by 2 times.

The number of recreation centers, homes and vacation bases (graph 2 - 6) has decreased during this period. The number of people who used their services increased by 2.4 times (from 13.4 thousand people to 32.8 thousand).

The ratio of people who received treatment in resorts compared to the total population in 2010 amounted to 1.5 %, which is by 1.2 % more than the same indicator in 2004.

Table 2 – Distribution of employees with vacation leave by the place of vacation (Republic of Kazakhstan = 100 %)

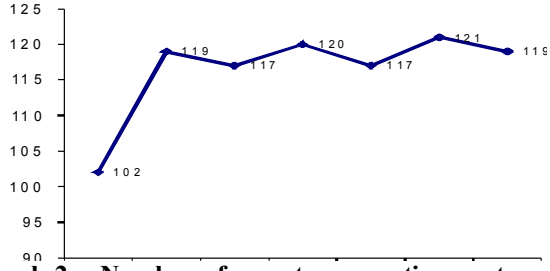
Vacation place	Years							2010 / 2004
	2004	2005	2006	2007	2008	2009	2010	
Rest homes, recreation centers	0.2	0.3	0.6	0.8	0.8	0.6	0.8	2.7
Health resorts	0.3	0.3	0.4	0.5	1.9	2.7	3.5	11.7
In resort areas with home rental	0.1	0.1	-	0.1	0.5	0.7	1.3	13
With relatives	4.3	4.0	3.1	2.8	1.1	1.2	1.4	0.4
Houses	95.1	92.8	92.9	92.3	95.7	94.8	93.0	1.0

This increase is related to the increase of average salary. Besides, a certain layer of people in the society started to have disposable monetary funds, which could be used for quality vacation.

Despite all of that, there are numerous reasons, which slow down the development of health resort and tourist facilities in Kazakhstan, and in particular, in Akmolinskaya region.

At the present time many people are unsatisfied by the conditions offered by recreation centers and rest homes, resorts and preventative centers. Many treatment centers were built in the Soviet time and were intended for middle class. There is a need to achieve European standard, when a certain percentage of vacationers require higher level of comfort.

Thus, establishment and development of market relations reinforce the influence on the health resorts sector, which has positive sides as well. The positive effect is the possibility to buy freely resort vouchers, and redistribution of medical personnel.



Graph 2 – Number of resorts, recreation centers, preventative centers, rest homes and vacation bases in the Republic of Kazakhstan in 2004-2010

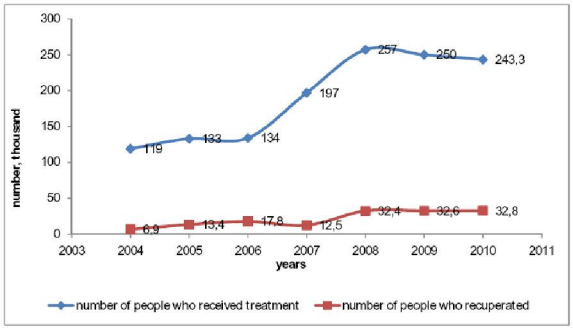
The negative effects include lower affordability of health resort services for many patients with lower level of income, rising price of medical services, unstable and sometimes critical conditions of health resorts.

The transition to self-sufficiency changed services of health resorts from being ordinary and necessary to the grade of unaffordable for the majority of the republic's population.

Researchers believe that in future most of the resorts using the experience of developed countries, possibly, will be reorganized into hotels, recreation centers, etc. Then in parallel it would be possible to establish diagnostic centers and sports clubs. Such a separation will allow significant decrease of resort vouchers prices and make health resorts more accessible for all classes of population.

A proposal by V.M. Kozyrev on creation of fiscal mechanism connected to the existing taxation system that would provide targeted financing for the industry might be useful in solving the problems of financing for health resorts. [5]

Clearly one should also consider the statement by A.P. Kortunov, who argues that a solution to this problem within the centralized accumulation of funds is impossible due to lack of control in distribution of accumulated finances by businesses making rental contributions. [6].



Graph 3 – Dynamics and number of services to patients in resorts, recreation centers, preventative centers, rest homes and vacation bases in 2004 – 2010.

Banking loans are quite attractive as an additional source of financing. Stable economic development much requires development of investment banks network. These banks are significant in countries with developed market economies, since they provide a connection between enterprises, institutions and capital markets.

Throughout the world the healthcare system is financed through three channels. The first two include: payment for services and voluntary insurance – which are private, and the third one – state financing – comprises two elements:

- Financing from general state revenues;
- State mandatory insurance.

Financial provision of healthcare systems in economically developed countries is realized through various sources: state budgets, insurance payments, private sources. The average spending by developed countries on healthcare services constitute 8 to 13% of the volume of gross national product (up to 17% in the USA).

Long-term historical trends indicate substantial room for improvement, especially when ECA's health outcomes are compared to those of the Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom (EU-15). Instead of catching up with their Western neighbors, many countries in ECA have been falling behind. This report, which explores the development challenge facing health sectors in ECA, identifies three key agendas for achieving more rapid convergence with the world's best-performing health systems: (i) the first is the health agenda, in which the main imperative is to strengthen public health and primary care interventions to help achieve the 'cardiovascular revolution' that has taken place in the west in recent decades; (ii) the second is the financing agenda, in which growing demand for medical care must be satisfied without imposing an undue burden on households, by achieving better financial protection, or on government budgets, by ensuring a more efficient use of resources; and (iii) the third agenda relates to broader institutional arrangements. Here, a few key reform ingredients are identified, each of which is common to most advanced health systems but lacking in many ECA countries. [7]

A number of authors [8] highlight three base models for financing of the healthcare system:

- State, financed predominantly from the budget sources (UK, Denmark);
- Budget insurance, financed at the expense of targeted allocations by business people, working citizens and state subsidies. Here financing is mostly allocated from extra-budgetary funds. (Germany, Sweden, France);
- Private, financed with payments of voluntary medical insurance and sales of paid medical services. (USA, Israel, S. Korea, the Netherlands).

For instance, in Canada all healthcare expenses are distributed in the following manner: 34.2% is allocated for hospital maintenance, 10% to other medical institutions, 14.4% for the work of physician, 8.8% for work of other specialists, 14.4% for medicines, 5% for social services, and the rest 13.2% for other expenses. About 70% of all healthcare expenses are financed by the state, including about 30% of them channeled from tax allocations paid in by private parties. Additional insurance purchased by citizens covers expenses for

individual rooms, medicine, dentistry, glasses and some other expenses. Some of patients' expenses are paid partially by the state. [5]

The United States mainly uses a private system of healthcare financing.

At presentm, about 15% of the total gross domestic product in the US is spent for healthcare (almost 4 times less is spent for defense). The regulation of state financed programs is coordinated by the Healthcare Financing Administration of Healthcare and Social Security Department of the United States. However, specifically national expenditures for healthcare in the US make insignificant part due to low share (30%) of total tax allocations to the budget in relation to the GDP volume (in the UK and Germany - 37%, in France - 44%). This slows down the growth of national spending on healthcare, which on average amount to over 75% in the Western Europe (over 90% in Norway) of all healthcare costs.

The indicated trend in supporting lower level of taxation weakens the role of the government, and in the US promotes the development of private medical services leading to a higher disproportion in rendering health services to various layers of the population, providing no evidence of reform possibilities at least in the example of Canada, where most of the healthcare financing is provided from the government funds.

The leading financing source for hospital and medical care is private insurance, while the second source of financing is the federal program Medicare (elderly support); Medicaid program funds (support for the poor) play a significant role in nursing services, while expenses for staying at nursing homes and outpatient care are covered by personal funds of citizens.

The study of organizational choice is crucial to the understanding of firms' efficiency. We consider this issue applied to contracts on health services. In particular, we analyze the circumstances under which it is better for an insurer to contract with both the hospital and the physician instead of contracting exclusively with the hospital, delegating to the latter the power to contract the physician.[9].

Only 20% of medical care is paid by the patients; the rest are paid by insurance companies as well as federal, state and local governments. The provision of medical insurance by employer is a primary source of financing of healthcare and is a private and voluntary initiative. The law does not oblige an employer to provide medical insurance to its employees, however, the decision of the Federal government on tax benefits for entrepreneurs providing medical benefits to employees, as well as exemption of employees from payment of taxes for providing medical services by their employer promoted development of private medical insurance. Up to 70% of the total number of employees with medical care received it at their place of work. However, with the loss of employment a person no longer can enjoy medical insurance from the former employer. The amount of insurance payment does not depend on the salary, and, as a rule, 70% is allocated by an employer, and 30% - by an employee.

Analyzing the sources of attracting funds for financing of health resort facilities, it is necessary to take into consideration advantages and disadvantages of those, in order to ensure higher effectiveness of related decision-making (Table 3).

Table 3 – Analysis of comparing sources of funding for resorts' operations.

Sources of funding	Advantages	Disadvantages
Attracting loans	1. No subdivision of share capital; 2. Interest is charged on the cost of product; 3. Flexibility in borrowing and paying of loans	1. Usually provided in type of short-term loan; 2. Requires a collateral; 3. Can impede or increase the cost of other forms of financing.
Own funds (net income and depreciation)	1. Possability of tax benefits in case of full use of depreciation charges	1. In case of multiple owners, can lead to conflict with them
Leasing	1. No dilution of share capital; 2. Payment for equipment in installments; 3. Leasing payments are included in the costs; 4. Leased equipment also serves as collateral; 5. Interest rate for leasing operations is lower than that of bank loans; 6. Failure to pay lease installments does not lead to bankruptcy; 7. Possibility to inspect the quality of equipment before paying its total price	1. Lessee's depreciation is not included in the cost of services (compensated by revenues); 2. Low-liquidity equipment usually requires additional collateral; 3. Leasing agreement often has additional terms.

Although the current regulation defines health resorts as medical and preventive institutions, they undeniably represent a fraction of the tourism industry.

Modern tourism emerged with provision of annual paid vacations to employees, which at the same time evidences the recognition of human right to rest and leisure. The significance of tourism is increasing with social and economic development of the society. It provides 1/10 portion of the global gross national product, over 11 % of international investments, 90 % of jobs in the global production. [10].

Today the tourism industry represents one of the most profitable and dynamically developing segments of international services trade, forming 8 % of world's revenues from exports, and 37 % of export services provided. Revenues from tourism steadily take the 3rd place after exports of oil, petroleum products and cars.

In order to establish a strong tourism infrastructure, as in Turkey, investments need to be made. State support can be provided in different forms, starting from events to create favorable touristic image of a country to provision of soft loans. For instance, Greece and Portugal use soft loans.

In Austria, in its turn, such loans make up a

half of all investments and are extended at 5 % annual interest for up to 20 years. Italy, France and the UK pay greater attention to subsidies.

Our country has high expectations in regard to establishment of the tourist cluster. Connecting in a cluster of all entities in tourist industry and health resorts into one unified system *may lead* to higher competitiveness and quality of services to tourists.

Development of tourism in Kazakhstan can result in three positive effects on the economy of the Republic:

a) Ensure inflow of foreign currency and will positively influence such economic indicators as payment balance and gross exports;

b) Promote higher employment of the population;

c) Promote development of infrastructure in the country and its regions.

In addition, the inbound tourism will increase occupancy of health resorts, which will in its turn positively affect health resorts operations.

This requires development and realization of regional programs: initiatives for promoting Kazakhstan in the global tourist market through annual participation of the country in major international tourist exhibits and fairs; conducting an international tourism fair in the country; development of economic and legal mechanisms for developing of the sector; investing and realization of projects, which envisage development of tourism infrastructure and international tourist routes.

At the first glance, health resorts and tourism sectors in the republic of Kazakhstan develop dynamically, providing revenues to these institutions and revenues to the state budget. The problem is that, on one hand, the Healthcare Ministry is in charge of resorts business, and on the other hand, according to the Law on tourism, Kazakhstan resorts are considered facilities of the tourism industry, while people arriving for health resort therapies are considered tourists.

Consequently, the resort business is necessary both for the healthcare system and the tourist business as complementary. This has caused fragmentation of mechanisms for managing these sectors, which are so significant for Kazakhstan.

Corresponding Author:

Dr.Iskendirova, okshetau State University named after Sh. Ualikhanov, Abai str.,76, Kokshetau, Kazakhstan, 020000.

References

1 Ma, Ching-to Albert, 1994. "Health Care Payment Systems: Cost and Quality Incentives," Journal of Economics & Management Strategy , Wiley Blackwell, vol.
2 A.T.Bykov. Strategi for developing resort tourism complex in transition period: Saint Petersburg, 1998.
3 Hausman, Dan & Le Grand, Julian, 1999. "Incentives and health policy: primary and secondary care in the British National Health Service," Social Science & Medicine, Elsevier, vol. 49(10),
4 N.A.Varkan, Ya.S.Yadgarov. Quality of services and culture of services to population. M.: Consumer goods and food industries, 1984.- p. 80.
5 V.I.Kozyrev. Tourist rent: Guidelines. – M.: Finance and Statistics, 1998.- p. 80.
6 A.Kortunov. Organizational and Economic principles of managing the development of health resort complex. – Saint Petersburg, 2001.- p. 40-45.
7 Moreno-Serra, Rodrigo & Wagstaff, Adam, 2010. "System-wide impacts of hospital payment reforms: Evidence from Central and Eastern Europe and Central Asia," Journal of Health Economics, Elsevier, vol. 29(4)
8 Mathauer, Inke & Carrin, Guy, 2011. "The role of institutional design and organizational practice for health financing performance and universal coverage," Health Policy, Elsevier, vol. 99(3),
9 Jelovac, I. & Macho-Stadler, I., 1998. "Comparing Organizational Structures in Health Services," UFAE and IAE Working Papers412.98, Unitat de Fonaments de l'Anàlisi Econòmica (UAB) and Institut d'Anàlisi Econòmica (CSIC).
10 R. Sherder. Allocation of payment in the policy of healthcare. TACIS EDRUS 9605 Program report. – M., 1999.

6/12/2014