



Health Care Systems in Transition

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Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of a health care system and of reform initiatives in progress or under development. The HiTs are a key element of the work of the European Observatory on Health Systems and Policies.

HiTs seek to provide relevant comparative information to support policy-makers and analysts in the development of health care systems in Europe. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services;
- to describe the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health care systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Due to the lack of a uniform data source,

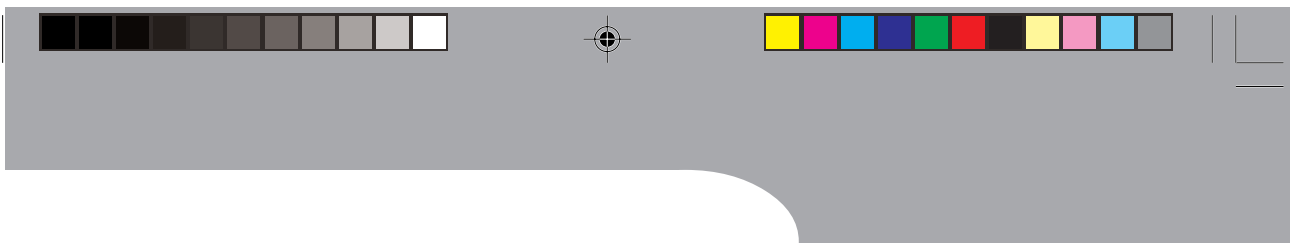
Russian Federation



quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health care systems. They can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to observatory@who.dk. HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's website at www.observatory.dk.





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The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The Observatory team

Russian Federation

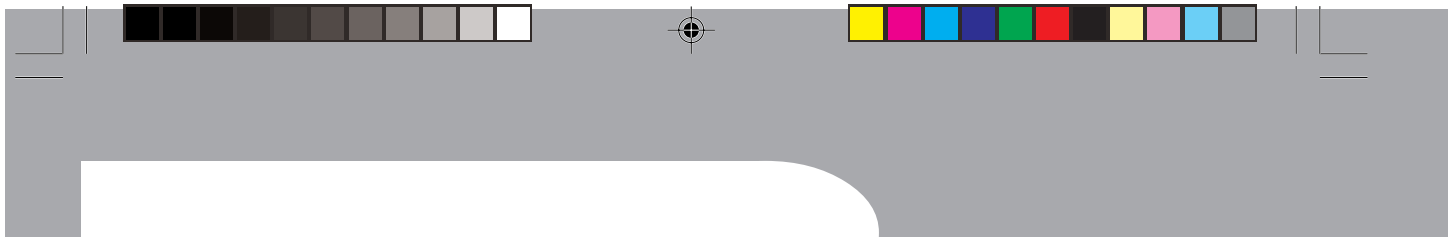


working on the HiT profiles is led by Josep Figueras, Head of the Secretariat, and research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is carried out by Susanne Grosse-Tebbe.

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Introduction and historical background

Introductory overview

General background

The Russian Federation, covering an area of 17 million km², is the largest country in the world in terms of surface area. It has a coastline of 37 653 km, and land boundaries of 19 961 km, bordering the following countries: Azerbaijan, Belarus, China, Estonia, Finland, Georgia, Kazakhstan, North Korea, Latvia, Lithuania, Mongolia, Norway, Poland and Ukraine. Its climates include those of steppes in the south; humid continental in European Russia; sub-arctic in Siberia; and tundra in the polar north. Winters vary from cool along the Black Sea to frigid in Siberia, and summers from warm in the steppes to cool in the arctic north.

Forests and woodland cover 46% of the land, and only 8% is arable, as the larger parts are either too cold or too dry for agriculture. The country is rich in natural resources, having major deposits of oil, natural gas, coal, timber and many strategic minerals. However, the climate, terrain and distances pose obstacles to full exploitation of these resources.

Environmentally, the Russian Federation suffers from air pollution caused by heavy industry, emissions of coal-fired electric plants and transportation in major urban areas; industrial and agricultural pollution of inland water ways and seacoasts; deforestation and soil erosion; radioactive contamination; soil contamination from agricultural chemicals; and ground water contamination from toxic waste.

The capital of the Russian Federation is Moscow, with a population of about nine million. Administratively, the country is divided into 49 oblasts (regions),



Fig. 1. Map of the Russian Federation¹

Source: The World Factbook, 2003.

21 republics, 10 autonomous okrugs (territories), 6 krajs, 2 federal cities (Moscow and Saint Petersburg), and 1 autonomous oblast. These make up a total of 89 equal “federal subjects”. Administrative reforms carried out in 2000 grouped the 89 subjects into 7 federal districts, and attempted to place restrictions on the authority of the heads of the subjects.

The population of the Russian Federation was estimated to be 144.8 million in April 2001,² and has been declining since 1992 due to an excess number of deaths over the number of births. (The demographic crisis will be discussed more fully in the section *Health status*.) A portion of the natural population decrease (about 40% in the late 1990s) is made up for by a positive migratory balance with the former Soviet republics. The largest influx has been from Azerbaijan, Kazakhstan, Uzbekistan and Ukraine, with most migrants being ethnic Russians. However, internally Russia is divided into two zones, one gaining and the other losing population. The northern and eastern parts of the Federation are losing population, while the southern border regions of the European part of Russia and the Urals, as well as the central region and western Siberia are gaining (2). The population is aging, as the proportion of people aged below 15 years fell from 22.9% in 1991 to 19% in 1999 and the proportion of people aged over 64 increased from 10.2% to 12.5% (1).

¹ The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Systems and Policies or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

² Goskomstat estimate (1). Goskomstat is the State Statistics Committee.

The official language is Russian. The largest religious group is Russian Orthodox which is estimated to have about 35–40 million followers (2). Part of the population is Muslim, and a substantial proportion are atheists. The main ethnic groups of the country are: Russian (81.5%), Tatar (3.8%), Ukrainian (3%), Chuvash (1.2%), Bashkir (0.9%), Byelorussian (0.8%), Moldovan (0.7%), other (8.1%) (3). There are in total over 100 registered minority nationalities.

The Russian Federation enjoys a very high literacy rate at 98.4% of the adult population (1997 data) (2). About 60% of the population over 16 years old have completed at least secondary education. Education is compulsory and free of charge for all children between ages 7 and 17. The UNDP Human Development Report of 1998 places the Russian Federation in the group of developed countries with respect to the number of students per population (2). As the demand for commercially-oriented education has increased since independence beyond the capacity of the public education system, there has been a rapid expansion in private institutions offering courses in economics, business, accountancy and law. According to the Ministry of Education, in 2000 there were 400 private universities absorbing 7% of all students (1). Due to a decline in budgetary funding of public universities, the state currently pays for about one third of operating costs of state universities. The balance is made up by fees, with an estimated one half of students paying for their university education, including the bribes often required to pass entry exams. The quality of education is high, though the curricula are often dated and resources (books, equipment, etc.) are in very short supply.

Political structure

Russia declared its independence on 12 June 1990 (Independence Day) after a Declaration on State Sovereignty of the Russian Soviet Federated Socialist Republic (RSFSR) was adopted by the Supreme Soviet of the RSFSR. One year later, on 12 June 1991, Boris Yeltsin became the first democratically elected Russian president. On 8 December 1991, the Presidents of Belarus, Russia and Ukraine signed a treaty to abolish the USSR and form the Commonwealth of Independent States (CIS, which later expanded to include eleven states of the former Soviet Union). The USSR formally ceased to exist on 25 December 1991, when President Gorbachev announced his resignation. On the same day, legislation entitled “On changing the name of the state RSFSR” was passed, according to which as of that date the name of the Russian state should be read and written as “Russian Federation” (RF).

In December 1993 the Russian Federation held its first free parliamentary elections. According to a new constitution, approved by national referendum

on 12 December 1993, the country is a federal democratic republic. Governing powers rest with the president, the Federal Assembly (Parliament), the Government (ministries) and the courts. The president, who is head of state, is elected by direct and universal suffrage. The presidential term of office is four years, with a maximum of two consecutive terms. The constitution granted sweeping executive powers to the president, including the power to appoint the prime minister, Central Bank governor, and chairman of the Constitutional Court, subject to parliamentary (State Duma) approval. However the president holds the power to dissolve the State Duma if his choice of prime minister is repeatedly rejected, or if two no-confidence votes are passed within three months. Further, the president may issue decrees and executive orders which are not subject to State Duma approval. President Putin, in power since March 2000, has further strengthened the presidency.

The Federal Assembly is the supreme legislative body and consists of two chambers, the Federation Council (which approves laws) and the State Duma (which proposes and adopts laws). The Federation Council is composed of two representatives of each "subject" (hence 178 deputies); the State Duma of 450 deputies elected for four-year terms. Both bodies tend to be relatively weak.

The judiciary consists of the Constitutional Court, which deals with cases involving compliance with federal laws, the constitution, state treaties, etc. and the Supreme Court, the highest authority on civil, criminal and administrative law. Its authority is also relatively limited (1).

The Ministry of Finance in recent years has become the key driving force of the economic stabilization programme. The Ministry for Economic Development and Trade has gained in importance; other powerful ministries include Interior, Defense and the Federal Security Service.

There were 26 political parties included on the ballot for the 1999 State Duma elections (down from 43 in 1995), only 6 of which received the 5% vote necessary for parliamentary representation. Most political parties are weak and fragmented.

The transition to a democratic regime remains fragile by all accounts, not least because there persists in Russia to this day a line of thought claiming that Russian traditions and culture may not be fully compatible with liberal values and democratic institutions, such that progress would only be possible under an authoritarian form of government with strong control over activities in all spheres. In an opposing view, it is argued that Russia must make a concerted effort to develop its democratic institutions and accelerate the processes of transformation that would make it an integral part of the global system, while strengthening its ties with democratic and technologically advanced countries (4).

Economic change and impacts on the standard of living

Whereas there was unquestionably an economic collapse in the Russian Federation following independence, it is difficult to accurately measure it, and it is likely that its extent has in fact been exaggerated by economic statistics. Measurement and comparison difficulties are related to the existence of several statistical series each attempting to improve upon others, and differing assumptions concerning the size of the black economy. Goskomstat estimates a black economy of about 25% of GDP and adjusts GDP figures accordingly, however according to other independent calculations the black economy accounts for as much as 40% of GDP (1). In addition, the probable overstatement of the size of the economic collapse is due to the fact that while enterprises during the Soviet period faced an incentive to overstate production, the switch from subsidy-receiving to tax-paying status following the economic transition created an incentive to understate actual production.

It is estimated that GDP fell by roughly 12% in real terms in 1991, while inflation rose to triple digits even prior to price liberalization. In contrast to other eastern European countries which managed to get back on track relatively quickly following their independence, GDP in the Russian Federation continued to contract for an additional four years. The reasons behind this downturn include the following (1): long-standing focus on industrial development with little regard for profitability, environmental concerns or opportunity cost; the breakdown of trade with eastern European countries; inability to sustain agriculture in the absence of former subsidies that were no longer affordable; the breakdown of the command economy without a functioning market economy to replace it; and conflicting currents of support for rapid reform and strong resistance from the old political elite.

Since 1992, the macroeconomic policy orientation has focused on price liberalization, macroeconomic stabilization and integration into the global economy. However, it has not been possible to embark upon effective implementation of structural reforms. Currently, most output and employment are in the private sector, though state involvement in the economy remains very strong.

Triple-digit inflation was curbed by 1995 and the economy experienced a small recovery in 1997. However, this ended with the financial crisis of 1998, which resulted in devaluation of the ruble and the government's debt default. These events have been attributed to persistent budget deficits and accumulating debt, incomplete reforms in the financial sector and lack of broad political support for reform initiatives, together with falling prices for the main export commodities (mainly oil) in 1997–1998. The competitive ruble and rising oil prices in the subsequent years led to a recovery in 1999 and 2000, with GDP

growth rising to 5.4% and 8.9% respectively. Inflation, which had increased following the devaluation, fell to about 20% at the end of 2000, and the government appeared to have taken control over its finances, helped by increased oil revenue and improved tax collection.

While these developments raised confidence that economic prospects for the country may have improved, growth slowed in 2001 and, more importantly, the government did not take advantage of the economic recovery to push ahead with structural reforms. Persistent serious problems include the Russian Federation's dependence on commodities (oil, natural gas, metals, timber) for over 80% of exports, whereas these are subject to wide and unpredictable price fluctuations (3); uncertainties in the agricultural sector due to questions over land ownership rights; the urgent need for modernization of the industrial base; the challenge posed by the "oligarchs"³ who are the most powerful obstacle to structural reform and a major deterrent to foreign investors, along with poorly defined and improperly enforced property rights, poor contract enforcement, and widespread corruption; exceedingly complex and contradictory legal and tax systems; capital flight; brain drain; and the significant deterioration in health status and demographic trends (discussed in detail below).

The process of transformation to a market economy has produced major economic and social dislocations for the people of the Russian Federation. The economic decline has clearly had a major impact on living standards, greatly increasing the percentage of the population living in poverty, or on incomes less than what is officially calculated to be the subsistence minimum. In the period 1992–1993, price liberalization gave rise to an overall 40% decline in real income. In 1992, an estimated 33.5% of the population were poor (i.e. lived on incomes below the subsistence minimum), while in 1993 this was 31.5%. In the years 1994–1998, the poor constituted roughly 21 to 25% of the population, but in 1999, due to the financial crisis of the previous year the proportion of poor rose to nearly 29% of the population (4).⁴

A key factor contributing to the increasing numbers of individuals living below the poverty line is the level of wages. The minimum wage in 1992 stood at 22% of the minimum subsistence level; in 1995 it stood at 14%, and by 1998 it had fallen to 8% (4). This means that over 60% of workers in agriculture, health care and culture received wages substantially below the subsistence level. The minimum pension is also below the pensioners' subsistence minimum,

³ This refers to a small group of well-connected businessmen who in the course of privatization used price irregularities and their close connections with the government to purchase controlling shares in some of the largest state enterprises (oil, gas, metals and financial sectors) at extremely low prices. These individuals have been concentrating on transferring their assets abroad, and have little interest in reforms of the economy.

⁴ The figures presented here should be taken as indicative, because of changes in the methods of calculating the subsistence minimum over time.

though the gap is smaller than in the case of the minimum wage. In 1992 the minimum pension was 85% of pensioners' subsistence minimum, but fell to 48% in 1998.

In terms of purchasing power parities, personal income in the Russian Federation is now equivalent to that of the United States in 1897 (5).

A second factor contributing to the high degree of poverty is pervasive wage arrears, which are encountered not only in economically weak enterprises (1) but in many sound ones as well, and are due to the lack of legal and social protection for employees (4). There is widespread informal remuneration for work, even in enterprises that are officially registered; an estimated one third of salaries are in the underground sector (5).

A further factor behind the growth in poverty is increased unemployment, which according to ILO calculations was just over 4% in 1992, about 13% in 1998, and fell to about 9% in 2000 (4).

The post-independence period has also seen significant increases in income inequality. Intersectoral wage differences were 8.4 times in 2000, while intrasectoral differences were as high as 30 times. The concentration of entrepreneurial and property incomes in the hands of a small elite contributes very significantly to enormous income differentials. Inflation has been a major factor in exacerbating income inequalities as the poorer segments of the population have been the hardest hit.

According to Goskomstat calculations, the ratio of the top 10% of income recipients to the bottom 10% in early 2001 was 13.8, compared to an estimated 3.5% during the Soviet period. Further, the top 10% account for about one third of total income, and the bottom 10% for less than 3% (1).

Health status

It is useful to begin an account of health status developments with a consideration of the Soviet period, as the present health crisis of the Russian Federation has its roots in events that long precede the collapse of the Soviet Union.

The period until 1991

At the end of the nineteenth century, life expectancy in Russia was 32 years, compared to 47 years in France and the United States. By 1938 the gap had increased: life expectancy was 43 years in Russia, while in France it had reached 59 years and in the United States over 63 years. In the course of roughly the next 15 years, however, Russia made huge strides and succeeded in closing

much of the gap. By 1965, life expectancy for males was 64.3, 67.5 and 66.8 for Russia, France and the United States respectively, and 73.4, 74.7 and 73.7 in the case of females (6). However this progress was not maintained in later years. The factors behind these developments will be outlined below.

Following the establishment of the “Semashko” model in 1918, Russia made massive strides in arresting the spread of infectious diseases. Drastic epidemic control measures were implemented, particularly in the cases of tuberculosis, typhoid fever, typhus, malaria and cholera. These involved community prevention approaches, routine check-ups, improvements in urban sanitation and hygiene, quarantines, etc. (For an account of health system conditions related to health status development see the section below *Historical background*).

Progress in controlling infectious diseases continued to be made throughout the entire Soviet period, with crude mortality rates from infectious diseases falling from 87 per 100 000 in 1960 to 21 in 1980 and 12 in 1991 (representing a fall of 86%) (7). Yet these successes were not reflected in improvements in the overall health status of the population. Whereas life expectancy in Soviet Russia (and the entire Soviet Union) showed continuous improvement until the 1960s, it subsequently stabilized, presaging a growing gap with western nations that were to experience continuously increasing life expectancies. By about 1990-91, male life expectancy was roughly at the same levels or lower than in the 1960s (63.8 years in 1990 compared to 63.0 years in 1959 and 64.3 in 1965), while female life expectancy had improved only slightly over the 30-year period (71.5 years in 1959, 73.4 years in 1965, and 74.3 in 1990). The variation in death rates after 1965 was particularly unfavourable in Russia’s male population (8). By the beginning of the 1980s the gender gap in life expectancy was about 12 years, which is largest of all countries in the world (9).

Infant mortality stood in 1971 at 22.9 per 1000, having fallen to less than one tenth of pre-revolutionary Russian figures and roughly one quarter of those of 1950 (although the use of the Soviet definition of a live birth prior to the mid 1990s means that these figures are about 20% lower than they would have been using the WHO definition) (10). However in subsequent years they began to climb, reaching 24.7 in 1972 and 27.4 in 1974. At that time, with the appearance of declining health status indices and widening gaps with the west, the Soviet authorities decided to stop publishing data.

The diverging paths of Russia and other industrialized nations with respect to health status from the 1960s onward has been attributed to the failure of the Russian health care system to successfully respond to the epidemiological transition. In a sense, the very factors making for the successes of the early

years in curbing the spread of infectious diseases were responsible for the inability to effectively cope with noncommunicable diseases that were becoming increasingly important. The Soviet health care system was based heavily on prevention, consisting of extensive screening measures and check-ups, although with little evidence for their effectiveness, which together with the introduction of antibiotics after the Second World War, contributed to major reductions in infectious diseases. This system of prevention, with its primarily medical orientation, did not evolve into one of population-based health promotion measures necessary for dealing with the new patterns of morbidity (due to noncommunicable diseases). While those in power were aware that an epidemiological transition was occurring, they responded by treating cardiovascular and other noncommunicable diseases as “social diseases”⁵ requiring a medical solution (7).

Over and above its medical orientation, the health care system suffered greatly from under-funding as the military demands of the Cold War, and in particular the race to build missiles, took precedence over all social issues (5). The paternalistic Soviet philosophy did not encourage the development of responsibility of the individual with respect to lifestyle issues that have a major bearing on health (alcohol use, smoking, diet, etc.), a situation exacerbated by the heavy dependence on alcohol sales as a means of circulating currency in a country with little access to consumer goods. And Soviet medical science was effectively isolated from developments in the West, not only in terms of knowledge of new treatments but also access to pharmaceuticals, technology, and the emerging evidence based medicine movement. The USSR failed to develop a modern pharmaceutical industry and was dependent on imports from eastern Europe and South Asia. As a consequence, many ineffective treatments that had either never been adopted or had long been abandoned in the West remained routine and innovations developed in the west were not adopted. The consequences can be seen from the way that rates of avoidable mortality, or deaths that should not occur in the presence of timely and effective care, remained high in Russia from the late 1960s onwards at a time when they were falling steadily in the west

By the 1980s, the gap between Russia and Western countries in life expectancy at birth came to about 10 years for men and 6 years for women, mostly due to high death rates among those of working age (6). In the mid-1980s, the government made an attempt to address this problem (9). It was by

⁵ The term “social diseases” was used to refer to diseases associated with the working and living conditions of workers, and included mainly infectious and occupational diseases, and maternal and child health problems.

then generally understood that potentially avoidable human losses were mostly attributable to excess adult age mortality from particular causes such as injuries, accidental poisoning, suicide, homicide, sudden cardiac death, hypertension and other conditions closely related to alcohol abuse and its consequences. A campaign against alcohol was launched, in which alcohol prices were raised and sales outlets cut, enforced by punitive measures (11). Although this large-scale anti-alcohol campaign was primarily introduced to tackle the loss in productivity from widespread alcohol use, it also had an impact on health. State production and sales of alcoholic beverages (the only legal source of alcohol in the USSR) dropped to less than one third, the prices of alcoholic beverages were raised, further measures were taken against the production of strong homemade alcoholic beverages, and legal sanctions were enforced. Further, the network of medical establishments for compulsory treatment of alcoholism was expanded.

The impact of these measures on death rates surpassed all expectations (12). In the period from 1984 to 1987 life expectancy at birth increased from 61.7 to 64.9 years for men, and from 73 to 74.4 years for women (13). Such a sharp rise in life expectancy over a period of just three years had never before been witnessed in the entire postwar history of the world's developed countries. Russia failed to maintain this record, however: by 1987 the USSR was no longer able to enforce the anti-alcohol campaign and death rates rapidly resumed their upward trend from 1988 onwards. The anti-alcohol campaign was largely prohibitive and did not affect the attitude of the majority of Russia's population towards alcohol.

Thus towards the end of the Soviet period, the Russian population, faced with mortality rates much higher and life expectancy lower than those of its western neighbors, was already confronting a health crisis which had been developing gradually over the previous two to three decades.

The period after 1991

The health status of the Russian population declined precipitously following the collapse of the Soviet Union in late 1991. By all accounts, in the last decade Russia has been experiencing a shock unprecedented in peacetime to its health and demographic profiles. This section will outline the evolution of health status indicators during this period.

A combination of a dramatic fall in the birth rate and increasing mortality meant that since the mid-1980s, Russia's population has shown declining growth rates, which became negative in 1992 (2). The size of the population, estimated at 144.8 million in 2000,⁶ has fallen by 3.5 million in the period 1992–2000.

⁶ Goskomstat estimate (1).

The decline would have been even greater had it not been for net immigration during the early 1990s due to the resettlement in the Russian Federation of ethnic Russians returning from other Soviet republics. In 1992, the death rate in the Russian Federation was greater than the birth rate for the first time, and has been so ever since. Until recently, deaths exceeded births by roughly 60% per year (2). Indications are that these trends have been accelerating, producing even larger population drops: in the first six months of 2000 deaths exceeded births by 84%, and in the corresponding period of 2001 the excess was 75% (14). The natural population loss rose from 200 000 in 1992 to 800 000–900 000 per year in recent years (2). In the first half of 2001 a natural decrease (i.e. not including migration) of 484 900 was reported and in the first half of 2000 the decrease was 522 700 (14). However these figures must be treated with some caution as it is believed that there was substantial under-registration in the 2002 Russian census.

The total period fertility rate fell from 2.2 children in the late Soviet period to 1.73 in 1991 and 1.2 in 2000, and is one of the lowest in the European Region (15). This is just over half of the population replacement rate of 2.1. This dramatic decline in the birth rate is common to nearly all of the countries in transition and has been interpreted as the result of decisions to postpone having children in times of economic uncertainty. Although less important in explaining the fall in the birth rate, the frequency of female infertility is increasing at more than 3% per year, due to the growing prevalence of sexually transmitted diseases (16).

During the 1990s, mortality rose for all age groups except infants and children, and for both sexes, though the increase was far greater for males. The greatest increase in mortality was among males aged 40–49, which nearly doubled (87% increase) in the period 1990–1994 (4).

Life expectancy is now among the lowest in Europe, particularly in the case of men, which is almost 13 years lower than the average for the European Union (2). As previously noted, in the period 1986–1987 there was a sharp increase resulting from President Gorbachev's anti-alcohol campaign; however, this was short-lived as by 1992 life expectancy fell to the same levels as in 1985, followed by a further sharp fall in the period 1993–1994, and then a gradual increase from 1995 onward. Male life expectancy dropped from 63.8 in 1990 to 57.6 in 1994, representing a loss of over six years within just half a decade. In 1998 it peaked at 61.39, but then began declining again, falling to 59.15 in 2000,⁷ and to 58.5 in 2001⁸ (see Fig. 2 and Fig. 3 below). Under present conditions, only 54% of 16-year-olds today will survive to age 60 (16).

⁷ WHO health for all database (13) and Federal Ministry of Health of the Russian Federation.

⁸ Federal Ministry of Health of the Russian Federation.

Female life expectancy, by contrast, has tended to be more stable, dropping from 74.4 in 1990 to 71.2 in 1994, or a loss of about two years. It peaked in 1997 at 72.96 years and subsequently fluctuated at lower levels, reaching 72.4 years in 2000 ⁹ (13) and 72.1 years in 2001.¹⁰

In the case of both male and female life expectancies, the bottom was reached in 1994, and both, particularly women, recovered much of the lost ground in the latter half of the 1990s (17), although these gains have reversed since 1998.

A striking issue concerns the size of the gender gap, which has long been the largest in Europe. This peaked at 13.6 years in 1994, when both female and male life expectancies bottomed, due to the far greater loss of years of male life expectancy. More recently (2000) it stands at 13.2 years.¹¹ However it should be noted that, while Russian women live much longer than their male counterparts, they have very high levels of poor health, so that healthy life expectancy is surprisingly similar for both men and women.

The leading cause of death in the Russia Federation is cardiovascular disease with rates that are the highest in the European Region. These deaths often occur at a younger age than in western countries and are much more likely to be sudden. While much of the cardiovascular disease in Russia is likely to be attributable to the traditional risk factors, such as a poor diet and smoking, there is now considerable evidence that many of the excess deaths especially among younger men are attributable to heavy alcohol consumption, with this factor explaining the large fluctuations in cardiovascular deaths since the mid 1980s. (18). (See the section below for a further discussion of this issue.)

The second most important cause of death involves external causes of injury and poisoning (which includes homicide, suicide, alcohol poisonings, etc.). As with cardiovascular diseases, these deaths peaked in 1994. The importance of this category of causes of death is unusual by the standards of most industrialized countries, where external causes tend to be superseded by cancer. A reduction in deaths from external causes after 1994 was reversed in 1998 and the Russian rate continues to be the highest in the European Region (2). The male mortality rate in this category is 4.4 times greater than that of women, accounting for about half the deaths of working-age men, and there is considerable evidence to link it to alcohol abuse.

External causes are followed in importance by cancer, which rose until 1995 and then began to fall (19). This fall will, however, be transient as it is due to a temporary decline in deaths from lung cancer reflecting reduced smoking rates in the immediate postwar period (20). While the incidence of

⁹ WHO health for all database (13) and Federal Ministry of Health of the Russian Federation.

¹⁰ Federal Ministry of Health of the Russian Federation

¹¹ WHO health for all database (13) and Federal Ministry of Health of the Russian Federation.

cancer is low for ages 65 and above compared to western European countries, it is very high in the below-65 age group. In addition, the rapid increase in smoking among young women means that their rates of lung cancer will rise considerably in the next few decades (21).

Maternal mortality (39.7 per 100 000 live births in 2000) is one of the highest in Europe, though it has been steadily falling, having dropped from 68 per 100 000 in 1980. It is interesting to note that there was a dramatic fall in the period 1995–2000 (from 53.3 to 39.7) (13), in spite of the economic crisis and pressures on the health system. Abortions, which are also the highest in the European Region and are still a common form of birth control, are the single greatest cause of maternal mortality (29.4%) (4). Other major causes of maternal mortality are hemorrhage (13.8%) and eclampsia (12%). More than two abortions occur for every live birth.

Infant mortality has been in the range of 16–20 per 1000 live births (13) during the last decade (although the figures should be treated with caution because of incomplete implementation of the WHO definition of a live birth), and it is one of the lowest in the NIS though significantly higher than in western European countries. Morbidity of newborns, however, is a matter of great concern, with some reports suggesting that up to 20% have a birth defect (although this remarkably high figure requires further study in view of definitional problems), and only 35% are considered “fully healthy” (4). Initial analyses of detailed information collected in Tula oblast indicate a high frequency of low birth weight, with large differences according to maternal education.

Mortality from infectious and parasitic diseases nearly doubled in the first half of the 1990s, then stabilized and is close to the average for the NIS, which is much higher than in western Europe (2). These mortality rates, however, hide some highly disturbing developments within specific disease categories. Tuberculosis has been rising sharply since 1990. In 1998 there were 74 cases per 100 000, placing the Russian Federation in the top ten countries in the world (16). There are indications that these figures may be underestimates, as unknown numbers of homeless people and refugees may have the disease. The prevalence of tuberculosis is especially high in the Russian Federation’s prisons, with one of ten prisoners infected and about one third of all TB sufferers in a penal institution (16). Even more worryingly, a growing proportion of tuberculosis infections are resistant to first line antibiotics, reflecting the gap between the civil and prison health systems, a failure to adhere to treatment regimes and an inadequate laboratory infrastructure (22). This issue is being addressed by several projects funded by, among others, the UK Department for International Development and the German Agency for Technical Co-operation (GTZ).

An outbreak in the early 1990s caused diphtheria to increase 54-fold and the mortality rate to increase 35-fold (2). This was due to a collapse of vaccination programmes as a result of HIV fears, as well as to failings in the State Sanitary Epidemiological Surveillance (san-epid) system at the time. Effective measures to improve the vaccination rate were undertaken. A growing concern now is rubella, vaccination against which is not on the official schedule, although some regions do provide it using local budgets. There were periods of relaxation of vaccination programmes in the middle of the 1980s and early 1990s due to the economic difficulties (2); in addition, in the early transition years parents were hesitant to have their children vaccinated for fear of dirty needles and poor quality vaccines (16). The incidence of sexually transmitted diseases is reaching epidemic proportions, with syphilis being particularly worrisome: its incidence has increased by 77 times since 1990, and about 50 times for girls 10–14 years old (16). In 1997 it was 279.2 per 100 000, the highest in the European Region. There has also been a 9-fold increase in congenital syphilis. In certain regions (such as the Tuva and Khakass republics and the Sakhalin and Kaliningrad provinces) the rates are double the national average (2). However, changes in the management of sexually transmitted diseases, in particular the growth of anonymous, and therefore unrecorded treatment in the private sector since 1993, mean that the more recent figures are likely to be underestimates (23). Further, there has been increased incidence of numerous other diseases that were earlier under control, including cholera, typhus, typhoid, whooping cough, measles, and hepatitis. It is noteworthy that even malaria is making a comeback: in Moscow over 200 cases of indigenous malaria were reported in 2001.

Rates of HIV infection began to increase sharply in the latter half of the 1990s. The officially registered incidence is as yet low compared to western countries; however, according to UNAIDS it is growing faster in the Russian Federation (and eastern Europe) than anywhere else in the world (24). The number of registered cases in the first half of 2001 showed a 60% increase compared to the previous six-month period. The increase to date is due mainly to spread within the intravenous drug using community. The steady increase in the number of drug users presents a bleak scenario for the future course of the AIDS epidemic. Drug abuse has reached epidemic proportions, with some estimates suggesting that levels of addiction have increased 12 times in the past decade and the number of adolescent drug abusers increasing ten-fold (24). According to the Ministry of the Interior, numbers of heroin users have increased by more than 15 times over the past decade (25). HIV infection is now breaking out to the broader population through sexual transmission, exacerbated by the lack of effective sex education in the Russian school

curriculum, with dire consequences for society. The struggle to contain the growth of AIDS has often been handicapped by the punitive stance taken against drug users, although there are now increasing numbers of projects undertaking harm reduction activities, such as needle exchange, funded mainly by the Soros Foundation and the UK Department for International Development (DFID).

As already noted, alcohol is an important cause of premature mortality in Russia. According to official data, alcohol consumption ranged from 11 to 14.5 litres of pure alcohol per person per year (1993 data) with 7.5 to 8.5 litres of this coming from illegal sources (2). However estimates of consumption are extremely problematic, not least because of the scale of illicit production. Following the collapse of the anti-alcohol campaign in 1987, alcohol consumption increased sharply. This was aided by lower price increases for alcohol than for other consumer goods. Almost a third of Russian men admit to drinking heavily on a regular basis (27).

Tobacco consumption among men increased from 53% in 1985 to 67% in 1993, which is one of the highest rates in the world (2). Smoking prevalence among men was 63.5% in 2001, and 14.2% among women (26). The growth in smoking among young women is of particular concern.

The health of children and adolescents is a very worrisome issue. The problem in large measure is related to the high proportion of children living under disadvantaged social and economic conditions. According to a *State Report on the Status of Children in the Russian Federation*, 12 million children live in families with incomes below the subsistence minimum; 20 million live in poor families; 2 million have dropped out of school; between 2 and 4 million are homeless beggars; and 600 000 children are not under the care of either of their parents (28). In the past decade there have been reports of marked increases in the incidence of a wide range of disorders, e.g. 380% for anaemia, 280% for disorders of the endocrine system and 190% each for disorders of the digestive system and the circulatory system (although these figures need to be treated with some caution because of definitional problems). The percentage of children suffering from stunted growth due to inadequate nutrition is reported to have risen to 8% (28). A significant proportion of children survive on inadequate diets.

It is estimated that 30 million Russians are affected by iodine deficiency disorders, while iron deficiency anemia and rickets are held to be common (29). The Russian diet is especially low in fresh fruit and vegetables, leading to widespread deficiency in micronutrients, which is thought to contribute considerably to the high levels of many chronic diseases. Dietary deficiencies are especially common among pensioners.

There was a marked increase in homicides during the 1990s, to a level about 20 times higher than in western Europe. Since 1990 those committing homicides have become much more diverse in terms of education and employment. As elsewhere, most victims know their killers and alcohol is an almost constant factor, for both victim and perpetrator (30).

High levels of environmental degradation mean that 40% of the urban population lives with high air pollution levels. It is commonly believed that this is associated with respiratory disease, although this is not borne out by empirical research. It is estimated that 50% of the Russian population consume substandard drinking water (29).

Regional variations

The indicators presented above for the Russian Federation mask enormous interregional variations stemming from the country's vast size and socioeconomic, ethnic, cultural and geographic heterogeneity. Life expectancy (male plus female) varies by as many as 16 years, ranging from a high of 72.5 years in the Republic of Ingushetia in the northern Caucasus and a low of 56.4 years in the Republic of Tuva in eastern Siberia (2). In general, the highest life expectancy is to be found in the Northwest, Central Chernozem, Volga and Northern Caucasus Regions, while the lowest is in Far East, Eastern and Western Siberia (16).

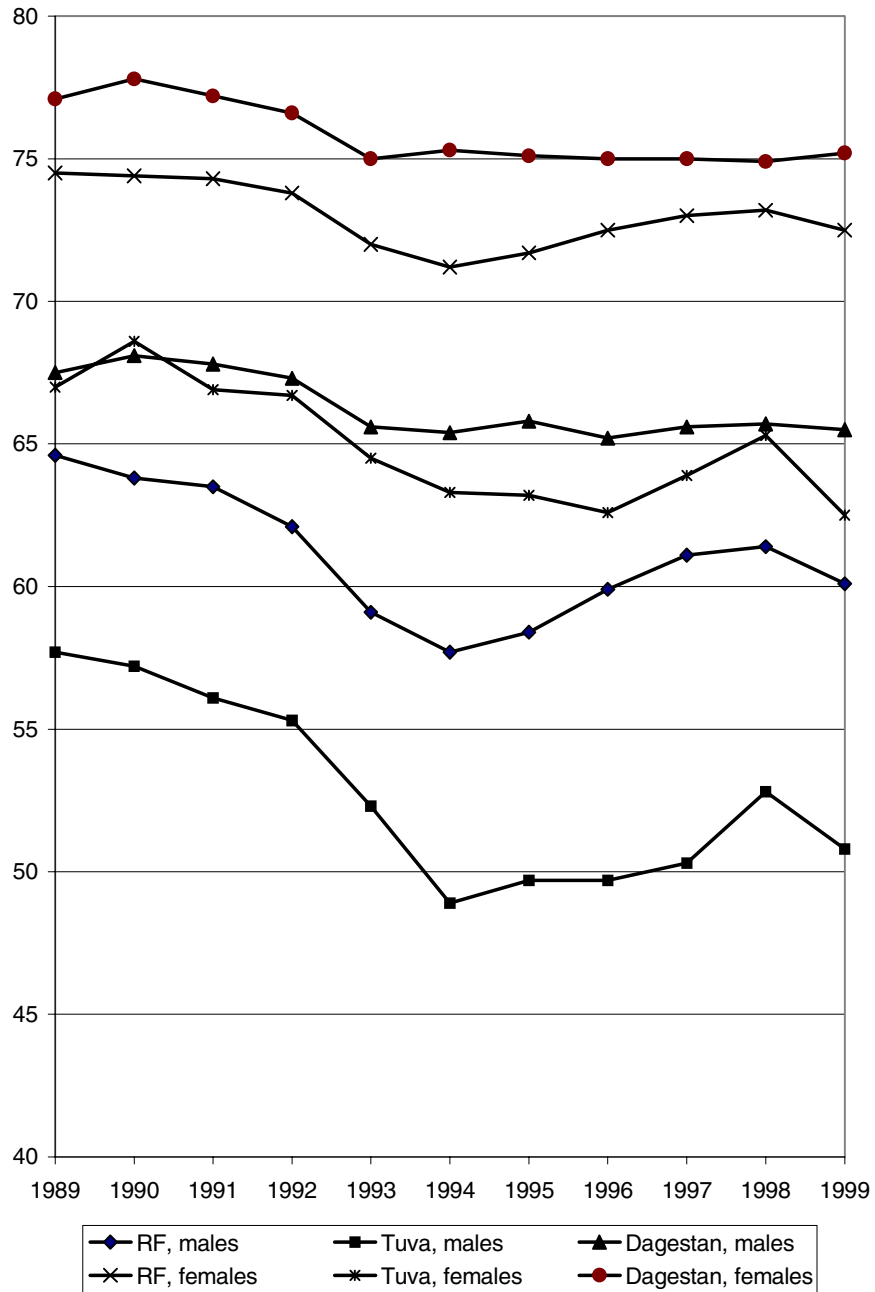
Fig. 2 shows male and female life expectancy patterns in the Russian Federation as a whole, and the Tuva and Dagestan Regions. The life expectancy differential between the highest (Dagestan females) and the lowest (Tuva males) is a noteworthy 20 to 27 years. The difference was smallest in the beginning of the period shown, 1989–1990, and reached its maximum in 1994 when Tuva male life expectancy dipped below 50 years. The very low life expectancy in Tuva is attributed to its very low level of economic development.¹²

At the level of macro-regions, life expectancy trends over time have been similar. This can be seen clearly in Fig. 3, showing male life expectancy in the Russian Federation's eleven macro-regions.¹³ All the regions show a sharp drop after 1990, a lowest point in 1994, and an increase thereafter. However, in times of declining life expectancy, as in 1990–1994, the gap between the higher and lower figures increased (16). This pattern is also depicted in Fig. 2, where the gap between the Dagestan and the Tuva Regions increased in the period 1992–1994 for both males and females.

¹² It should be noted that while the data presented here are from official governmental statistics, these two regions constitute outliers, and some critics have questioned the quality of mortality data (especially in Dagestan).

¹³ Macro-regions do not refer to administrative units but rather are a convenient breakdown of the country involving fewer and larger units than the 89 subjects.

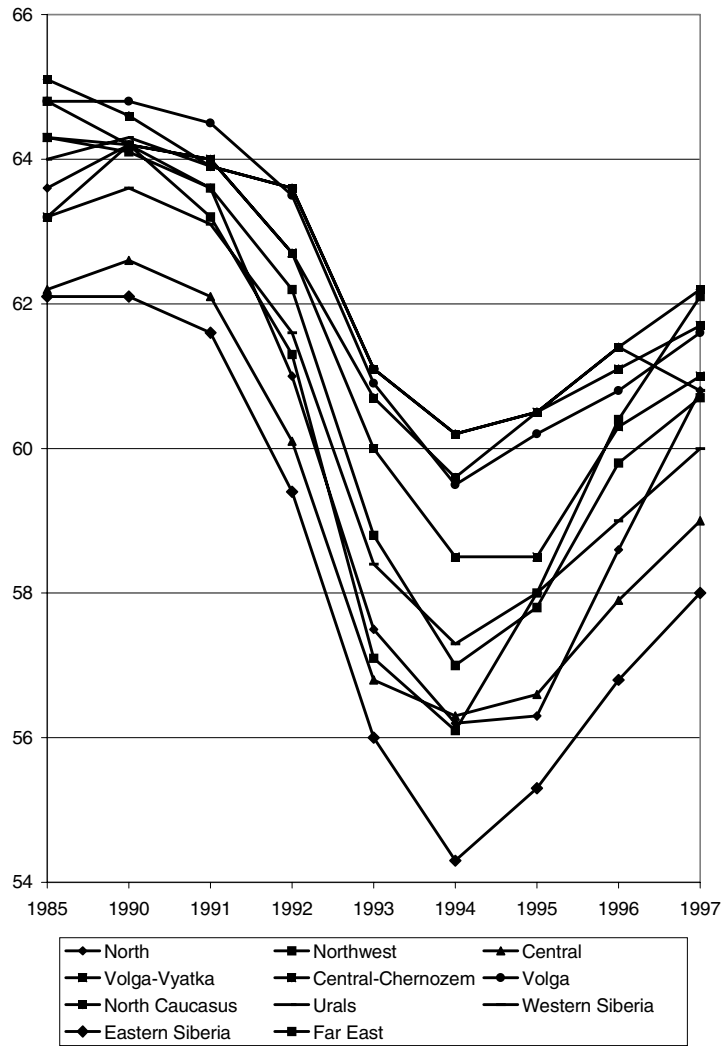
Fig. 2. Life expectancy trends, Russian Federation, Dagestan, Tuva, 1989 – 1999



Source: Varavikova, Health trends in Russia, 1989 – 1998, The regional perspective (32).

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Fig 3. Male life expectancy at birth in the Russian Federation, by macroregion, 1986 – 1997



Source: J. Twigg, Russian Health Status in the 1990s: National Trends and Regional variation (16).

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However, at the oblast level there have been considerable differences in the pattern of life expectancy trends. In the early 1990s the declines in life expectancy were greatest in those oblasts that experienced the most rapid pace of economic transition and the highest increases in crime rates (in particular the large cities). The differences in life expectancy were driven almost entirely by deaths from causes in which alcohol plays a major role (31).

Causes of the mortality crisis

The underlying causes of the developments described above have been debated at length, and can be briefly summarized as the impact of a major social and economic shock in a population already vulnerable because of poor diet, high levels of smoking, and weak systems of social support, in which alcohol and, increasingly, intravenous drugs, are easily available. This is in a country where the health care system is poorly equipped to respond to these challenges.

The group that has been hardest hit has been adult males of working age. In the period 1994–1995, which witnessed the largest mortality increases, cardiovascular disease and external causes and injuries were responsible for over 65% of the fall in life expectancy, and it is believed that alcohol (heavy consumption, binge drinking) played a decisive role in both these cases (16,17,18,33).

The role of alcohol and specifically the tradition of drinking vodka as a way for men to cope with stress could also help explain the very wide differential between female and male mortality. Women, in contrast to men, have assumed the role of providers of stability, strength and continuity (10,16). This does not mean that women were not affected by the crisis; they also experienced declining life expectancy, albeit to a much smaller degree.

The rapid fluctuations in mortality in Russia since the mid-1980s caution against attempts at prediction. However life expectancy has continued to fall steadily since the 1998 currency crisis and, on the basis of preliminary data from more recent years, shows no sign of recovery. Furthermore new threats are emerging, in the form of infectious and parasitic diseases, including sexually transmitted diseases, and in particular AIDS, whose incidence, as noted earlier, has been growing exponentially since the latter half of the 1990s.

Among senior politicians there is now grave concern about the demographic situation. According to predictions by the State Statistics Committee, the Russian population will decline to 134 million in 2016, from 148 million in 1992 (15) (the year when the size of the Russian population peaked). There are also concerns about depopulation of some regions, especially in the far

north, where migration is compounding the situation of low birth and high death rates; in some regions of Russia deaths outnumber births by 3 to 1 (15). This situation imposes an enormous burden on the health care system, a problem exacerbated by the re-emergence of communicable diseases.

The government of the Russian Federation clearly recognizes the urgency of the health and demographic crises. The Minister of Health Y. L. Shevchenko for instance, referred to the public health system as a significant factor in “national security” of the nation.¹⁴ President Putin, in a speech to the State Duma on 8 July 2000, stated that a persistence of recent demographic trends would endanger the survival of the nation (5).

On the other hand, it appears, too, that a gap persists between the priority attached to health improvements on an official level and the actual political commitment to such improvements.

Historical Background

Introduction

The Rus civilization (a precursor of both the Russian and Ukrainian nations) emerged during the 8th and 9th centuries along the northern Volga River, with Novgorod as its centre of gravity, and expanded southward to Kiev, reaching the Byzantine Empire. Other principalities eventually arose, including Tver, Vladimir and Muscovy (Moscow). The area came under Tatar-Mongolian control from the 12th until the late 15th century when Muscovy, having achieved prominence, gained liberation from Tatar-Mongolia and reunited the subjugated principalities in a Russian state.

Under Czar Peter the Great (1689–1725), Russia underwent a number of “western” reforms, appropriated the Baltic provinces and territories to the south and east, and was proclaimed an empire (1721). Following the defeat of Napoleon (1812–1813) Russia was recognized as a great power. By the mid-1800s it had more territory and population than any other European nation, though it remained an autocratic state with a primarily agrarian economy based on feudal serfdom. Serfdom was abolished in 1861 by Czar Alexander II, in part due to the need for labour mobility for industrialization. Other liberal reforms in finance, the legal system, local government (the establishment of rural district councils or *zemstvos*) and the military, were undertaken. However

¹⁴ Abstract from article “Public health system in the Russian Federation: On the verge of a new century (2000)”.

the conditions of the bulk of the population did not improve and there was growing opposition to the repressive czarist rule.

The assassination of Alexander II in 1881 was marked by the beginning of a conservative period, and czarist rule under Alexander III and Nicholas II in the latter part of the 19th century became increasingly repressive. Defeat in the war with Japan in 1904–1905 led to growing unrest. The 1905 revolution forced Nicholas II to concede some powers and the first Duma (Parliament) was established, though with large representation of landowners. Nicholas II remained the absolute ruler and severe repression continued.

In early 1917, following the catastrophic impacts of the First World War with its massive human and physical losses, the 300-year-old Romanov dynasty was overthrown, giving way to constitutional monarchy and a tentative parliamentary democracy. In October/November of the same year the government was seized by the Bolsheviks, led by Vladimir Ilyitch Lenin. A civil war ensued (1918–1920) with disastrous consequences for the economy and society, culminating with the famine of 1920–1921. The Union of Soviet Socialist Republics (USSR), in which Russia became the dominant force, was formed in 1922.

In 1924, Lenin was succeeded by Joseph Stalin, who introduced a massive industrialization drive based on a centralized command economy and forced collectivization of agriculture. At a huge human cost, the Soviet Union under his leadership became an industrialized nation and a superpower. Following Stalin's death in 1953, Nikita Khrushchev emerged as successor and ushered in a period of de-stalinization via relaxation of numerous restrictions and introduction of some price signals. While living standards rose considerably, the Soviet Union was unable to keep pace economically with Western industrialized nations. Growing social, political and economic discontent in the communist block countries in the 1950s and 1960s was forcibly stifled. Under Leonid Brezhnev there was a renewed crackdown on dissent and on attempts to introduce reform. By the 1970s severe weaknesses in economic performance were revealed, and were accompanied by growing social and nationalist tensions within the Soviet Union.

From the mid-1980s Soviet hegemony began to wane and since 1985 under Mikhail Gorbachev there occurred a relaxation of government controls on the economy and restrictions on dissent. The reforms ushered in by *perestroika* (restructuring) and *glasnost* (openness) led to an uncontrollable pressure for change. A failed coup attempt by hard-liners in October 1991 saw all Soviet republics declare independence, with the Russian Federation emerging as the largest and most powerful of these. Under Boris Yeltsin as its first president, elected in June 1991, the Russian Federation began making a transition to a

democratic form of government and to an economy based on free enterprise. On 25 December 1991 the Soviet Union was formally abolished. In 1993 a new Russian constitution was adopted with a two-chamber parliament replacing the Supreme Soviet. Since then the country has continued to experience rapid change and a degree of conflict (including a further failed coup attempt in autumn 1993). Boris Yeltsin was succeeded by Vladimir Putin in March 2000.

Development of the Russian health care system

In czarist Russia, the overwhelming part of the population consisted of impoverished rural farmers. Serfdom was abolished in 1861; however this did little to improve the conditions of peasant farmers. In 1864, as part of the liberal reforms enacted by Czar Alexander II, public medical care and other social services were established for the rural poor under the local district assemblies (*Zemstvo*). Numerous medical stations emerged, staffed by a doctor and several auxiliary personnel, as well as some hospitals. The services were tax financed and were free of charge. By 1890, about 16% of Russian doctors worked in the *zemstvo* system. By 1913 there were 4367 rural medical stations, 4539 feldsher posts, and 49 087 hospital beds (35). This network, while inadequate to cover the needs of 80 million people, provided a solid basis upon which the Soviet system was later built, as it demonstrated the feasibility of providing medical care as a free public service provided by salaried health care professionals (35).

Industrialization brought increased urbanization and a growing proletariat to a number of cities. Bismarckian style social insurance for medical and sickness benefits was established in 1912 and covered 20% of industrial workers. In general, the State tended to foster initiatives focused on public health, sanitation and the control of infectious diseases rather than care delivery. Medical care facilities and health workers were insufficient to satisfy the needs: in 1913 there was one doctor for every 6900 people on average throughout the Russian Empire. There were 1.3 hospital beds per 1000 people, and the geographical distribution of these facilities was highly uneven.

In the first part of the twentieth century, the cumulative experience of First World War, the civil war and the subsequent famine and mass epidemics were devastating in health terms, having destroyed much of the existing infrastructure and created a long-term health burden. Shortly after the Revolution, 3 million deaths resulted from 20 to 30 million cases of typhus fever alone (35).

Planning for reconstruction included development by Nikolai Semashko of the health care principles upon which the Soviet health care system was to be based:

- government responsibility for health
- universal access to free services
- a preventive approach to “social diseases”
- quality professional care
- a close relation between science and medical practice
- continuity of care between health promotion, treatment and rehabilitation.

Based on these principles, the state developed a unified health system which provided free medical services for everyone. Enormous emphasis was placed upon epidemic control and prevention of infectious diseases from 1920 onward. Small hygienic units were set up, later to become “sanitary-epidemiological stations”. Under the first Five-Year Plan of 1928, the Ministry of Health intensified efforts for the organization of health services in the form of polyclinics for industrial workers and farmers, and set out to establish medical school facilities so as to expand the health care workforce. In 1937 the social insurance funds were abolished. Hospitals, pharmacies and other health facilities were nationalized and brought under district health management. Parallel health care services were set up for certain industries and ministries and other categories (party leadership, defence, security, miners, heavy industry workers, transport workers, and others).

The health care system was under the centralized control of the state, which financed services by general government revenues as part of national social and economic development plans. All health care personnel became employees of the centralized state, which paid salaries and provided supplies to all medical institutions. The Ministry of Health under strict regulation by the Communist Party, enacted compulsory norms for facilities and manpower. The main policy orientation throughout this period was to increase numbers of hospital beds and medical personnel (29).

By 1941, when Russia entered the Second World War, the health care system was well developed and had succeeded in bringing comprehensive health care services to the entire population. During the war it was able to meet the massive demands of providing care for huge numbers of military and civilian casualties. Moreover, no mass epidemics occurred in spite of extremely harsh conditions for the population. The emerging health infrastructure was devastated and enormous loss of life was incurred.

Following the Second World War, attention was focused on rebuilding and expanding human and physical capacity, as well as achieving equal access to health care services. Thus a system emerged whereby each district was supposed to have sanitary-epidemiological stations, hospitals, polyclinics, and specialized

treatment facilities in accordance with centrally set norms according to population.

The postwar governments of the Soviet Union were influenced both by the experience of epidemics consequent to war and famine and by their political belief in the pre-eminence of the worker. They tended to focus activities both on control of infectious diseases and delivery of health care through the workplace. There was also a strong pro-natalist bias and an emphasis on maternal and child health, prompted in part by Russian traditions and in part by a sense of nation building. The Semashko system dominated the national conception of public health and led to extensive epidemiological monitoring networks, a focus on “sanitary” medicine and the institution of systematic checks on the health of children and workers. *Medsanchest* clinics attached to industrial plants provided occupational health services. A network of rehabilitation and recuperation centres was fully resourced and was regarded as an essential corollary to standard provision.

The focus on infectious diseases led not only to extensive preventive measures but also to the creation of an enormous bed capacity which allowed for the isolation of infectious cases. However, the epidemiological shift of the 1960s saw the government unprepared psychologically and lacking adequate infrastructure to respond. There was a reluctance to accept the growing impact of noncommunicable diseases and an institutional inability to re-gear the health system. Rather than review their approach, governments chose to suppress data and to create yet more beds. With chronic diseases on the rise, the Brezhnev era saw annual health checks extended to the entire population. The *dispensarizate* (check-ups) involved a programme for the entire population that was provided in polyclinics, hospitals and specialized clinics. The procedure of check-ups and treatment included clinical care, and follow-up ambulatory or hospital care, sanatoria and, if necessary, change of work (29). However, as additional financial resources were not made available for this programme, the primary care system was overstretched, with demand for care spilling over into hospital services.

The focus on bed and personnel numbers and the strong bias toward hospital care continued until the late Soviet period. In the mid-1980s, the Ministry of Health stated that health policy would continue to concentrate on “development of preventive medicine and improvement of health care facilities through a programme for building general and specialized hospital establishments” (29).

The consequences of many of the Soviet preoccupations can still be seen in the post-Soviet health system. The facilities for rehabilitation remain, as does a marked over-provision of beds. The tendency to carry out mass screening has



also persisted with little thought as to how any detected needs will be met. A further legacy of the state's past attitudes is the undervaluing of medical staff. The Soviet era held doctors and nurses to be part of the non-productive sector of society and consequently disfavoured their pay and conditions. The fact that the majority of doctors were women tended to exacerbate this situation. This has left a long-standing tradition of underpayment of medical staff relative to industrial workers.

Yet the Soviet system, in spite of a number of flaws, represented a very real achievement. It succeeded in conquering communicable diseases; it made comprehensive health care services available to a huge population, parts of which lived in sparsely populated areas; it provided a basis for community health activities including mandatory immunization and periodic health checks; and it fostered a generation committed to solidarity in health care provision. In the 1950s it was emulated in eastern Europe and in many newly independent states in Africa, Asia, the Middle East and Latin America. Further, it has influenced the development of the Alma Ata approach to primary health care (29).

Despite the enormous challenges facing the country at present, the belief in a health care system centred on need rather than ability to pay remains intact. There is, however, a growing awareness of the necessity to improve efficiency and a real desire to enhance user satisfaction while urgently addressing the pressing issues of the demographic and health crises. These concerns, coupled with a recognition of the need to confront issues of sustainability, have prompted a major reform of the health system centred around financing mechanisms. Funding which was previously from general taxation has shifted in part to a social insurance system, and it is this shift which provides the background for the health care reform process of the Russian Federation.







Organizational structure and management

Organizational structure of the health care system

Historical background



Until 1991 the health system of the Soviet Union was organized along highly centralized lines with the Supreme Soviet holding ultimate authority. Responsibility for health care provision was delegated to the Ministry of Health of the USSR which regulated management and resource allocation through the Ministries of Health within the 15 Soviet Socialist Republics, including that of Russia. Russian health care, then, was subject to the supervision of the Russian Soviet Socialist Republic's Ministry of Health, which covered more than 80% of the territory of the Soviet Union. However, it took little part in policy formation and tended to carry out nationally determined supra-soviet directives. Departments within the All-Soviet Ministry included:

- curative health care services
- maternal and child health care
- medical and nursing education
- sanitary epidemiological services
- sanatoria and resorts.

The Ministry also directly supervised special, All-Soviet health services and institutions (largely highly specialized and research oriented) and oversaw the Plague Research Institutes and the USSR Academy of Medical Sciences, which in turn regulated individual republican research institutes.

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This structure was broadly replicated within Ministries at the republican level. The Russian Ministry, through the agency of its various departments, provided both special republican health services and institutions, again with a tertiary and research focus, and supervised regular health services. These republican organizations included medical educational institutes and research centres (some with beds and clinics), specialist republican hospitals and polyclinics (outpatient centres), nursing schools and sanatoria. The republican administration also directly controlled oblast (regional) san-epid centres responsible for monitoring infectious disease and environmental hazards, and oblast nursing schools.

The mainstream health service delivery was mediated through a series of local government structures, all incorporated within the formal local government organization, which provided accountability through the elected nature of local assemblies. City health authorities managed city hospitals and polyclinics for adults, women and children. Regional (oblast), autonomous republic or krai governments provided both tertiary and secondary hospitals, and outpatient services at a 'state' level. They also monitored "rayon bodies", the next tier of administration down. Rayons oversaw smaller territories or districts and provided a central hospital and outpatient service (polyclinic). There were further rural councils providing *uchastok* ("micro-district") hospitals and in remote areas either doctor-led ambulatory clinics or feldsher-midwife stations.

Current organization of the health care system

The Russian Federation is administratively divided into three levels: the federal, the regional – comprising 21 republics, 6 krais, 49 oblasts, 11 autonomous entities and the cities of Moscow and St. Petersburg – and the municipal, consisting of rayons, cities, towns, villages and rural settlements.

Depending on their size, cities may be divided into rayons or constitute a single rayon. The republics, krais, oblasts, autonomous entities and the two cities of Moscow and St. Petersburg (also known as "Federal subjects") are referred to as territories at the oblast or regional level. There were 73 oblast-level administrative territories until 1991, after which the addition of 5 republics and 11 autonomous entities raised the total to 89.

Following decentralization of the Russian administrative system after the dissolution of the Soviet Union, the health care system was also decentralized (see the section *Decentralization of the health care system*). The health care system follows the administrative structure of the country and is divided into federal, regional (oblast-level) and municipal (rayon-level) administrative levels.

According to the Constitution of the Russian Federation, the state is to be responsible for the regulation and protection of human and citizen rights and freedoms, and the federal and regional levels are to be jointly responsible for the coordination of health care issues. Legislation entitled “Fundamentals of the Russian Federation legislation on citizens’ health protection” of 1993 defines the following as the responsibilities of the federal government (36):

- protection of human and citizen rights and freedoms in the area of health protection;
- elaboration of a federal policy to protect citizens’ health;
- elaboration and implementation of federal programmes on health care development, disease prevention, medical care delivery, public health education and other issues to protect citizens’ health;
- definition of the percentage of expenditures for health care within the federal budget; elaboration of a fiscal policy (including tax exemptions, duties and other payments to the budget) in relation to health protection;
- management of federal property used in health protection;
- establishment of a common federal statistics and accounting system in health protection;
- development of common criteria and federal education programmes for medical and pharmaceutical training, determination of a list of specialties in health care;
- establishment of medical care quality standards and control over compliance with them;
- development and approval of a basic programme of compulsory health insurance and establishment of tariffs for its premiums;
- defining benefits for certain population groups receiving medical-social care and pharmaceutical supplies;
- organization of the State Sanitary Epidemiological Surveillance (SSES); development and approval of federal sanitary regulations, norms and hygienic standards; securing state-sanitary epidemiological surveillance; organization of the system for the sanitary protection of the RF territory;
- coordination of the activity of state and administrative authorities, sectors of the economy, and of the state, municipal and private health care systems;
- establishment of procedures for medical expertise;
- establishment of procedures for licensing of medical and pharmaceutical activity.

According to the same legislation, the regions' responsibilities are defined to be the following:

- development and allocation of the regional budgets;
- material-technical supply for the health care facilities under the ownership of the region;
- approval of territorial compulsory health insurance programmes;
- establishment of additional benefits for certain population groups receiving medical-social care and pharmaceutical supplies;
- coordination of activity of state authorities, municipal and private health care systems' subjects in the area of health protection;
- organization and coordination of training of health protection personnel;
- licensing of medical and pharmaceutical activity within the regions.

Finally the legislation stipulates the following responsibilities for the municipal (rayon) level:¹⁵

- organization, maintenance and development of municipal health care facilities;
- securing the sanitary wellbeing of the population;
- development of the local budget for health care expenditures.

The legislation is vague concerning the precise delineation of responsibilities of the federal level toward the regional, as well as of the regional level toward the municipal.

In November 1991, the All-Union Ministry of Health ceased to exist and was re-established as the new Ministry of Health and Medical Industry of the Russian Federation. This involved what was in effect a merger of both the all-Soviet ministry and the Russian republican ministry. While there was a degree of conflict over the relative responsibilities of the two hierarchies, the similarities in structure allowed for their relatively smooth incorporation. In the same year, the Academy of Medical Sciences of the USSR which had been responsible for medical research was re-established as the Russian Academy of Medical Sciences, an independent organization.

Also in 1991, sanitary and epidemiological services were upgraded and constituted as the State Sanitary Epidemiological Surveillance, institutionally and financially independent of the Ministry of Health. This new autonomous status included responsibility for Plague Research Institutes, regional Centres for Sanitary-Epidemiological Surveillance and some epidemiological

¹⁵ In addition to the legislation noted above, additional legislation specifying responsibilities at this level is "On general principles of organization of local self-government in the Russian Federation" of 1995.

institutions and was the only major change in ministerial structure. It was intended to ensure the independence of health services monitoring and to highlight the identified health status trends. However, this decision was a reflection of the outdated perception that the poor performance of the public health system was due to failures with respect to communicable diseases.

In August 1996, the State Sanitary Epidemiological Surveillance was reintegrated into the Ministry of Health as a department,¹⁶ and responsibility for the medical industry reverted to the trade and industry sector. Attempts to integrate the Ministry for Social Protection into the health protection system have been abandoned and it has been absorbed into the Ministry of Labour.

Fig. 4 shows the administrative structure of the health system; each component appearing in the figure will be discussed in turn.

The Ministry of Health system

The federal level. The Ministry of Health¹⁷ is the highest administrative level, headed by a minister appointed by the prime minister and approved by parliament. It is the central policy formulating body for the Russian Federation and retains nominal rights to oversee the work and decisions devolved to the regions. However, with the growth of the power of the oblasts, particularly in budget setting, the ministry no longer expects to command compliance with all central directives.¹⁸ Its main official responsibilities include:

- developing and implementing state policy in health care;
- developing and implementing federal health programmes, including initiatives on diabetes, tuberculosis, health promotion, health education, disease prevention and forensic medicine;
- developing draft legislation and presenting it to the State Duma;
- governance of federal medical facilities;
- medical education and manpower development;
- epidemiological and environmental health monitoring and health statistics;
- control of infectious diseases;
- development of health regulations;

¹⁶ The resulting loss of independence gave rise to some resentment on the part of the san-epid system toward the Ministry of Health. There are two Deputy Ministers in the Ministry of Health, one of whom always represents the san-epid system.

¹⁷ It may be pointed out that what is referred to as the Ministry of Health would be more correctly translated from Russian as "Ministry of Health Care". This document follows the convention of referring to it as the Ministry of Health.

¹⁸ These issues will be discussed in detail in the section *Planning, regulation and management*.

- development of federal standards and recommendations for quality assurance;
- development and implementation of federal health programmes (TB, AIDS, health promotion, etc.);
- control and licensing of drugs;
- disaster relief (catastrophic medicine).

Fig. 5 shows the current organizational structure of the Federal Ministry of Health (as of early 2002). The Ministry of Health undergoes frequent changes in its organizational structure, involving mergers of departments or creation of new ones, as well as consolidation or reallocation of functions. The present organizational structure reflects changes introduced in April 2000 and August 2001, involving the creation, elimination and merging of departments and changed subordination. These changes were pursued with the intention of increasing control over reform implementation, strengthening strategic forecasting and generally improving the overall coordination and effectiveness of the Ministry's functions.

Provision at the federal level includes highly specialized medical institutions providing tertiary care. In addition, the Ministry of Health has federal targeted programmes which normally deal with the following issues:

- diabetes
- tuberculosis
- immunization
- high technologies
- HIV/AIDS
- emergency medicine
- mother-and-child care
- medical industry development
- medical-sanitary provision to the nuclear energy complex and other dangerous industries.

The san-epid system consists of an independent service within the Ministry of Health. Unlike the management of health care which has been decentralized, the san-epid system has retained its hierarchical structure, with rayon level centres reporting to the oblast level, and oblast centres reporting to the federal level. Each hospital facility has san-epid doctors and epidemiologists, who must report all infectious diseases to the san-epid system. The vertical system of organization allows information to flow up and warnings to flow down.

Fig. 4. Organizational structure of the health system of the Russian Federation

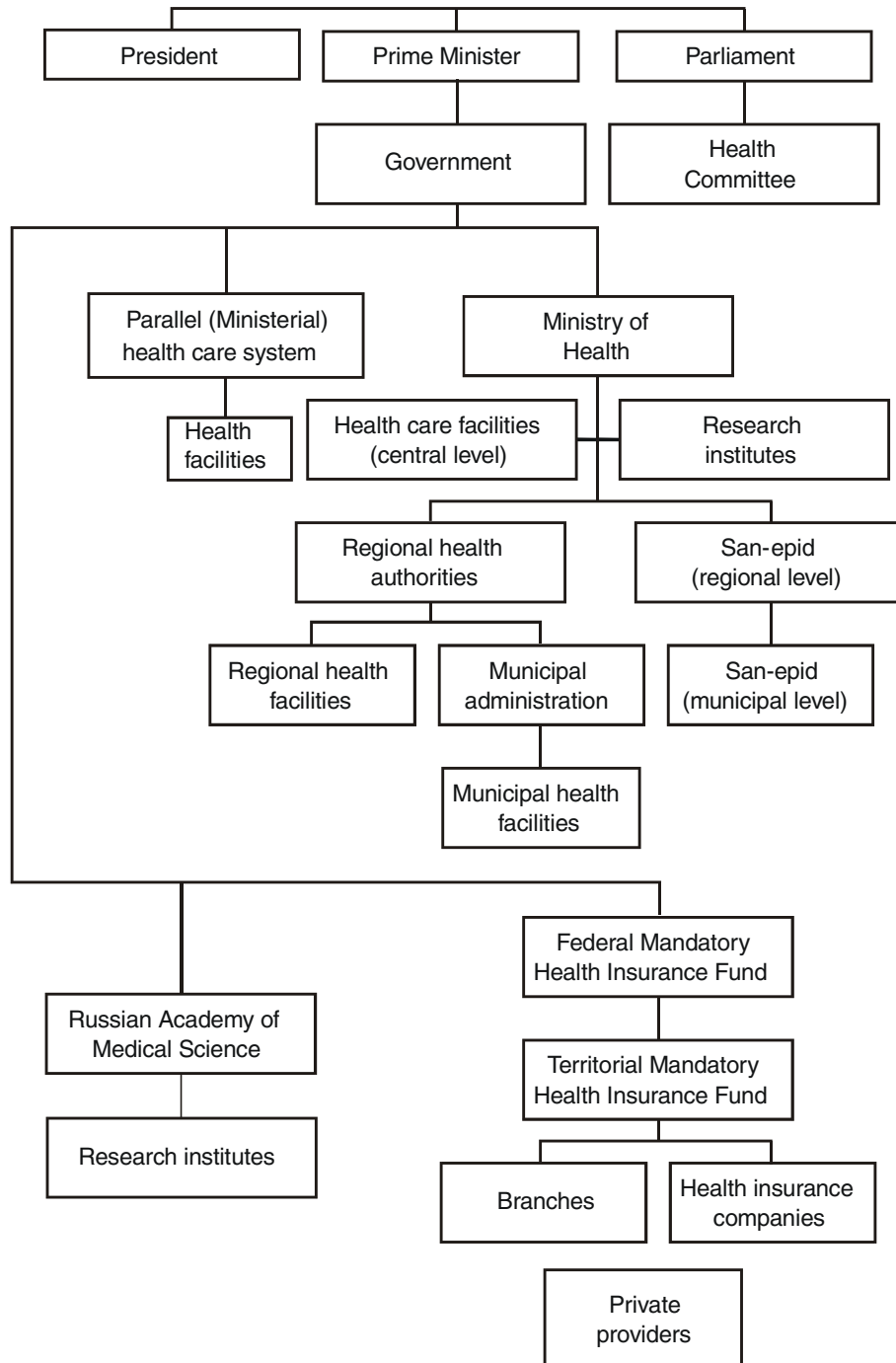
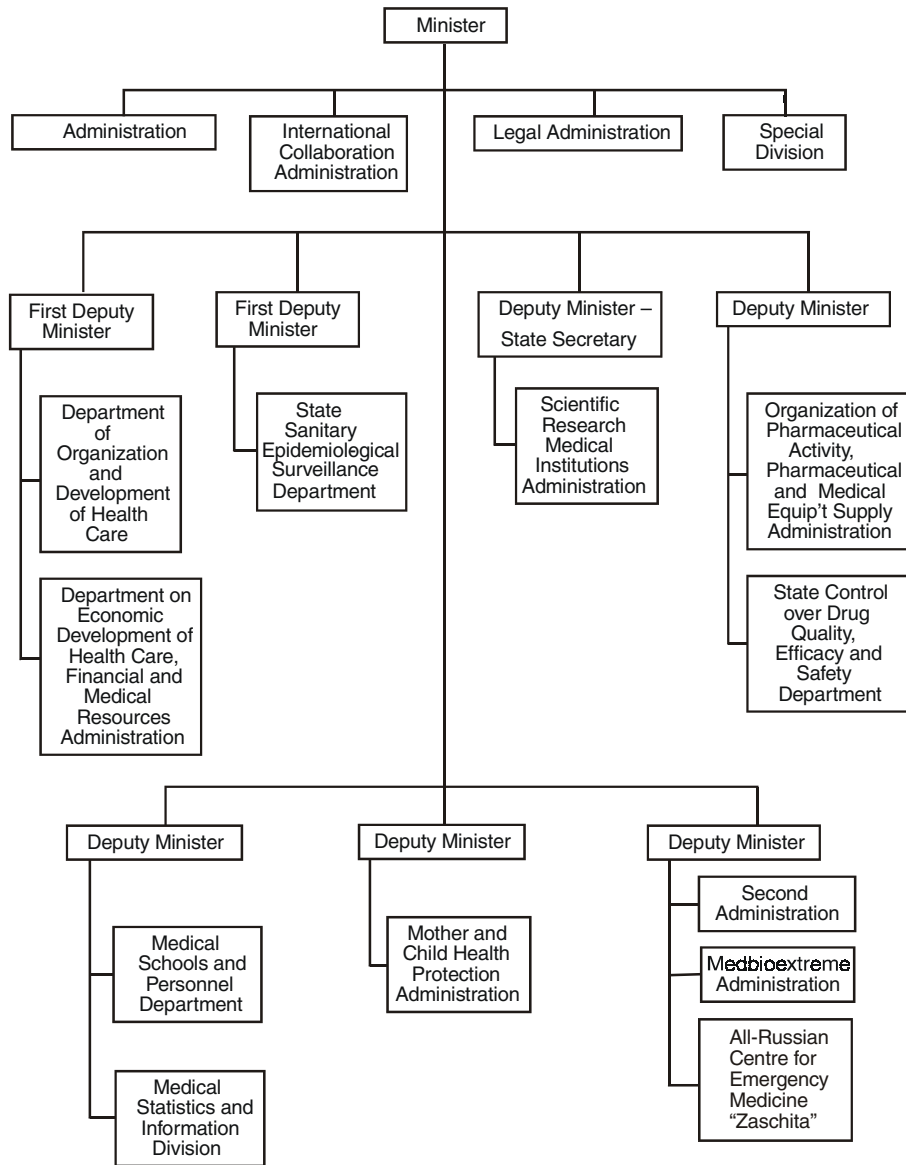


Fig. 5. Organizational structure of the Federal Ministry of Health of the Russian Federation



Source: Adapted from Tacis, *Russian Federation: Support to Public Health Management* (36).

The Ministry of Health is allocated its budgetary resources from the Ministry of Finance, and uses these resources to fund scientific and research institutes, the clinical activity of the Russian Academy of Medical Science, scientific centres and medical schools. Federal medical facilities account for about 4% of total bed capacity in the Russian Federation.

The federal level of the Ministry of Health system currently controls only a small portion of total public resources available to health care, estimated to be about 5%. (For more information see the section *Complementary sources of financing*.)

The regional level. The administrative units at this level govern regional health care. Prior to the 1993 legislation establishing a mandatory health insurance system, regional governments had full control of regional funds for health care. Following implementation of mandatory health insurance (see below), they lost a portion of this control to the newly established territorial mandatory health insurance funds (MHIFs). Due to the only partial implementation of the health insurance system, however, regional and local governments currently control roughly two thirds of public financing for health care, and so retain a significant role in its management.¹⁹ The regions must ensure compliance with federal programmes, in particular those focused on the control of conditions and infectious diseases defined as being of high social priority, but do not have to report to the Ministry of Health. Following decentralization in the early to mid-1990s, they enjoy considerable autonomy within their administrative units. Some regional health departments are heavily involved in setting reform agendas, monitoring quality and taking similar initiatives, while others are not particularly active. (For more information see the section *Health care financing and expenditure*.)

Regarding provision, regional-level facilities typically include a circa 1000-bed general hospital for adults and a 400-bed hospital for children, with both inpatient and outpatient facilities, intended to provide services for the entire population of the region. In addition, this level includes specialized medical institutions for infectious diseases, tuberculosis, mental illness, and others, as well as about a quarter of dispensaries and over 70% of diagnostic centres.

Local (municipal) level. In many larger cities rayon authorities appear to be actively engaged in the reform process, while in rural areas the health authorities' functions have tended to become the responsibility of central district hospital chiefs. Following the 1995 law "On general principles of organization of local

¹⁹ It was originally envisaged that implementation of the new health insurance system would eventually lower the financing share of the regional/local health departments to about 30% of public (tax plus social health insurance) financing, however this has not materialized as planned.

self-government in the Russian Federation”, municipal level governments do not have to report to the federal or oblast level governments, though they do have to comply with Ministry orders. This poses a problem for health policy since rayons do not have to comply with oblast level health reforms or other policies, and are only obliged to provide statutory health care services within their jurisdiction. In practice, many regions and rayons have developed a negotiating procedure so that the local governments remain within the regional Ministry of Health sphere of influence.

Urban rayons (cities) typically have a multi-specialty city hospital for adults with about 250 beds, and city hospital for children with about 200 beds. In addition, there are hospitals for emergency care, a 700-bed specialized hospital for infectious diseases and tuberculosis, maternity hospitals, mental and psycho-neurological hospitals (of which a few are at the oblast level), and other hospitals for invalids. Most dispensaries, independent polyclinics, and some diagnostic centres are found at this level.

In the case of rural rayons, institutions typically include a central hospital with approximately 250 beds, which may also serve as a polyclinic. Some rayons may have a smaller hospital with about 100 beds. There may be independent polyclinics (not part of a hospital), small polyclinics or “ambulatories” and health posts staffed by feldshers.

The parallel system

The parallel system (otherwise known as “departmental” or “ministerial”) consists of ministries other than the Ministry of Health as well as public enterprises which traditionally have provided health care services exclusively for their respective employees and their families. The Ministries of Defence, Railways, River and Marine Transportation, Interior and many others (in all over 20) all have polyclinic networks and some also provide inpatient facilities. These health care services are generally of superior quality. In the case of the 18 civil parallel systems, funding comes from the federal budget via the Ministry of Finance. In the case of the military/security systems, funding is from a combination of the federal budget and extra-budgetary resources which are not presented in official statistics; therefore no one knows the exact amounts involved. In addition, large public enterprises continue to house health care providers and to finance their activities, though there are pressures for industries facing financial difficulties to divest themselves of health care provision.

The parallel system accounts for about 15% of all outpatient facilities and about 6% of inpatient facilities.

Some coordination has emerged between the regional and municipal provider systems, and the ministerial systems located in their territories. The coordination is based on contracts between the Territorial MHIFs and the ministerial health care facilities. Most ministerial facilities (even the Federal Security Service, or “FSS” hospital, considered to be one of the more exclusive parallel systems) contract with the health insurance funds for provision of services to fund members. The proportion of services contracted out by the ministerial facilities varies widely, with the railroad hospitals contracting out a large proportion, and the military hospitals only a small one. Overall, however, only a relatively small portion of these higher-quality services are made available to the broader population.

In addition, there is access to most of these services on a private basis, i.e. when the patient pays out-of-pocket or via voluntary (private) insurance; however, the very high cost of these services precludes broader access. There is no discussion at present of making these services available to the broader public.

Russian Academy of Medical Sciences

With the independence of the Russian Federation in 1991, the former Academy of Medical Sciences of the USSR became the Academy of Medical Sciences of the Russian Federation, and continued to be responsible for medical research. As a carry-over from the Soviet Union, it has maintained its independence from the Federal Ministry of Health. It is financed through the federal budget, receiving its research allocation from the Ministry of Finance in agreement with the Ministry of Science, and its allocation for clinical activity from the Ministry of Health.

The continued separation of the Academy of Medical Sciences underlines the tradition of separating the practice of medical science and research from medical education which is carried out in the Medical Institutes (part of the university system). This separation of research from education reflects the Soviet perception that doctors are like technicians who “fix” the human body much the way a mechanic fixes a machine. There was no place for science and research in the training and education of doctors. This perception is still current, and may account for any difficulty Russian doctors may have with the concept of evidence-based medicine.²⁰

²⁰ Very briefly, this refers to medicine based on research that identifies ineffective interventions and removes them from statutory provision.

Other ministries involved with the health care system

As in most countries, the Ministry of Finance has a significant role in health care in so far as determining funding levels. However, even in the Soviet era, direct central government allocations (as opposed to locally levied taxes) accounted for a small proportion of total health care financing, and this continues to be the case. (See also the section *Complementary sources of financing*.) The Ministry continues to formulate national budgets and to recommend spending levels for local government. It has a department dealing with all issues of health care financing, including the level of health insurance contributions. In addition, surveillance programmes for particular disease groups and certain types of capital expenditure are financed from federal sources.

The Ministry for Social Protection, established to protect the interests of the most vulnerable, has been reabsorbed into the Ministry of Labour, forming the Ministry of Labour and Social Protection, which works closely with the Ministry of Health. It has now taken on responsibility for social care and (in conjunction with Ministries of Trade/Industry) for health and safety practices.

The Ministry of Labour also determines the normative level of medical workers' salaries, and discusses their qualification standards. The Ministry of Economy coordinates investment in health care, i.e. all capital construction (excluding repairs), and is responsible for reconstruction and purchases of very expensive equipment bought with loans. In addition it deals with all federal target programmes as well as loans for all purposes.

The federal and territorial mandatory health insurance funds and their branches

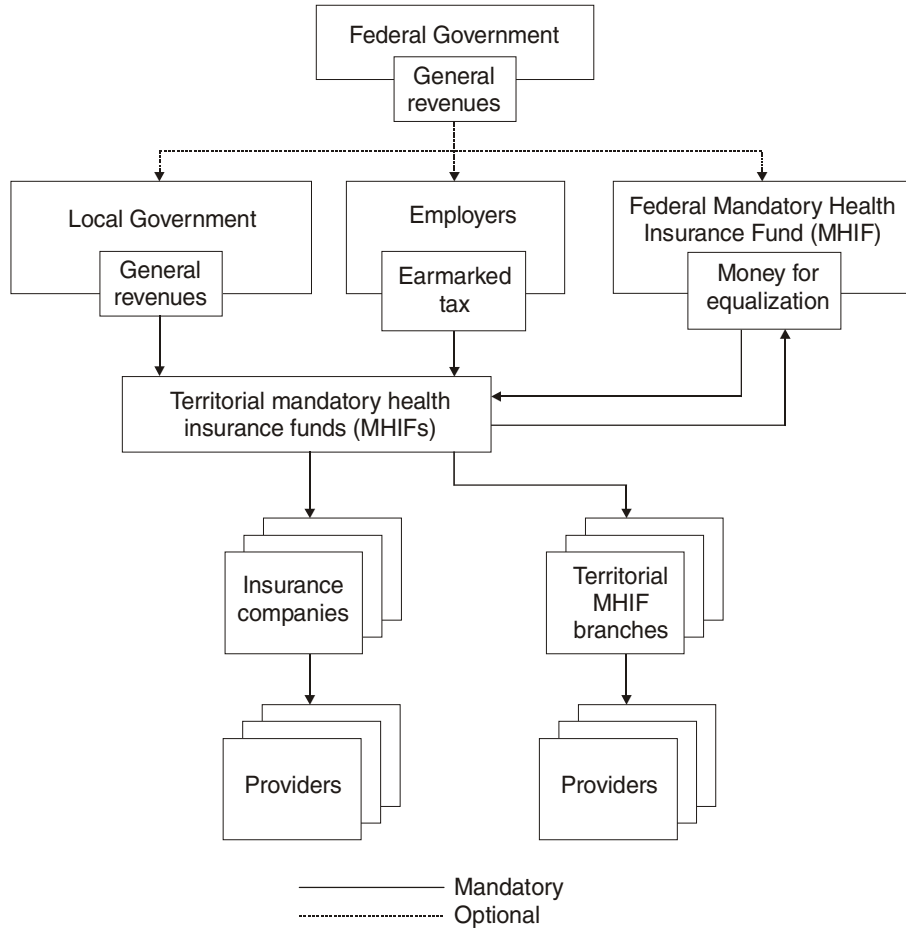
Health care reform legislation of 1991,²¹ amended in 1993,²² established a compulsory health insurance system intended to address the problem of severe under-funding of health care, while at the same time conforming to prevailing ideological trends on the necessity of making a radical transition to a market-based economy.²³ This was to be accomplished by a purchaser-provider split which would increase efficiency, quality and equity in the health care system through the operation of market forces. Fig. 6 illustrates the main bodies involved and their relationships. A key feature of the new financing system is the establishment of a federal mandatory health insurance fund (MHIF) and territorial MHIFs (one in each subject of the Federation) at the regional level.

²¹ Law of the RSFSR "On health insurance of the citizens of the RSFSR" (No. 1499-1) of 28 June 1991.

²² Law of the RF "On health insurance of the citizens of the RF" (No. 4741-1) of 2 April 1993.

²³ The legislation itself, as well as implementation experience will be discussed in detail in the section *Health care financing and expenditure*. The purpose of the discussion here is to introduce the organizational aspects of the new insurance system.

Fig. 6. Health system finance and administration under the 1993 health insurance legislation of the Russian Federation



Source: Adapted from D. Chernichovsky and E. Potapchik, Health System Reform Under the Russian Health Insurance Legislation (37).

The purpose of the territorial funds is to collect and manage insurance revenues from a 3.6% payroll tax on employers on behalf of the working population, as well as regional government contributions on behalf of the non-working population (children, pensioners, the unemployed, etc.), and distribute these funds to insurance companies (see below) or territorial MHIF branches which then contract for care on behalf of their members.

Of the 3.6% payroll tax, 3.4% is to go to oblast-level territorial MHIFs, and 0.2% the federal MHIF, which is to use these funds for trans-regional subsidies

to equalize funding. Both the federal and territorial funds were established as public non-profit financing institutions. The federal fund is an independent legal entity and does not report to the Ministry of Health, though the Ministry of Health retains oversight of the federal fund's administration through membership on its board.

The federal MHIF supervises and regulates the operation of the 89 territorial MHIFs, which are congruent to existing oblast-level administrations. Its key responsibilities include implementation of the equalization mechanism and regulation of the overall insurance system.

The territorial MHIFs are responsible for accumulating contributions and for implementation of the programme of state benefits.

Insurance Organizations

A second key feature of the health care reform legislation is the establishment of independent third-party payers to purchase health care on behalf of subscribers. These third-party payers may take two forms: independent carriers (insurance companies), and branches of territorial MHIFs, in the event that no insurance companies have been set up in a given oblast. Insurance companies (and branches of territorial MHIFs) are to receive their financing under contract from the territorial MHIFs on a per capita basis, and are expected to engage in selective contracting with providers, so as to encourage competition between them and thereby promote lower-cost, higher-quality care. Their role is to monitor utilization and quality and finance accordingly, and they are expected to encourage a shift of emphasis to both primary care and preventive measures. They are also permitted to provide voluntary insurance.

The insurance organizations as defined in the legislation would be allowed to operate as health maintenance organizations (HMOs), preferred provider organizations (PPOs) and budget-holding general practitioners who control their patients' health budget. The legislation does not explicitly mention these organizational forms, but is consistent with their development should insurance organizations wish to move in any of these directions.

By the late 1990s, the mandatory health insurance system consisted of the federal MHIF, 89 territorial MHIFs, 1170 branches of territorial MHIFs (of which 478 acted as insurers) and 415 insurance companies (38). Currently there are an estimated 300 insurance companies in operation, and there is a general downward trend in their numbers due to bankruptcies and mergers. The emergence of such large numbers of independent insurance carriers in the health arena was mainly due to the expansion of already existing private insurers in other areas (private insurance had been permitted since the late 1980s), and many of these were pushing for diversification into health.

Implementation of the health insurance law has met with numerous obstacles that are discussed in detail in the section *Health care financing and expenditure*. The law has in fact been only partially implemented, and there are very broad interregional variations in the financing patterns that have emerged. It should be noted that about a quarter of oblasts have no insurance companies; in 16% the third-party payer is the territorial fund, and in 9% third-party it is a branch of the territorial fund. On the other hand, in another quarter of oblasts there are both insurance companies and branches of territorial funds acting as third-party payers. The remaining oblasts, or roughly half, have only insurance companies in the role of third-party payers, as foreseen by the legislation. In very broad terms, a dual financing system in health care has resulted, which is highly problematic for providers. The competitive, market-based model has failed to emerge except in isolated instances, and the expected increase in financial resources and improvements in efficiency was not as great as had been hoped.

There are ongoing discussions about the future role of the insurance carriers. There is a growing tendency to view them as wasteful bureaucratic agencies that rather impede efficiency in the new financing mechanism, and some regions have gone so far as to have got rid of them altogether.

The private sector

Private provision, while legally permissible, has yet to develop to a significant extent in the health sector, though there is evidence of emerging private activity with a potential for growth. The health sector was not incorporated in the plans for rapid privatization that overwhelmed other sectors; it was intentionally excluded on the grounds that health care facilities and providers should not become profit-seeking institutions, so as to uphold the principles of equality and access to services.

Hospitals are entitled to charge for services not included in the basic package but it appears that this generates no more than 5% of officially reported income. In addition, hospitals provide beds to enterprises and providers of voluntary health insurance who pay on behalf of their respective employees and subscribers. Ownership of hospitals, however, remains almost exclusively in the public sector. Legal uncertainty about the security of leases purchased from the state has discouraged a large-scale shift to private ownership. The option of creating not-for-profit or 'trust' hospitals is also a problem, with considerable uncertainty of the tax position of charitable institutions and general hostility from state bodies to the encroachment of nongovernmental organizations into their traditional spheres of activity (39).

The private sector is relatively well-developed in the case of pharmaceutical supplies, and dentistry and ophthalmology follow closely behind in developing a commercial sector. Outpatient drugs are not covered by the basic package and must be bought from pharmacies,²⁴ which were among the first health sector enterprises to be privatized. All but the most basic dental services are only available on a fee-for-service basis, and the provision of dentures and other prostheses is largely through the private sector. Other areas in which private sector facilities are developing include diagnostic centres, rehabilitation facilities, and private outpatient medical practices in the case of certain specialties.

There is currently a draft law under consideration in the State Duma concerning regulation of private medical activity. This is urgently needed in view of rapid unregulated growth in this area, which is clearly associated with significant loss of tax revenues for the government.

Professional groups

The Soviet Union had a wide range of scientific and professional associations, but these never established a tradition of genuine independence. The establishment of the Russian Federation has seen the emergence of more autonomous entities, although the number of competing organizations has frustrated the emergence of clear professional leadership. The Russian Medical Association is, however, beginning to voice a distinct and united professional view on medical and health policy issues. There are plans to transfer some Ministry of Health functions related to professional activities to this organization, including postgraduate training, certification, attestation, professional standards, quality assurance and salaries. In addition, there are associations of physicians of particular specialties. Nurses and midwives have proved less successful in articulating or securing recognition for their collective views, while specialist professional groups still tend to be divided along regional lines. These limitations notwithstanding, doctors are lobbying on health legislation and their support is increasingly sought by the insurance industry.

The Soviet tradition of clinicians taking on research and policy-making roles persists, and although policy/research institutes are restricted in their access to research funds, contributions to the policy debate are normally informed by the medical experience of personnel. Similarly, it is commonplace for doctors to enter politics and the Minister as well as deputy ministers of health are always medically qualified. This secures the medical professions a

²⁴ This is one of the factors leading to over-hospitalization, to be discussed in the section *Secondary and tertiary care*.

certain degree of access to decision-makers and ensures a sympathetic hearing of professional concerns.

The voluntary sector

The voluntary or nongovernmental sector is still underdeveloped and faces hostility from many traditional state agencies and uncertainty about its legal status. Charitable organizations have had a poor track record in terms of financial probity and have been open to abuse in the past. The federal laws “On Charity Activities and Charity Organizations” (June 1995) and “On Non-Profit Organizations” (December 1995) laid down a clearer framework for the sector, but ambiguities over liabilities, tax status, commercial activities and regulation persist (39). Nonetheless, nongovernmental organizations have been encouraged by international agencies. Although they tend not to be in a position to deliver services themselves, their role as advocates for particular interest groups is developing.

Certain associations of patients have developed, e.g. for diabetics and others, which tend to be vocal and active in promoting the interests of their members.

While much of the structure of the Soviet health care system has been retained, there have been profound organizational modifications, particularly in the establishment of federal and territorial MHIFs. The perceived problems of rigidity and over-centralization have been addressed, but there are difficulties in the operation of the new structures and in their interrelationships in particular. Lines of communication tend to be ad hoc and there are categories of issues that fall between the areas of responsibility of the reconstituted administrative bodies. In addition to the lack of coordination between centres of authority, it is clear that in some of the more remote regions there are gaps in the health sector authority and accountability. (See also the section *Planning, Regulation and Management*.)

The direction of future adjustments of the organizational structure is uncertain. There is a possibility that health services delivery will be more closely aligned with social protection, but under the auspices of the Ministry of Labour rather than the Ministry of Health. There are also conflicting demands from oblasts, some of which would like even greater autonomy, while others seek a return to a more centralized model of organization and funding. All further changes will require investment in management and administrative training if they are to translate into greater health services efficiency.

Planning, regulation and management

Planning, regulation and management are areas that were previously clearly delineated and subject to central control. Planning was the most highly centralized, but all three were carried out according to policies and standards determined at the level of the Soviet Ministry of Health. The post-1991 decentralization process has been so rapid and far-reaching, however, that there are fears that there may be a breakdown of core planning and regulatory mechanisms.

The range and depth of the attempted changes does much to explain these difficulties. Decentralization has occurred on a massive scale, resulting in a fragmented system of highly autonomous regions. There has been a move from an integrated model – with little distinction between third-party payers and providers – to a contract model. There have been attempts to separate provider and purchaser functions, at least in those areas where key reforms have been successfully implemented. Although providers continue to be state owned, in large part, third-party payments are partially channelled through public insurance funds and for-profit insurance companies rather than through local health committees. Purchaser-provider relationships are governed by contract, shifting the burden of planning and quality control, if not regulation, to a new and relatively untested style of organization.

Nominally, the Ministry of Health has retained responsibility for oversight of the system (excepting the parallel networks), oblast and rayon governments own and monitor health care institutions, and MHIFs deal with cash flows and insurance companies. However, the respective roles of the various players in planning, regulation and management has been obscured and the focus of the federal government on crisis management and systemic reform has left a leadership vacuum in many areas.

Planning

The Soviet model of central planning focused overwhelmingly on the allocation of capital, the pursuit of supranational ‘norms’ and the production of human resources. Planners relied on a formulaic approach which allowed historical incrementalism to dominate. The key building block was inputs (numbers of beds and doctors) rather than outputs, which were originally determined by population levels. Resources, both fiscal and human, then followed bed numbers.

Much of the thrust of development centred on the creation of additional institutions and the provision of extra beds. There was an adjustment of funding



across regions to reflect variations in standardized mortality data, which conferred a greater degree of equity, but there was little response to local conditions. The annual budget cycle produced clear short-term plans, but these drew heavily on historical precedent and did not allow for strategic or innovative thinking. The presumption that things would continue very much as they had done in the previous year, together with the fact that this was indeed the case, meant that the mechanisms for implementing change remained underdeveloped.

The reform process has presented a major challenge to this planning approach. There is still a clear need for a national approach to public health issues, yet the Ministry of Health funds little of the health care provision within the Russian Federation and thus has limited leverage. The federal and territorial MHIFs are not yet fully functional. Where they are directing purchasing decisions at a branch level or guiding insurance companies they appear to be bound, to a significant extent, to the custom and practice of the Soviet era. Health departments in the oblasts, krajs, autonomous regions and rayons still have a vested interest in capital and human resource planning which affect their own facilities and staff, but tend to face severe economic constraints and uncertainty about their new role. The relationships between these various bodies are tentative and the mechanisms whereby the agenda of any one player can influence the actions of another have yet to be fully defined.

Gaps in the framework for the transmission of authority appear to have encouraged an abdication of responsibility for planning even at the previous, rather mechanistic level. This tendency is exacerbated by the widely held perception that central planning is inherently authoritarian but, more significantly, is the result of the economic chaos experienced by disadvantaged regions. The legal requirement for local government to send proposed budgets to the Ministry for approval has been waived and there is little that central government can do to enforce spending guidelines. This undermines the Ministry's stated aim of maintaining a basic package of health care across the whole Federation. A high degree of regional variation has entered the system, defying central target setting and conflicting with the concepts of effective planning and equity of health care provision.

The central state continues to collect data on health status through the activities of the san-epid system. This might be expected to form the basis of health care planning, and has indeed informed it at the central level. However, the inequality between regions, in terms of their income generating potential and the structural inability of the system to fully address the imbalance in territorial MHIF funding imperils the ability of the health service to respond to the federal agenda. The division of funding, commissioning and provider

activities is not supported by any formal coordinating mechanisms between MHIFs, insurers and local government, and responsibility for planning has fallen by the wayside.

The assumption was that market mechanisms would ensure both the rational utilization of the resources available and an increasingly cost-conscious approach to planning. Financial incentives, i.e. the potential to make efficiency savings from per capita allowances, were expected to encourage insurance companies to prioritize cost-effective care and set health targets locally. It was also envisaged that hospitals and polyclinics would refocus their own policies in response. Competition between insurance companies and providers was to maximize the benefits of the system while MHIFs and health authorities were to discourage abuses, as opposed to initiating policy development. However, in practice budgets at all levels have been determined by wider financial constraints, rather than any independent measure of need. Competition between insurance companies has been confined to large cities. Much of the system is characterized by the presence of single providers and single insurers operating in conditions of monopoly and/or monopsony, and this has rendered the incentives to plan and refocus policy ineffective.

Furthermore, many areas feel profoundly threatened by the prevailing economic uncertainty, and this has undermined their attempts to set priorities or develop meaningful plans. The legal duty of insurance funds to cover the basic package and the cost of the comprehensive bundle of care they must guarantee has stretched resources in many areas. It is common therefore for both purchasers and providers to take a short-term view and to focus on meeting immediate needs rather than attempting strategic planning. The scope for redefining approaches to care provision is highly constrained even in those areas which are economically stable.

Even the Soviet era ability to plan bed and staff numbers has been compromised by financial constraints. These have led to cuts being made in response to economic factors, rather than as part of a rational review of development. Given the over-capacity of the Soviet system this has not yet undermined health care delivery to any serious extent but it does bode ill for future attempts to plan services.

The production of doctors and nurses is still the subject of forecasting carried out by the Ministry of Health at the federal level. Efforts are made to calculate the number of medical and nursing staff that will be required to maintain given levels of services. The figures produced take into consideration the age profile of those in post, their distribution across specialties, and the expected attrition rate. However, these cannot be said to constitute meaningful human resource plans because access to regional medical and nursing schools is not tightly

controlled, and because regional and local governments (the main employers of health service staff) do, on occasion, close facilities and make staff redundant with little warning. None of the certainties of the Soviet era remain intact. The ratio of doctors to beds or nurses to population is no longer fixed and there is no planning response that can accommodate all the vagaries of current practice.²⁵

At the moment there is little perceived need to invest in new hospitals or clinics but there is considerable need for money for equipment and repairs to existing buildings. According to present legislation, all major capital investments are to be funded from general budget revenues of all administrative levels for the respective institutions within their jurisdiction. Minor investments are to be funded from provider revenues. Insurance companies, in turn, are expected to include a component to cover recurrent expenditure including maintenance (though not depreciation) in case-payments to hospitals and polyclinics. However, in practice, since budgetary funds are insufficient, major capital investments fail to be undertaken; minor investments are pursued only to the extent that there are adequate provider revenues. Moreover, as insurance funds and insurance companies have not yet taken on a role in acquisitions, the few purchases that are made are funded by the regional and local health authorities.

In practice, where investment takes place, it is funded by local government, but without the constraints or regulation that operated in the Soviet era. Thus there have been few attempts to integrate these acquisitions into a national or regional policy, nor do they contribute to any coherent local plan. Instead acquisitions seem to reflect the fact that certain oblasts have surplus funds and are disposed to making one-off purchases for the health sector. There is therefore no regard for possible duplication, and this usually is in violation of budgeting priorities (which should focus, for example, on primary care development). In contrast, many regions report a complete interruption of investment with no capital inputs in the health sector and no capital expenditure plan.

It is the rapid shift to regional autonomy, above all else, that has undermined planning efforts. The impact of decentralization has been to exacerbate inequalities between regions and to undermine attempts to plan capital expenditure or human resources rationally. Some oblasts are developing explicit decision-making mechanisms, but many more are making choices on a purely ad hoc basis and often in response to overwhelming financial pressure. The culture and the skills base in the oblasts is not sufficient to the tasks previously carried out centrally, and the Ministry of Health is unable to offer the support needed. Given these constraints there are many areas in which the development of new plans has fallen back on 'historical precedent'. Implementation also

²⁵ The fact that many people continue working beyond retirement age and into their 70s greatly complicates the task of human resource planning.

appears to be very much hit-and-miss except in those areas favoured financially or in human resources. It is unclear how the more disadvantaged oblasts will cope in the absence of federal guidance.

Since 1998, efforts were initiated to introduce a new planning mechanism that involves the key administrative entities at both levels of authority in a cooperative venture. This took the form of “tripartite agreements” between the Ministry of Health, the federal MHIF and regional health authorities, setting the Guaranteed Package Programme as a mechanism to balance commitments to free health care and available resources. (This will be discussed in greater detail in the section *Health care benefits and rationing*.) The Guaranteed Package Programme determines the minimum types and volumes of care that are to be provided free of charge by the regions of the Federation, and is a planning tool on two counts. It is intended to facilitate a restructuring process away from inpatient care and toward increased outpatient care and moreover, it attempts to match free service provision with the total amount of funds available for this purpose.

There are two levels of developing and costing the package. The Federal Ministry of Health plans the programme together with the federal MHIF. Further, the local health departments in cooperation with local governments and territorial funds jointly plan the territorial programmes of state guarantees. The regions are obligated to develop territorial programmes complying with Ministry of Health norms, but are free to include additional free services. The federal programme is approved by the federal government, and the territorial programme is approved by the territorial governments; both are reviewed and revised annually.

In practice, the federal government sets utilization targets which determine a minimum set of services for the regions, and simultaneously serve as targets for a restructuring process. The targets are volumes of inpatient care (based on such norms as bed-days per person, the number of emergency visits per person, number of visits to day care centers per person, etc.) and are used to cost the package of medical services in terms of unit costs.

The programme is focused on how to restructure health care provision by stipulating decreases in bed-days that will permit cost savings and increases in the volume of outpatient care. It was initially planned that an 18.5% reduction in hospital utilization would give rise to cost savings that would allow a 27% increase in publicly provided outpatient care costs in 1999 (and a 35–40% increase in later years).

Further, the government objective is to plan utilization together with the available financial resources in order to determine how much the government



can provide free of charge. The regions then develop their own norms, which must not be lower than federal norms.

However, public funds are insufficient to meet the commitments to free health care. In 1999 for example, it was estimated that public funding would be sufficient to cover only 75% of costs. Such shortfalls do not, however, lead to downward revisions of the guaranteed benefits. As comprehensive services provision is guaranteed by the Constitution, the Guaranteed Package Programme falls short of its promise to match free benefits with available resources. The shortfall in resources is made up by informal charges and charges for privately provided services by the regions (i.e. services that are not included in the benefits package).²⁶

While most of the regions are currently involved in this process, in some cases political problems have arisen in the relations between the regions and the centre due to attempts on the part of the latter to impose its authority and on the part of the former to assert their autonomy.

However, in those regions that are active in this process, health departments have improved their planning capacity and for the first time have become involved in work planning and information management, resulting in increased cost consciousness and accountability. This is completely contrary to the previous system, which was grounded in historically-based activities and utilization patterns. Moreover, this initiative represents a significant attempt to fill the planning vacuum created by rapid decentralization and assertion of regional autonomy.

Regulation

Regulation has also been strongly affected by the shift of authority from the centre and the breakdown of some of the regulatory mechanisms of the Soviet era. Before 1991 the All-Soviet Ministry of Health was ultimately responsible for the regulation of pharmaceuticals, medical technology, standards of medical staff and medical institutions, and the training of doctors and nurses. Typically policy and standards were set centrally and the republican level Ministries of Health held responsibility for enforcement within their own territories. They in turn looked to oblast and rayon health committees to monitor and implement standards at the more local level. The san-epid network also played an important part in reviewing sanitary and environmental conditions and enforcing hygiene regulations.

²⁶ The Ministry of Health is aware of the problem with the deficit and accepts that the programme is not balanced, but has no ideas on how to deal with this issue. The Minister of Health for the first time mentioned cost sharing in June 2001, however there has not been any public discussion of this issue nor are there any plans at the present time to introduce formal cost sharing.

Decentralization has meant that regulatory powers have been devolved to a significant degree. Increasing responsibility has been placed on the health departments or committees of regional and local authorities as the enforcers of national guidelines with MHIFs expected to play a lesser role in demanding that quality criteria be met. The fact that health care facilities are owned by the regional and local governments themselves is not regarded as creating any significant conflict of interest in terms of regulation.

The ability of health departments to fulfil their role appears to vary significantly across regions. In those areas that are struggling to maintain a basic service, monitoring and regulation appear to have been crowded out.

The san-epid network continues to play a national role in regulation, inspection and monitoring of facilities and standards, reporting to the Federal Ministry of Health. It has the power to enforce legislation relating to hygiene and sanitary conditions and environmental health issues. However, the ability to impose compliance has been compromised, and it is generally held that the san-epid system holds less authority over the regions than the Ministry of Health. On a grass roots level the san-epid's work is also compromised by corruption: it is common knowledge that flaws in food handling or other public services can be settled by bribing san-epid inspectors.

In general, the regulatory role of the regions has been increasing, and this has produced some conflicts with the federal level, which attempts to impose its waning authority. More recently the Ministry of Health has been examining activities at the regional level, with a view to imposing a more uniform regulatory framework for the Federation.

Pharmaceuticals

Pharmaceuticals are theoretically subject to regulation at various points in the supply chain. Their manufacture is under the auspices of the federal Ministry of Industry, while the Ministry of Health licenses production and oversees imports, and the san-epid network is responsible for ensuring that production processes are not environmentally damaging. By 2002 the pharmaceutical industry did not have the WHP GMP (Good Manufacturing Practice) standardization, though work to achieve this is ongoing. Little active monitoring or regulation goes on in any of these areas, although the supply of controlled drugs is policed.

Pharmaceuticals are dispensed either through hospitals, where they remain nominally free of charge (in practice patients often have to pay), or via pharmacies, which may be either public or private. Chief doctors are responsible for prescribing to inpatients, and local authorities check standards in pharmacies



regardless of ownership. Dispensing staff must be qualified and local taxes paid but there is no attempt to limit the number of outlets opening privately. While efforts have been made to set margins for wholesale and retail prices, here too enforcement of regulations by local government is extremely patchy, with widely variable prices found across regions. Until recently there was no regulation of the entry price (the first price of the wholesaler did not need to be disclosed), resulting in huge profit margins. In 2000 the government introduced the registration of import prices, which could potentially be used to regulate prices. However, in practice the system is not effective. (See also the section *Pharmaceuticals and health care technology assessment*.)

High technology

Controls over the acquisition of high technology have also fallen into disuse and although the production and importation of equipment is nominally still subject to ministerial oversight, the centre for the most part no longer has the power to dictate policy to the regions. Very recently a rule was introduced concerning centralized procurement (by the federal and regional governments) on a tendering basis, but only for very expensive equipment. Otherwise, local decisions may be made without reference to federal guidance and the key factor in determining purchases is the availability of funds. Nor does local government have the formal power to challenge hospital or clinic purchasing decisions. Since health authorities fund most purchases, however (as insurance funds have yet to play a major part in acquisitions), they are in a strong position to exert their overall responsibility for health care facilities. In evaluating requests for equipment, judging their clinical merits, or even reviewing the condition and maintenance quality of existing equipment, however, health committees do not appear to have a systematic approach. Sophisticated equipment may therefore be purchased when funds become available, rather than imposing stated commitments to weight funding towards primary care.

Staff qualifications

There is no demand for the formal regulation of individuals who are to use new technology. Rather, it is accepted that suppliers of equipment provide training in the relevant skills and that the discretion of senior staff will protect against underqualified staff practising inappropriately. In fact little is done in general to regulate doctors and nurses once they enter practice.

No ongoing licensing of medical staff takes place and although such a scheme has been mooted, no license is required for staff to carry out particular procedures. Qualification confers the right to practice. The Soviet system, which required doctors to attend postgraduate/in service training every five years, is

in default. A cycle of training courses is still on offer and doctors commonly opt to attend training; they do so, however, because it is seen as a route to advancement and salary bonuses,²⁷ not because the requirement is enforced. Doctors who do not choose to seek recognition of their increasing experience through the existing upgrading procedures are able to avoid any formal monitoring of their skills. Nonetheless, hospital directors do review the performance of colleagues, not least because they are accountable for the services provided within their institutions. These practices are not unlike what is encountered in many other countries throughout Europe.

Formal accountability is to the local health department. Theoretically, medical institutions practice only with the authority of oblast or rayon health committees, but there is little evidence that these bodies make explicit licensing decisions or use clear quality criteria. While they do have the right to review physical conditions, staff qualifications and medical practice, and ultimately the power to close facilities, most local authorities are more heavily involved in seeking to keep services going than in regulating providers.

Hospitals/polyclinics wishing to charge patients on a fee-for-service basis are in a slightly different situation, inasmuch as they are legally required to apply for a special license and inform the local health committee of proposed fee levels. However, these regulations appear to be extensively ignored (at least in large cities) and there is no evidence of local government bodies challenging the established fee levels. Other hospital financing mechanisms and budgetary decisions, including levels of pay for staff, bonuses and the contracts with insurance funds, are under the control of the hospital director but may be scrutinized by local authorities.

Despite this trend towards the decentralization of regulation, there are areas of governmental oversight on a national level. The territorial MHIFs are scrutinized by the Federal MHIF which monitors the performance and financial probity of territorial funds and seeks to make funding adjustments that will restore equity across regions. However, in practice the effectiveness of the equalization mechanism is limited, and there is evidence that inequities between regions are actually increasing. The federal MHIF is, in turn, regulated through Parliament and the Federal Ministry of Health. The level of payroll contributions is set centrally as is the scope of minimum benefits guaranteed by the basic package.

Similarly, medical education remains under the regulatory powers of the ministry at a national level. The production of doctors and nurses is still within the public sector and the Ministry of Health will not allow the recognition of

²⁷ Doctors are graded as either standard (immediately post-qualification), second or first degree and salary increments of 5% and 7% are payable to staff who have reached a higher grade.

private medical schools. It liaises with the Ministry of Education to oversee standards, monitor syllabuses, regulate the conduct of exams and so on. However, just as in the Soviet era, some of these functions are carried out at a regional level and the Ministry is not able to scrutinize closely the quality of local regulatory procedures. Nor is it able or willing to enforce a *numerus clausus* approach, limiting the number of students admitted to regional medical schools. The number of medical students therefore remains high although graduates are no longer guaranteed life long employment.

Specialist training also falls under the regulatory responsibilities of the central authorities and the Ministry of Health sets out the training requirements for each of the specialist medical career routes. These have been restructured since 1991, with a three-year programme for family doctors/general practitioners. However, as with undergraduate education, once the core content has been agreed and the quality criteria put in place, it is the oblast health department which is expected to scrutinize activity locally.

Standards

It is clear that the level of control previously exercised by the centre has been diluted over recent years. This cannot be said to have caused the emerging inequities between regions or the declining condition of equipment and facilities, since these are the result of financial constraints. Nonetheless, the weakening of authoritative central monitoring of standards has done nothing to assist regions struggling to cope. Increasingly hospitals, clinics and health committees in disadvantaged areas confine themselves to crisis management and allow standards to drift, while those areas with funds available tend to respond to demands in an ad hoc manner and without taking a long-term view. There are no plans to introduce further regulatory bodies at present. Rather it is hoped that the general situation will stabilize, allowing existing bodies and insurance funds and/or insurers to carry out their roles more effectively.

Management

The federal centre and the regions

At the federal level, the effectiveness of the current health care management system is compromised by Ministry of Health weakness. Ministry of Finance (MOF) priorities and policy directions in key areas are often in conflict with the Ministry of Health, giving rise to contradictory results. The MOF informs the Ministry of Health of the level of resources for health care and how these should be spent, insisting on the use of budgetary resources for the salaries of federal medical facility staff. However, the number of patients in these facilities

is falling and the quality of services rendered is deteriorating due to overstretched resources. The MOF, bearing no responsibility for the consequences of its decisions, provides signals for the staff to remain employed in these facilities (36).

The Ministry of Economy (MOE) is in a similar situation since it identifies investment projects; however, it is the MOF that decides which ones will be funded, when, and in what amounts, with limited consultations with the Ministry of Health and the MOE (36).

Further, the MOF intervenes in the implementation process of the Guaranteed Package Programme and in investment programmes, intruding in areas that are the responsibility of the Ministry of Health, the MOE and the federal MHIF. In using its own methods of public resource management, it prevents the implementation of efficiency-promoting efforts which the Ministry of Health could otherwise promote. The MOF provides budgetary resources on the principle that the existing networks of health care facilities should be maintained regardless of activity levels, thus contradicting the principles of volume and quality-based payments and incentives intended for the health insurance system.

In contrast to this pattern of conflicting priorities, and despite unclear legislation regarding their respective authorities, the relations between the Ministry of Health and the federal MHIF are positive and improving. The federal MHIF took on a number of responsibilities that were formerly carried out by the Ministry of Health (e.g. quality control, health care standardization, IT development, development of the basic package). Now, however, the Ministry of Health in effect defines policy while the federal MHIF implements it with their cooperation.

The resources at the disposal of the Ministry of Health to influence the regions include the following (36):

- authority to set standards for diagnosis and treatment, health care facilities equipment, medical supplies and equipment, pharmaceuticals and medical care volumes
- budgetary resources to fund the capacity of federal medical facilities
- federally targeted health care programmes
- information resources
- human resources development.

These resources are highly inadequate for the purposes of ensuring that the Ministry of Health can meet its objectives in health care restructuring throughout the Russian Federation. As noted in previous sections, while the Ministry of Health can set standards it cannot effectively ensure compliance with them, as

implementation is the responsibility of the regions. In virtually all areas (except the san-epid system, which has maintained its old vertical administrative structure) the Ministry of Health is unable to enforce its authority. Its management mechanisms include countrywide conferences involving heads of health care authorities and MHIFs, which have been used for policy coordination; signing of agreements on joint activities; tripartite agreements between the Ministry of Health, federal MHIF and regional administrations;²⁸ listening to heads of regional authorities at Ministry of Health Collegium meetings; and identifying pilot territories for testing reform initiatives.

In addition to being stripped of its authority through decentralization, the Ministry of Health suffers from internal weaknesses that further limit its ability to influence the regions. Its management system reflects priority given to dealing with day-to-day issues as opposed to pursuing strategic, long-range objectives. Whereas the short-term tasks have a well-developed procedural system (albeit centralized and bureaucratic), the strategic functions are not governed by adequate mechanisms. The Ministry of Health focuses on assistance to the regions in extraordinary circumstances, rather the promotion of structural change. Further, its organizational structure does not reflect the importance attached to specific activities that rank high on the reform agenda. For example, there is no subdivision responsible for PHC development, inpatient care, development and implementation of new technologies. Neither is there any structural unit for strategic planning nor a subdivision handling work with the regions. Moreover, existing departments do not allocate sufficient time to reform activities, with too much time spent on day-to-day operational issues, or planning and financing federal facilities, for example, and too little time allocated to the needs of the regions (36).

Interviews carried out with oblast and city-level health authorities to determine their opinions on the role of the Ministry of Health revealed that a return to pre-decentralization arrangements is not favoured (36). Decentralization is thought to confer numerous advantages to management, including better knowledge of the needs of local populations and more efficient decision-making. The authorities expect the Ministry of Health to: provide assistance in transferring medical equipment from regions of low need to regions of high need; provide information on manufacturers' prices on drugs; develop guidelines and standards in several areas, including the minimum provision for the target population and treatment guidelines; and implement federal programmes. Not all of these activities are actually carried out.

²⁸ These have been used for example in the making agreements on the Guaranteed Package Programme, discussed in full in the section *Health care benefits and rationing*.

Ministry of Health weakness with respect to strategic planning in health sector development was not referred to by the regional and local health care officials. They do not view the Ministry of Health as a body responsible for strategy development for the sector.

In 2000, the Ministry of Health was trying to recentralize and regain its authority by indirectly imposing a vertical structure through special agreements with the regions about their respective responsibilities (“Tripartite agreements”; see the section *Health care benefits and rationing*). However, controlling only a very limited portion of health care resources (about 5%²⁹) and facing a shortfall of managerial and administrative skills, the ministry was finding the task difficult. Many regions, particularly the economically stronger ones, have gained experience and skills in resource management, are developing clear notions on what they would like to do, and have begun to think in terms of their own health care policy. Thus tension has arisen between the Ministry of Health, which favours recentralization, and regions that have used their growing independence to develop administrative capacities and are unwilling to surrender it to a central authority. The extent to which these relations have developed varies; weaker regions remain dependent on the Ministry of Health for guidance.

At the regional level, organizational structures of regional health authorities suffer from a number of deficiencies. For example, they tend to be organized based on tradition, rather than strategic objectives. Structural units for important functions (strategic planning, information technologies, development of diagnostic and treatment standards, among others) are often lacking. Functionally related units may report to different managers, while functionally unrelated units may report to a single manager. Organizational structures of regional health authorities differ from region to region, and they are entitled to establish organizational structures of their own preference.

Relations between the regional health authorities and the territorial MHIFs (as well as insurance organizations) have been strained from the beginning. Many regional health authorities of the Federation, seeing these new entities as encroaching upon their traditional areas of jurisdiction, did not support the establishment of territorial funds. What little support there was stemmed from an interest in seeing finances for health care increase; however, it stopped short of support for the full implementation of the health insurance system.³⁰ In general, the weaker the financial and administrative capacity of a region, the greater was its opposition to the health insurance system. Financial and

²⁹ See section *Health care financing and expenditure* for more details.

³⁰ This is an important reason explaining the less than full implementation of the health insurance legislation. These issues will be discussed in greater detail in the section *Health care financing and expenditure*.

administrative weakness meant a greater dependence on budget funds, and a lower capacity for – hence greater resistance to – change. In 1994 most regional authorities demanded that they get full control of the money collected by the territorial MHIFs. Some further demanded that the territorial funds should be brought under the control of the regional health authorities, while insurance carriers should be eliminated altogether. However, these initiatives were blocked by the State Duma. At present, relations between the local authorities and the funds are variable across regions. While good partnerships have developed in a few regions, there is more typically a lack of cooperation, with the funds and local authorities acting rather independently of each other; in still others the funds are controlled by the health authorities.

Lines of accountability have been clouded by the reform of the financing system and the disruption of the regulatory mechanisms following decentralization. Regional and local health authorities, as the owners of institutions and the formal guarantors of employment contracts, continue to have a role in overseeing the provision of care, yet have little scope for monitoring conditions or enforcing standards. To date, hospitals and polyclinics have not appointed governing boards or any other executive bodies nor are they required to do so. Indeed, there is no provision for meaningful citizens' participation in planning or management. Instead, insurance companies or branch funds, as the new third-party payers, are expected to take on many of those management functions that would ensure efficiency, effectiveness and humanity of care. They must also, by default, take on some of the strategic decision making at the level of the oblast or region under the auspices of the territorial MHIF.

The heads of territorial MHIFs then, are broadly responsible for ensuring that companies are setting local purchasing priorities and commissioning appropriate care from the relevant providers within the available financial limits. However, there is insufficient expertise to allow them to take a truly proactive role or to guarantee quality local inputs. Planning is largely based on past practice and custom. This is partly because the entitlement of the population to the basic package of care constrains the choices of purchasers, but more importantly, it is because the contracting cycle, which relies on purchasers to determine the balance between the primary, secondary and tertiary sectors, has yet to yield sufficient scientific evidence for the commissioning agencies. The epidemiological data required to carry out a needs assessment is available to health authorities, but is not linked to the structures of the health insurance fund system (with the exception of some infectious diseases) and in practice is not used in developing health policy and planning. The public health function, as it exists in commissioning agencies elsewhere, has yet to develop in much of the Russian Federation, and purchasers have not really exploited their

potential to influence the behaviour of providers through contracts. Nor have the mechanisms which might allow third-party payers to measure performance or outcomes been developed. Purchasing thus conforms more to centrally set minimum requirements and past practice than to a rigorous purchasing strategy.

While the scope for managers in the local setting has increased, the management of the system as a whole and its coordination has declined. The local government bodies or health committees that might have taken on this role in the past are compromised by no longer controlling their own funding, which weakens their position vis-à-vis hospitals and clinics. They are also severely overstretched in other areas. The health insurance funds, however, have not yet been able to fill the strategic management vacuum. There is thus a lack of overall regional management perspective in most, if not all, areas of the country.

Liberalization of management at the level of provider institutions

One of the aims of the reform process and indeed of Soviet experiments with the New Economic Mechanism (NEM)³¹ was to “liberalize” management. Previously the planning and regulatory systems determined the framework within which services would be delivered, and management, at whatever level, was responsible for enacting the stated specifications. The system was administered rather than managed, and individual managers had very little leeway for independent action. Local government officials were appointed centrally and hospital and polyclinic directors worked within such clearly prescribed constraints that there was little scope for effective management intervention.

The Kemorovo experiment in the late 1980s was among the first to attempt to empower individual hospital managers, allowing them the discretion to hire and fire, negotiate pay and bonus packages and make performance demands of staff. They were also given a degree of financial autonomy and allowed to generate income and retain profits within the hospital or polyclinic. A model whereby the insurance funds make purchasing decisions independently of providers is now preferred, but the shift in managerial roles has been widely generalized and managers are expected to be more autonomous in the new system.

The focus on empowering individual managers has sought to effect change from the bottom up but has not fully encompassed the need for strategic management of overarching health care issues. Primary, secondary and tertiary

³¹ This refers to experiments in health sector organization and financing that were undertaken in the period 1987–1991; see section *Health care finance and expenditure* for more information.

care providers are all managed increasingly independently at the institutional level. Even traditional ties between polyclinics and hospitals have been weakened. There is little coordination or skills-sharing within oblasts and even less between regions. Although the san-epid network continues to report to the centre and to apply nationally agreed standards, other public health functions have been divided between local health authorities and insurance funds and are not viewed integrally at the district or regional level. There are no well defined mechanisms that allow management to feed back into the planning process or vice versa. Managers are constrained only by the national standards set by the Ministry of Health and the population's basic entitlement to care and there is no enforcement of standards or entitlements in place.

Hospital and polyclinic directors now have extended rights, although the legal basis of some, for example the ability to sack staff, are questionable.³² The chief doctor is in effect the general manager and is responsible for budgets, financial administration and income generation, negotiating and signing contracts with insurance companies or employers, and making the arrangements to charge patients on a fee-for-service basis. They are accountable for a range of standards to the local health committee but answer to third-party payers when appropriate. The increase in flexibility appears to be broadly welcomed, but the increased volume of paperwork for invoices and contract management has prompted complaints, as well as concerns about the heightened stress that comes with dealing with issues that are effectively beyond the control of individual managers.

Decentralization of the health care system

Until the late 1980s the structure of health services in the Soviet Union was highly centralized. Following the break-up of the Soviet Union, every form of decentralization has been a part of reforms in the Russian Federation.

Devolution

Devolution of powers in the health sector began nominally in 1989 as part of the NEM, when the Council of Ministers of the USSR issued regulations stipulating a change from central, vertical management to decentralized management. It was stated that most of the resources needed for a local health system would

³² In fact directors often cannot fire staff, including even individuals who have reached retirement age.

be controlled by the local councils of the people's deputies. Further, staff norms, a main mechanism of central control during the Soviet period, were no longer to be compulsory. Beginning in 1989 the heads of provider institutions were entitled to determine staff levels and salaries independently, and could transfer funds from one line item to another (with the exception of salaries, food and pharmaceuticals), and from 1991 the entire budget could be reallocated across line items (40).

However, because of a lack of managerial capacity on the part of local authorities, these new freedoms were hardly implemented. The actual devolution of powers in the health sector should instead be placed in the context of broader growth of regional autonomy in the face of increasing central weakness in the Russian Federation. Early in the reform process conflicts arose between the centre and the regional governments, with the latter often withholding tax payments or refusing to comply with central policy prescriptions. Whereas the centre initially foresaw a process of "decentralization from above", it gradually became more reactive than proactive in its relations with the regions as they took on increasing powers. As the centre began to default on its jurisdictional responsibilities toward the regions, in the face of severe economic difficulties, many of them began exercising autonomy beyond that provided for in the Constitution of 1993, federal laws or other bilateral agreements between the parties (41). This resulted in a de facto autonomy of the regions, although they rarely had either the legal authority, or financial or administrative ability to act effectively.

According to 1991 legislation on the budget process of administrative units,³³ the councils of the respective units are allowed to develop, approve and implement their budgets independently. As a result, they no longer needed further approval from either the Ministry of Health or the MOF. Broader changes in the administrative and budgetary systems followed in 1992 legislation³⁴ making the rights of oblasts and krajs equal to those of the republics of the Russian Federation in the spheres of social and economic development. The constitution of 1993 confirmed the rights of local authorities granted by the previous laws. All this legislation laid the foundation for the complete devolution of power from the centre to regional and local governments, which could now manage their own finances and medical services, appoint their own heads of health authorities and medical facilities, and develop their own programmes for health care, health promotion and disease prevention. Regional authorities

³³ Law "On the budget process of rayons, cities, city rayons, towns, rural settlements and other administrative territorial units of the RSFSR" of October 1991 (No. 1734-1).

³⁴ Law "On krai and oblast councils and krai and oblast administrative bodies" of March 1992 (No. 2449).



now manage medical facilities over which they have property rights, and local governments similarly manage their municipal hospitals and outpatient clinics.³⁵

The ensuing highly decentralized and fragmented structure has created a health care system resembling a multitude of loosely linked, semi-independent, territorial units. It has been argued that the health care system today consists of five uncoordinated administrations: the Ministry of Health system, the mandatory health insurance system, the san-epid system, the parallel systems, and the Russian Academy of Medical Sciences. Moreover, the first two of these are decentralized vertically (40). The result is a lack of governance for the health care system, as the Ministry of Health is no longer able to set policy and priorities in the form of recommendations. The enormous fragmentation of the system prevents it from being able to operate as a single national system and there is a serious risk that the Russian health care system may disintegrate as a national system (40).

In 2000 an administrative reform grouped the country's 89 subjects into 7 presidential districts (*Okrugs*), each under a governing body headed by a "fully authorized representative of the president" appointed by himself. As yet this process has had a minimal impact on the health sector. In each of these districts permanent representatives of the president have been installed, including representatives of the Ministry of Health. Some efforts have been directed toward coordination of patient flows within districts and setting of standards, however no results have yet emerged.

There has been some attempt on the part of the Ministry of Health to indirectly impose a vertical structure upon the health care system through a series of agreements between the regions and the centre (Tripartite Agreements), however the results so far are tenuous at best. There is also draft legislation ("On public health care services in the Russian Federation") which addresses this issue and attempts to restore vertical authority of the Ministry of Health and to increase federal budget funding of the health care system. However, the draft faces government opposition due to a lack of financial resources.

Delegation

Another significant form of decentralization in the Russian federation is delegation, prompted by the 1991/1993 health insurance legislation which led to the establishment of MHIFs. The rationale here was to create a purchaser-provider split in a nongovernmental system of organization, management and

³⁵ For a more precise specification of the respective responsibilities of each level see the section *Organizational structure of the health care system*.

financing, based on competitive market forces that would promote efficiency but remain under public control. The structure of the insurance scheme is quasi-public with the federal MHIF, territorial MHIFs and their branches having quasi-public status, i.e. nongovernmental, yet within government control.

Deconcentration

Deconcentration of powers occurred through the transfer of responsibilities for the monitoring and regulation of standards from the Ministry of Health to the oblast and rayon health committees (see the section *Organizational structure of the health care system*).

Privatization

The 1991/1993 purchaser-provider split paved the way for competing private insurance companies to offer cover on the local level. In addition, private-sector provision of services has been permitted for doctors, dentists and pharmacists. The actual transfer of ownership of physical facilities of the health delivery system has been confined mostly to pharmacies, medical equipment industrial enterprises, and some dental polyclinics. Private medical practitioners consist of such specialists as dentists, gynaecologists, dermatologists and others. Private diagnostic facilities are limited to ultrasound and commercial X-ray units, though some private clinics offer more sophisticated diagnostic equipment.

A “Concept of health care and medical science development in the Russian Federation” developed by the Ministry of Health in 1997 asserts (among other things) the need to develop the private sector as the most important structural transformation that should be pursued in the health sector.

As of 1999 there was a bill pending in the Duma relating to private practice, entitled “On regulation of private medical activity”. This would have established a right to private practice, a regulatory framework, and a right for private practitioners to contract with insurers and territorial MHIF branches. This law was never passed, though it is still under consideration. It has had many opponents, and the preferred direction for the institutional transformation of provision initially was “non-profit privatization”, meaning the transformation of state and municipal facilities into autonomous, quasi-public, non-profit organizations. This model was at one point considered a possible solution to the problem of facilities owned by privatized industrial enterprises (part of the parallel system). In view of the shortage of municipal funds, this seemed a viable alternative. The municipal authorities and privatized enterprises would

have been co-founders of the health care facilities and would have shared the responsibility of financing and running them. However, this never materialized and the issue is no longer discussed. It is also considered unlikely that the law on private practice will be passed in the near future.

An amended version of the private practice bill noted above had passed the Samara oblast legislature prior to 1999; this extended the right to private practice to psychiatrists and specialists treating drug and alcohol addiction, and “diseases of social importance”. In addition, it specified that private practitioners have an obligation to treat emergency cases, and that the government and MHIFs must compensate private practitioners for work carried out in the event of emergencies.

Although private practice is permitted, it is not supported by the state. Constraints to the development of a private sector in health care include very high taxes and capital requirements for the purchase of medical facilities. This gives rise to very high prices for privately provided services. Numerous restrictive factors discourage the participation of private providers in the statutory system (42).

Private health care institutions have been operating without a well developed legislative basis; moreover they started to develop later than private businesses in other sectors. In health care private provision has developed farthest in the case of dental care. Hospital care remains concentrated in the public sector. Private hospitals in 1997 received 0.4% of households, compared to 1.1% who received care in departmental (parallel system) hospitals and 13.6% in public hospitals. In terms of percentages of total households receiving hospital care, 2.6% did so in private hospitals, 7.3% in departmental hospitals, and 90.1% in public hospitals (43).

The haste with which decentralization was undertaken resulted in a lack of appropriate delineation of rights and responsibilities among federal, regional and local governments, and between government and the newly created MHIFs. With most decisions now resting with regional and local authorities, and the power of the federal centre severely curtailed, the health care system is unable to pursue efficient policy-making.

The strains on the health system imposed by the shift in power and the breakdown in central authority are exacerbated by the lack of a properly established legal framework governing private and privatized organizations.

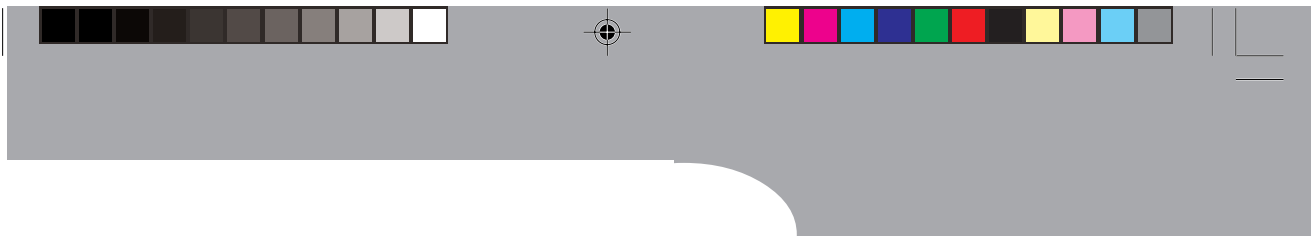


There is no formal regulatory framework governing the sale of public assets to the private sector and there are very real concerns about the legality of some of the privatization that has taken place. While this has acted to some degree as a restraining factor, banks have continued to provide funds for privatization in an effort to buoy up government income streams, allowing for inappropriate asset stripping.³⁶ Even where not-for-profit organizations have sought to get involved in provision of services the legal situation has hampered their ability to take on what were government functions.³⁷

The tendency to abolish traditional mechanisms before new ones have been established has created real difficulties in disadvantaged areas, and there is increasing evidence of inequalities entering the system. While the latest trend is in the direction of recentralization, there are obstacles as newly entrenched interests created by decentralization resist any pressure to relinquish their hold on power. Many of the impacts of the process of uncontrolled decentralization of the 1990s will be discussed at length in the next section.

³⁶ There are still legal doubts about the status of privatized enterprises.

³⁷ The federal laws “On Charity Activities and Charity Organizations” (June 1995) and “On Non-Profit Organizations” (December 1995) failed to clarify the status of such organizations and have allowed the state to sustain its hostility to their activities.



Health care financing and expenditure

Main system of financing and coverage

Historical background

Under the Soviet system health care was almost exclusively financed through state budgetary resources at several levels. Republican facilities were paid for from republican budgets, while rayons covered the costs of health care facilities within their boundaries. The all-Soviet Ministries of Health and Finance made some attempt to equalize income disparities between republics and to support USSR-wide initiatives. There were no “sin taxes” (for example, for tobacco and alcohol) and no earmarked insurance contributions. However, large enterprises (both industrial and agricultural) did provide health services on-site thus contributing to the costs of health care delivery, as did other Ministries running parallel health care systems. All services were publicly provided as only a minimal amount of private provision was officially tolerated.

At the Soviet level, the allocation of resources to health was in accordance with government-determined five-year and annual plans. The plans determined priorities for current and capital expenditures, spending on research and development, education and training, medical equipment and pharmaceuticals production, public health services (health education, epidemiological surveillance, etc.) and health services delivery. It is difficult to estimate precisely the share of GNP which was devoted to health, but this figure is generally placed at about 3–3.5% of GNP, particularly in the later years of the Soviet Union (29). This is quite low compared to Western standards, and results from the use of what is widely referred to as the “residual principle”, whereby the allocation to health and other social services was determined by what was left

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over after all other priority areas (military, heavy industry, etc.) received theirs. Moreover, expenditure on salaries was kept artificially low; if salaries had been increased to an average salary level the GDP share would have been substantially higher.

A key characteristic of the Soviet system was entitlement of the entire population to a comprehensive range of services. The Soviet Union was in fact the first state to guarantee constitutionally free medical services to all citizens. Health care services were thus officially free at the point of service, with the exception of pharmaceuticals prescribed on an outpatient basis, though there were several categories of people who were exempt from payment.³⁸ In practice, patients frequently had to pay directly and out-of-pocket for services, albeit under the table.

Weaknesses of the Soviet system of financing

The objectives of universal and equitable access and provision in the Soviet Union were pursued with insufficient budgetary resources, to the detriment of quality, and cost and efficiency considerations. The result was an under-funded and highly inefficient health care system offering low quality services that did not achieve the desired equity and failed to make the requisite contribution to maintaining the health of the population. The Soviet health care system, like the Soviet economy in general, was beset by problems caused by the overwhelming emphasis on central planning, leading to the prevalence of perverse incentives and major structural imbalances. The weaknesses of the system can be briefly summarized as follows:³⁹

- The residual principle of funding for health care led to an increasingly severe underfunding of the system. Spending on health care had declined from a respectable 6–6.5% of GNP in the 1960s to about 3–3.5% around the time of the break-up of the Soviet Union. Budget priorities did not favour the health sector as heavy emphasis was placed on the military and industrial development.
- Input-based funding led to spending on production of excessively large numbers of doctors and hospital beds with no regard for efficiency or quality. This ended up absorbing a significant portion of the health budget without making a commensurate contribution to the system's ability to provide quality health care services. In the period from 1970 to 1985, there was a

³⁸ These included children, pensioners, pregnant women, invalids, war veterans, and several others.

³⁹ The weaknesses included here refer only to those which have some direct bearing to the system of financing. There are many other problems of the system, including patient lack of free choice, citizens' dissatisfaction with the health care system, weak primary health care, excessively curative orientation, etc. each of which is discussed in the relevant sections of this document.

75% increase in the number of doctors and a 35% increase in hospital beds (44). On the positive side, these efforts resulted in a relatively high degree of equity in the distribution of health resources – a significant achievement in view of the vast size of the regions covered. However, this did not create a similar degree of equity in quality of facilities or access (see below). In the words of the Minister of Health, Yevgeny Chazov, in a speech in 1987, “We have striven to achieve the planned number of hospital beds, not caring whether they conform to the requirements of medical technology or even sanitary standards” (44). He also noted that “in only 35% of the rural district hospitals of the country is there a supply of hot water, and in 27% there is no sewerage system, and in 17% no running water at all” (44).⁴⁰

- All health care facilities (hospitals and polyclinics) were remunerated mainly on the basis of norms for bed-days, leading to perverse incentives. At the end of the year, each hospital reported the number of beds that were actually used. In the following year, the hospital would get paid in accordance with the previous year’s use of beds. Thus the hospital faced the incentive to use as many beds as possible, for as long as possible, and not to treat complicated cases. Briefly, the incentive was to keep healthy people as inpatients for as long as possible. (This incentive structure, as will be discussed later, still holds for most of the country.)

Polyclinics were budgeted on the basis of the number of patient visits the facility and staff were able to receive. The result was that polyclinic doctors faced incentives not to treat patients but to simply push them on to higher levels of care. As a result, fewer than half of polyclinic patients received treatment at the level of the polyclinic (compared with 85–90% of patients in Western countries with highly developed primary care systems). Hospitals were eager to receive patients from the polyclinic level for the reasons noted above. Sometimes patients remained in hospitals for weeks waiting for surgery to be performed or for diagnostic tests to be carried out.

Planning exclusively according to throughput led to waste of already scarce resources and low quality of care as resources had to be spread over large areas and excessive numbers of facilities. In addition, this perverse incentive system encouraged hospital-oriented curative care, while the development of primary care was strongly discouraged. Salary-based payments of health care personnel, which did not vary according to workload, further contributed to disincentives with respect to improvement of the system’s efficiency.

⁴⁰ An October 1988 sample survey of Soviet hospitals found a worse situation, with 49% of total hospitals without hot water and 24% without sewerage systems.

- Excessive state commitments for available funding did not allow them to be fulfilled, and resulted in widespread illegal out-of-pocket payments, often for the full cost of treatment, and hence in an irrational use of private resources (compared to cost-sharing). Free health care was in fact an illusion, as patients frequently had to make payments to doctors and nurses in order to receive care. This practice was reinforced by the very low levels of salaries prevailing in the health sector, making the underground payments seem morally justifiable. It is not possible to accurately estimate the size of this black economy but according to one study in the late 1980s it amounted to one seventh of the total budget for health care. This is a key factor which is thought to have compromised equity in access to services.
- There was a lack of information on outputs, as the Ministry of Health did not collect statistics concerning specific cases, the real cost of services, cross-boundary flows, utilization rates, etc.
- Another weakness in financing and organization concerned parallel systems of health care services. These parallel health care systems had been using public funds to offer higher quality services to their members (the “nomenklatura” or higher ranking civil servants), and have clearly been another key factor working against the achievement of equity from the Soviet period up to the present. When those who make the decisions concerning improvements in public services can escape the use of standard and sub-standard level services, the incentive for improvement is effectively removed.

Health care financing reform in the RSFSR in the late Soviet period⁴¹

Efforts to reform the Soviet health care system and address its shortcomings date as far back as the 1960s; however, it was not until the development of a market-oriented environment in the late Soviet period that more dramatic change began to be envisaged and implemented.

From the mid-1980s Soviet hegemony began to wane and liberalization of central planning in the form of *perestroika* (restructuring) and *glasnost* (openness) allowed for experimentation in health care organization. A quest began for new organizational and financing methods which improve efficiency and quality in health care services by introducing some flexibility into the system. In the period 1987–1991 the NEM of financing methods was introduced in three pilot areas: St. Petersburg, Kemerovo oblast and Samara oblast.

⁴¹ This refers to the Russian Soviet Federated Socialist Republic.

These experiments were intended to allow health system managers greater flexibility and control of resources, which was expected to lead to greater responsiveness to patient needs and ultimately to a stronger focus on primary care. The Kemorovo⁴² scheme saw per capita funding for the local population placed in the hands of polyclinics acting as purchasers of care for their listed patients. Polyclinic budgets included an allowance for diagnostic tests, hospital referrals, care, and emergency services. Hospitals and polyclinics established autonomous teams with their own clinical budgets, and used internal financial incentives for their personnel. Institutions were free to hire staff, negotiate pay and sell care to private patients, retaining income for reinvestment or bonuses. Practice and quality were monitored on agreed “medico-economic” standards or protocols to ensure against the risk of under-treatment as a cost saving measure. Performance-related compensation was introduced at the group practice level, with a weighted ranking system based on specific indicators, e.g. days of disability, delayed diagnosis, vaccination levels, complications and complaints. This then formed the basis for a cross-sectional comparison of group performance. Bonuses were paid on this weighted measure of medical outcomes which, however, lacked a formal control component for quality of care.

The St. Petersburg model⁴³ took a similar approach, devolving purchasing decisions to groups of practitioners. A group practice system was set up in parts of the city with each unit consisting of three generalists, two paediatricians and a gynaecologist, covering a population of 8000. Per capita payments were made to include a broad package of outpatient care and those para-clinical services offered within polyclinics. All relationships between teams were governed by contract, with providers themselves contracted either to the clinic or the Territorial Management Association (TMA). The TMA was made up of local providers and held collective responsibility for the volume and quality of care.

It was expected that the ability to retain savings made at the primary level would encourage a reduction in over-referrals to specialists, and this was borne out in practice. In the first four years of the Kemorovo pilot scheme, bed numbers were reduced by 1500, while admissions in St. Petersburg fell by 5% in two years (from 846 500 in 1988 to 804 700 in 1989). Efficiency savings were also made, with the average length of stay in St. Petersburg falling from 19 to 17 days over the same period. Two thousand five-hundred beds were deemed to have

⁴² Kemorovo is an industrial/mining oblast in south west Siberia with a population of 3.5 million.

⁴³ St. Petersburg has a population of five million and was served by numerous polyclinics, 100 hospitals, 29 research centres and four medical education institutes all of which participated in the experimental scheme.

become redundant, some of which were converted to long-term nursing care. Some restructuring of secondary care was also evident following the assumption of a greater part of the burden of care in the primary setting. Numbers of paediatric, trauma, and general surgical beds fell, while there was increased capacity in specialized areas like oncology. In Samara, which followed a similar reform process, the average length of stay in hospitals was reduced by 7% and the total number of hospital beds was reduced by 5500. The more recent experience of Samara will be discussed at length below as an example of successful reform in the Russian Federation.

Efficiency savings in Kemerovo were invested in management information systems and public health/management training. In St. Petersburg funds were released for the purchase of new diagnostic and treatment facilities and staff benefits. While the pilot approaches created incentives for effective primary care and a more efficient utilization of secondary and tertiary medicine, there was also evidence of a tendency to restrict hospital admissions for financial rather than clinical reasons. Some of the benefits of the scheme also seem to have fallen away as the economic situation has worsened, raising doubts about sustainability. Nonetheless these models were enormously powerful in defining the scope of the current reform process.

The success of the early experiments encouraged other regions to attempt to replicate them; however, Russia's economic collapse in 1991 signalled the end of the NEM, due to the shortage of budgetary funds and extremely high inflation. While hospitals demanded escalating payments to treat patients, the polyclinics, operating with fixed capitation payments from the government budget, were unable to pay. In effect, the lack of funds often led to the temptation not to refer, as the financial risk was too great.

The introduction of mandatory health insurance legislation in the Russian Federation

In the late Soviet period, a small group of Russian academics had begun to plan a more generalized finance reform. With the break-up of the Soviet Union, these discussions were transferred to the Russian setting. A key consideration in the search for a financing model was the need to confront the severe funding shortage in health care, and to secure a steady flow of funds that would be insulated from the fluctuations of budget financing. A Beveridge type of system, as found in the United Kingdom and Nordic countries, with the government as single payer was rejected offhand as being too similar to the Soviet system. The requirement that the population be responsible for a large portion of financing through out-of-pocket payments was similarly rejected on the grounds that it sacrifices the equity objective. Thus, a system of compulsory health

insurance presented itself as the solution. Physicians, whose income levels had always been low and now were unable to keep up with inflation, supported the rapid introduction of a health insurance system in the belief that this would improve their income. A nascent insurance industry in other sectors similarly supported the notion of market-based health insurance. In line therefore with the rapid introduction of market oriented reforms in other sectors of the Russian economy, it was decided that Russia would introduce a system of mandatory health insurance that would rely heavily on market forces to correct the many ills of Russian health care

Under the pressure of severe financial difficulties due to stagnation of the economy, budget cuts and price liberalization, the Supreme Soviet of the RSFSR passed the Law “On health insurance of the citizens of the RSFSR” in June 1991 as an initial attempt to provide a statutory framework for the far-reaching changes that were planned for health care financing. This law was considered to have some fundamental weaknesses; it was therefore amended and reissued in April 1993, and was accepted as the basis for the subsequent implementation of the health insurance system.

Key objectives of the legislation were to provide new sources of non-budget financing in order to augment the existing budgetary sources, to provide a mechanism for the pooling of all funds, and to continue to provide universal access and comprehensive coverage for the population while introducing patient freedom of choice of provider and insurer. Achievement of these objectives was to be facilitated through improved management of the health care system and the introduction of incentive mechanisms that would rely heavily on the market principle of competition among insurers and providers, respectively.

The new financing system envisaged by the health insurance legislation would include the following elements:

- A change in health care financing through the establishment of a non-budgetary source of revenues in order increase the total amount of funds available for health without displacing any existing sources of funds;
- Establishment of a federal MHIF;
- Establishment of oblast-level territorial MHIFs;
- Payroll contribution rates of 3.4% of wages, paid only by the employer, to be transferred to the territorial funds and 0.2% of wages to the federal fund for equalization purposes;
- Local government payment for the non-working population (in an unspecified amount);
- An undefined scope of insurance benefits left to subsequent regulations at the federal level, with regions free to define benefits above the minimum;

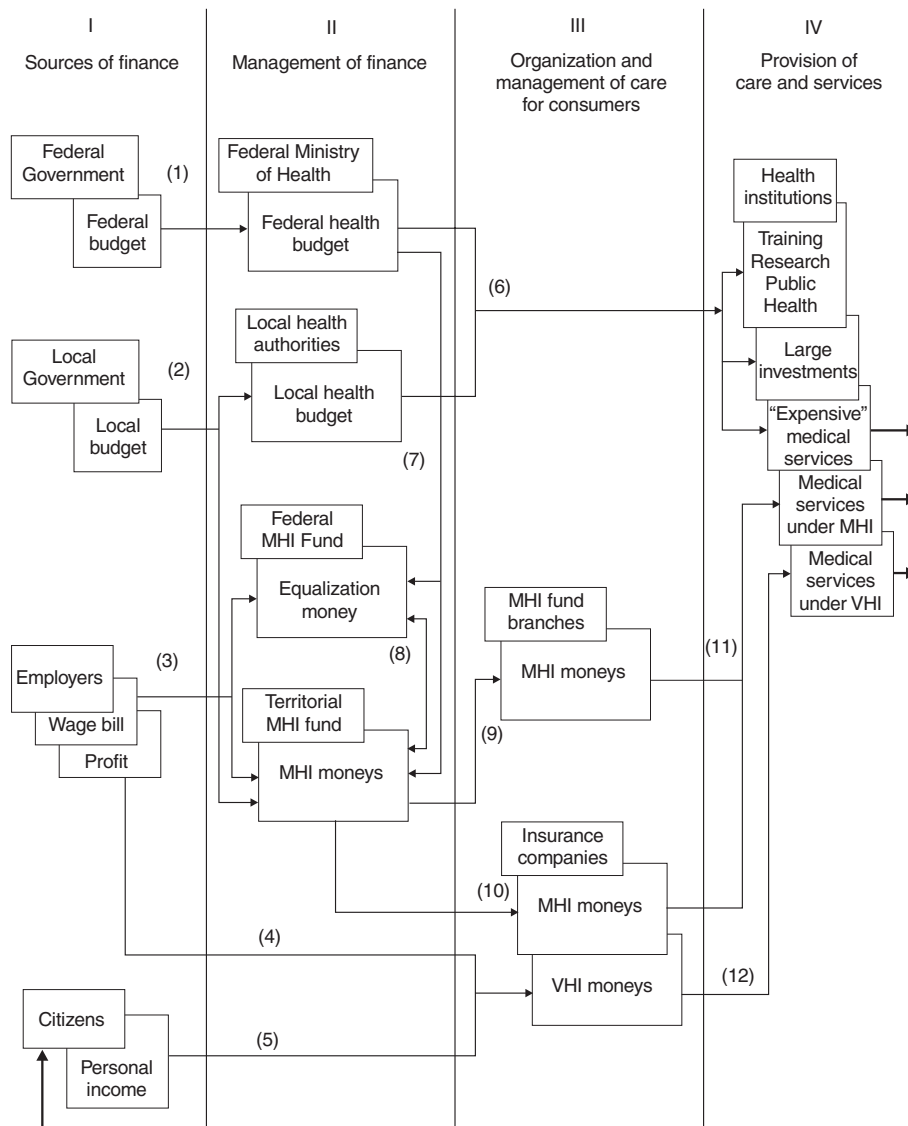
- Voluntary insurance permitted to cover services outside the basic compulsory insurance package;
- Purchasing of care on behalf of citizens to be carried out by private insurance companies and branches of territorial MHIFs, the latter if there are none of the former and only until such private insurers are established.
- Territorial funds to pool all funds and pay insurers on the basis of risk-adjusted capitation;
- Insurers to pay providers on the basis of performance-related methods, according to annually renegotiated tariffs agreed by the territorial fund, regional health authorities, local governments, medical associations, and others at the discretion of the region.

A schematic representation of the new financing system as envisaged by the legislation is shown in Fig. 7. The new system can be conceptually divided into four panels as shown in the figure. Panel I consists of sources of finance, Panel II shows the institutions to be involved with the management of finance, Panel III lists the institutions involved with the organization and management of care for consumers, and finally Panel IV shows the institutions involved with health care provision.

The sources of finance in Panel I include the federal and local budgets, employer contributions to the mandatory scheme and voluntary schemes (if desired), and last, citizens through voluntary insurance schemes and out-of-pocket payments. It was estimated at the time that continuation of federal and local budget financing at roughly current (1990–1991) levels would provide about 55% of total health care financing, but that this share would subsequently decline to about 30% as the mandatory health insurance share increased over time.

Funds allocated at the federal level from the federal budget are to go mainly to the Ministry of Health in Panel II (line 1), which in turn are to be used to finance training, research and public health activities, large investments and high cost treatments appearing in Panel IV (line 6). Funds from the local budgets go to the local health authorities (line 2) to finance the same activities as the federal government but at the local level (line 6). In addition, local budget funds are to finance contributions for the non-working and non-paying portions of their respective populations (line 7). These payments are to be made on a per capita basis agreed at the oblast level, and cannot be below the average contribution made by employers for each worker. The payment rates were not set by the legislation. At the same time, some funds may flow from the local budgets to provide some discretionary support to health services provision (also line 7).

Fig. 7. Schematic representation of health insurance legislation in the Russian Federation (1993)



Source: H. Barnum, D. Chernochovsky and E. Potapchik, Health Sector Reform in Russia: the Health Finance Perspective (45).

The next financing source, involving employers (both private and government organizations), consists of wage-based social insurance contributions paid by employers to the MHIFs (line 3): 0.2% of the wage bill is paid to the federal fund for equalization purposes, and 3.4% of the wage bill to the territorial funds. In addition, employers may decide to purchase voluntary health insurance for their employees for coverage of services not included in statutory provision (line 4). Purchase of voluntary health insurance is to be subsidized by the government through tax relief.

Finally, citizens may also purchase voluntary health insurance if they wish (line 5) and/or may pay directly pay for health care services out-of-pocket.

The federal and territorial funds were to be established as independent, non-profit institutions. Initially they would be responsible for the management of financial resources of the health insurance system, and eventually for the management of all financial resources of the health system at the oblast level: health insurance plus budget, i.e. they would be poolers for all oblast-level health care financial resources. The funds now have boards which act as management bodies. The actual day-to-day administration is carried out by an executive director. The boards consist of representatives of government authorities, the Central Bank, health insurance companies, professional medical associations, trade unions and insurers. The purpose of the federal fund is to achieve equal access and coverage by redistributing health insurance revenues across regions. For this to be accomplished, funds may flow from the federal fund to the territorial funds (line 8). The legislation did not stipulate the magnitude of such possible flows. In addition, federal government budget revenues may additionally flow into the federal or territorial funds to be used for the achievement of interregional equity (line 7).

The legislation foresees two types of institutions responsible for the organization and management of care for consumers, as shown in Panel III. These are insurers, which are to be private, profit-seeking insurance companies, and branches of territorial MHIFs. These institutions are to contract with providers (under Panel IV) and are to be funded by the territorial MHIFs under contract on a capitation basis (lines 9 and 10). The legislation allows insurers to act as care managers or providers by using salaried personnel in their own facilities, or by buying services from other care providers. Thus the law in effect allows for the development of health maintenance organizations (HMOs) and preferred provider organizations (PPOs), although these possibilities are not explicitly mentioned in the legislation.⁴⁴

⁴⁴ Therefore the legislation is consistent with the experiences of the areas under the New Economic Mechanism.

As shown in Panel III, insurance may be compulsory or voluntary, and insurers are permitted to provide both.

The establishment of branches of the territorial MHIFs was considered by the legislation to be a temporary measure in that they were to operate only in areas where there are no insurers, and only until insurers were established. This was believed to be appropriate for rural and sparsely populated areas, and initially was to apply only until 1993.⁴⁵

Citizens are provided with two levels of choice. The first is the right to choose and periodically change the insurer, independently of the employer. The second is the choice of a provider. As insurers are to contract with specific providers, it is clear that consumers' choice of the provider is circumscribed by their choice of the insurer.

The providers of care (Panel IV) may be private or public. Whatever the case, they are to compete with each other for contracts with the insurers (i.e. branches of territorial MHIFs or insurance companies) – lines 11 and 12. Reimbursement of providers is to be on the basis of predetermined tariffs negotiated by the insurers, professional associations, and local health authorities.

Expected benefits of the new health care financing system

The health insurance law was a flexible instrument attempting to create a nongovernmental organization of the health care system that nonetheless remained under public control, allowing for the development of a variety of organizational arrangements to suit each of the regions' preferences and institutional capabilities. It was expected to lead to increased, more efficiently used resources while preserving the equity of access and comprehensive coverage that were hallmarks of the Soviet system.

There were a number of benefits that were anticipated to emerge from implementation of the insurance law. First, as it was stipulated that health insurance financing was to supplement and not replace budget financing, total funds for health care were to increase; according to Ministry of Health calculations the health insurance component of funding could initially add 30% to the health sector planned budget (46). Moreover, health insurance financing would constitute a stable and predictable source of funds that would not fluctuate with the budget, nor would it compete with other sectors for its budget allocation. This would therefore resolve the problem of funding according to the residual principle that was used in the past.

⁴⁵ However, as will be discussed in detail, territorial branch insurance funds are still in operation in many regions of the Russian Federation.

The key structural feature that would lead to increased efficiency and quality was the separation of health care purchasers from providers. The development of the purchaser function through the establishment of insurers who could contract with providers would give rise to a complete overhaul of the existing incentive structure, replacing the old command-and-control system of administration with a flexible competitive system that would ultimately be driven by the needs and demands of consumers. This would materialize through the development of competition on two levels: (a) insurers would compete for consumer subscribers to their insurance plans, and the consumers would make their selection of insurer on the basis of the particular provider institutions with which the insurer had contracted, as well as on the insurer's ability to carry out a quality-control function; and (b) hospitals, polyclinics, and all providers in general, whether private or public, would compete with each other for contracts with insurers. Rather than having a guaranteed income based on a budget (for institutional providers) or salary (for health professionals), they would receive payments specified by the contracts with insurers. Insurers, working on the profit principle (hence themselves not guaranteed an income), would face the incentive to select efficient providers who would deliver high quality services. Providers, competing for contracts with insurers, would face incentives to deliver higher quality services at lower costs.

The market mechanism would address not only the issues of inefficiency and poor quality, but also the problem of excess capacity, since the inefficient, higher cost or poorer quality providers would disappear as the lack of contracts with insurers would force them to go out of business.

Further, much of the above would depend crucially on the introduction of consumer choice, a feature which was absent under the Soviet system, where patients were assigned to a local polyclinic and physician. Ultimately free consumer choice would drive the competitive mechanism, and the system would become responsive to the consumer.

Implementation experience

Implementation of the health care reform legislation began in 1993 with the establishment of the federal mandatory fund and territorial health insurance funds, which began to collect insurance contributions. By the start of 1994, 79 regional funds and 587 of their branches, as well as 164 insurance companies had been established. By the late 1990s there were 89 territorial funds (one in each subject of the Federation), 1170 branches of territorial funds, and 415 insurance companies. More recently there are estimated to be about 300 insurance companies, due to mergers and bankruptcies. Implementation has proceeded unevenly, and has met with numerous financial, bureaucratic,

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and operational problems, in addition to fraud. Decentralization of financing and administration has meant that the Ministry of Health has had minimal involvement with health insurance implementation at the oblast level.

Roughly a decade after the introduction of the initial health insurance legislation, the health care financing system in the Russian Federation is still in a state of flux and beset with difficulties. The financing and purchasing mechanism envisaged by the law has not yet been fully implemented in any of the regions, with the possible exception of Samara. The only component of the planned system which at present functions mostly as expected is the role of the territorial funds in payroll tax (premium contribution) collection.⁴⁶ As for the remaining components, they show a combination of old and new financing elements, with enormous regional variations in the pace of transition and relative success of implementation.

In some regions the new financing system has not been implemented at all; in other regions the system has been implemented only in some rayons; in still others it has been implemented without insurance companies as it has not been profitable for these to establish themselves. Full insurance and coverage of the population has nominally been accomplished, even though payment for this coverage, whether by insurance companies, territorial fund branches, or local health authorities in the case of the non-working population, is far from complete.

The discussion that follows will highlight the key achievements and weaknesses that have emerged from efforts to implement the health insurance legislation. In view of the vast size of the country and the great diversity in experiences, it would be highly misleading to attempt to make generalizations about the reform experiences.

Positive developments

In spite of the numerous difficulties, a number of positive developments have been set into motion as a result of implementation of the financing reform. Contractual relations with clear-cut commitments on all sides have helped to foster a sense of accountability. Implementation of the new system has necessitated the development of new administrative and information management skills. Computerized information systems on patients, providers, insurers, services and standards are increasingly being developed. Performance-related methods of payment, though not yet universally introduced, have begun

⁴⁶ However, even in this case an estimated 12% of the population live in areas where most health care financing comes mainly from the budget, and both insurers and health insurance funds play a marginal role.

to make inroads, and have greatly raised awareness of their efficiency-promoting potential. There is an increased cost-consciousness. Elements of external quality control are beginning to appear; here, too, there is an increased awareness of the issues involved and of the need for greater discipline. There is also an increased awareness of patients' rights, with the possibility of seeking legal recourse with the support of insurance companies. Revenues from the insurance component of financing have stabilized and are even increasing in some regions. It is in fact likely that public funds available for health care would have fallen substantially in the absence of health insurance, as evidenced by the substantial drops in funding experienced by other social sectors that rely exclusively on budgetary funds.

Problems arising in the course of implementation

Partial replacement of budget financing by health insurance financing

The initiation of health insurance payroll tax collection resulted in an initial windfall for the health sector, and it appears that in the early years of its operation (1993–1994) the health insurance system contributed to increasing revenues for the health care system. In 1993 public funds increased by 35%, as expected (47). In 1994–1995, however, some local governments began to cut back on their budget allocations for health on the grounds that medical facilities were now being paid from health insurance revenues. By 1997, public funding was 27% below 1993 levels (47). Additional factors contributing to this development included the vagueness of the legislation concerning the contribution levels of the regional health authorities, and the serious economic difficulties faced by many of the oblasts. Thus health insurance financing lost at least some of its intended supplementary role, and became instead a partial replacement of budget funding. However, it has also been argued that had the health care system remained completely budget-financed, the economic difficulties of the 1990s would have resulted in much larger drops in health care spending. For example, in the period 1991–1997, GDP fell by 38%, spending on education and cultural activities fell by 36% and 40% respectively, whereas spending on health care fell by only 21% (47). Thus health insurance funding may have protected the health care system from meeting with even larger cuts.

Ultimately, the objective of the new insurance system to increase overall funding for health care has not been met, as the system continues to be severely underfunded. It has been argued that to raise sufficient financial resources to finance the free benefits package guaranteed to the population, there should have been a 7% rather than 3.6% payroll tax for health insurance. On the other hand, this would have been unsustainable for many enterprises faced with



serious financial difficulties; many have been unable or unwilling to comply even with the 3.6% requirement.

Fragmentary and incomplete implementation

In approximately one quarter of the 89 regions of the Russian Federation, no insurance companies have as yet appeared, with the result that these regions are being served by territorial MHIF branches or the territorial funds themselves. Contrary to stipulations in the health insurance legislation of 1993, territorial MHIFs were eventually granted the right to act as insurers themselves and to purchase services directly from providers. In another quarter of the regions, third-party payments are made both by insurance companies and territorial funds or their branches. In sparsely populated rural areas, potential insurers do not perceive any potential for profit. Initially, the branches were to operate temporarily for one year only, until insurers would be set; this was then extended to 1997. Now it appears that branches are a permanent feature of the insurance system in rural areas. Some regions have eliminated insurance carriers from the financing system, relying instead on payment directly from the territorial fund. In a number of regions no health insurance payments are made out of local budgets on behalf of the non-working populations. Of those regions that do make payments, many do not do so in full. Reasons for non-compliance of regional governments include financial difficulties as well as fear of erosion of their power. Rather than pay contributions they prefer to fund health facilities directly. A perceived advantage is that in the event of economic difficulties they can stop hospital and polyclinic reimbursement without facing penalties, whereas delays in payment of contributions would subject them to financial penalties. An additional reason is the desire of some regional governments to undermine the operation of the health insurance system.

Confusion of dual financing through budget and insurance

In most of the regions budget financing co-exists with insurance financing, and there are many variations across regions in the resulting arrangements. For example, in some areas the budget pays for all outpatient care while insurance pays for all inpatient care; in others insurance covers only inpatient care for adults; in still others insurance pays for the working population while the budget pays for all non-working people. Clearly, the territorial funds have failed to become poolers of health insurance plus budget funds. A serious problem here is that providers receive conflicting signals and incentives depending on who is the payer of services, on what basis contractual agreements for provision of services are made, and what payment methods are used. Also, planning and accounting activities become highly complicated procedures for the providers.

As long as there are multiple payers with different priorities and motives, it will be impossible to avoid the confusion arising from conflicting signals to providers.

Absence of competition and selective contracting

The introduction of competition between insurers on the one hand, and providers on the other was a cornerstone of the reform. In the case of insurers, as noted above, in one third of the regions there are none, so that territorial funds or their branches act as monopsonistic purchasers of health care, obviously precluding any form of competition. In sparsely populated rural areas, potential insurers do not see any likelihood of profit. Where insurers have appeared, real competition is only possible in urban areas; it is estimated that more than half of insurance companies are concentrated in the three largest cities alone: Moscow, St. Petersburg and Ekaterinburg. However, even in the regions where there is more than one insurance company, what has emerged is not competition but rather a division of the insurers' spheres of influence. In St. Petersburg, for example, the population is divided into sectors, and each fund has been given one sector. In these situations, the territorial funds contract with insurance companies for rigid assignments of catchment areas, thus precluding any element of choice for both employers and consumers.

Thus, under the above conditions, where the insurers are guaranteed their members, there is limited incentive to monitor cost and quality and engage in selective contracting. There is in fact a general perception in the Russian Federation that no insurance companies act as active purchasers anywhere.

Provider competition, on the other hand, is contingent upon selective contracting, to be undertaken by the purchaser of health care services (as envisaged in the 1991–1993 health insurance legislation). It will be recalled that providers are to compete with each other in order to secure contracts with the insurers, and that consumer choice of provider (another competition-stimulating element) is circumscribed by the choice of insurer. If the insurance company or territorial branch fund does not engage in selective contracting (and it does not appear that any does) and if consumers only choose the provider indirectly, through their choice of insurer,⁴⁷ it is clear that there can be no provider competition.

But in addition to the above, there are further constraints to the emergence of provider competition arising from the particular conditions prevailing in the Russian Federation. A key barrier comes from the surviving Soviet-era practice of hospitals and polyclinics having a monopoly in their geographical area. In

⁴⁷ Actually, in the cases where the population is divided into sectors, consumers do not even have a choice of insurer.

sparsely populated areas, economies of scale do not permit the establishment of rival provider institutions, and even in situations where there is room for new entrants, high start-up costs together with economic and regulatory barriers prevent the emergence of competitors. Thus, provider competition can presumably arise only in large urban areas where many are concentrated, yet only limited competition seems to have appeared even in such areas.

Selective contracting, though crucial to the success of the new financing system, meets with opposition on several fronts. Health authorities resist it because to the degree that market mechanisms take hold, their authority is diminished. In addition, hospital and polyclinic administrators often resist it because, despite the potential for greater revenues, it threatens the established way of doing things and creates uncertainties. Even the Russian people remain uncomfortable with the notion of choice between competing provider institutions, preferring passive dependence on the state (48). The head of the Moscow City MHIF, a strong supporter of health system reform, reveals his doubts regarding competitive forces when noting that “basically all the polyclinics in Moscow are the same – the same level of services, the same qualifications of physicians.”⁴⁸

Insurance companies are not always risk-bearing institutions

Insurance companies appear to be confronted with a set of perverse incentives. On the one hand they are supposed to be private, for-profit institutions. This means that they should also be risk-bearing, so that just as they can make profits, they should also be liable to incur losses. Yet if they have losses, they do not absorb them themselves. Formally, it is the territorial funds that would absorb the loss, but they can avoid this by lowering their rates of pay to the providers; thus it is ultimately the patients who bear the risk by being asked to pay out-of-pocket to compensate for the lack of public funds.

It will be recalled that according to the 1993 legislation, insurance companies were to receive from the territorial MHIF a prospective per capita amount for each individual covered. They would then face the incentive to minimize their payments to provider institutions (through a selection of efficiency-enhancing, prospective payment methods), and thereby maximize their profits. However, eventually, territorial MHIFs began reimbursing insurance companies (and/or fund branches) retrospectively.⁴⁹ This arrangement completely eliminated any incentive the insurance companies may have had to engage in selective contracting and pursue efficiency and quality-enhancing measures for providers. If the expenditures of the insurance companies are greater than the allowable

⁴⁸ Il'ya Lomakin-Rumyantsev, quoted in J.L. Twigg, *Balancing the state and the market* (48).

⁴⁹ The reasons for this are discussed in the section *Payment of hospitals*.

amount, the territorial funds cover the deficit. The insurance companies' profits are a fixed percentage of each intervention billed to the territorial fund. With an assured income, the insurers have no incentive whatever to impose cost-saving behaviour on the providers.⁵⁰ Moreover, they also have an incentive to collude or make agreements with the providers to increase the volume of services in order to increase their profits. As long as the insurance companies do not behave as real risk-bearing institutions, without assured profits, the potential benefits of increased provider efficiency will be lost.

This discussion has focused on insurance companies, however it is equally valid for the case of the territorial MHIF branches, which, since they are part of the mandatory health insurance system, will clearly have no incentives to behave as risk-bearing institutions.

Decentralization of administrative and financial authority

Implementation of the insurance legislation was based on extensive decentralization of administrative and financial authority of the health insurance system at the regional level.

A major problem has arisen concerning payment for services provided within a given region to patients from a different region. During the Soviet period there was a network of specialized interregional clinical and diagnostic centres serving populations of neighbouring rayons, with a mechanism that compensated medical facilities for the treatment of patients from nearby oblasts. This permitted rayons to specialize in the provision of different services, so that among several rayons a comprehensive range of services could be provided. The use of such extra-territorial services was the subject of thorough planning at the central and regional levels. However, due to the territorial funds' financial shortage, they have been unable to pay for the extra-territorial services in recent years, thus being in effect unable to provide a full range of services (49). Currently, patients requiring treatment in a neighbouring oblast's facility must pay out-of-pocket. The federal centre is now responsible only for federal programmes. There is a newly emerging tendency to address this problem through interregional cooperation, but there are barely any observable results as yet.

This breakdown of interregional cooperation amounts to an "atomization" of the health care system, with an accompanying process of regional "sovereignization" (48). Some regions are now interested in establishing their own network of health care services, creating duplication of services and unwise capital investment patterns. This tendency leads to inefficient provision of highly

⁵⁰ The income of insurance companies is actually doubly assured: first because of retrospective payments from territorial MHIFs, and second because of the division of the population into "sectors", thus eliminating the possibility of competition between them.

specialized services and equipment without creating the conditions for increased provider competition.

Decentralization has hit the federal level clinical and research facilities especially hard, as mandatory insurance is not permitted to pay for treatment at the federal hospitals, and federal budget cuts have reached federal health care institutions, many of which have closed. Others have been forced to rely on out-of-pocket payments for what were formerly free services in order to remain viable, thus putting highly specialized treatment beyond the reach of the bulk of the Russian population. Research facilities deprived of federal funds have been forced to close down.

Regional disparities and weakness of the equalization mechanism

The legislation foresaw payment of 0.2% of the wage bill into the Federal MHIF, to be used for equalization purposes. However, the economic disparities among Russia's regions, exacerbated by differing abilities to cope with the economic crises of the 1990s, have reached proportions beyond the federal fund's ability to compensate. Some regions enjoy a strong industrial base, others suffer from severe unemployment and local government budget deficits. The regional disparities are continually growing. In 1992, the ratio of lowest to highest per capita spending in health care was 1:4.3 and in 1998 it was 1:7.6 (38).

Failure to change the structure of incentives to providers

According to the health insurance legislation, providers can be paid in a variety of ways: capitation, fee-for-service, diagnosis related groups (DRGs), or any other method or combination of methods on which there is mutual agreement. The law provides flexibility so that each region is free to decide its preferred payment method. However, in the case of health care personnel, most regions have not made any significant changes in their methods of payment since the Soviet period. Doctors remain mostly salaried employees of their institution, thus employees of the regional government. While innovations in hospital payment methods have been introduced, these remain retrospective (see also the section *Payment of hospitals*). As a result, the incentive structure facing polyclinics and hospitals does not promote efficiency but rather encourages the old patterns of overuse of the health care system. In this regard insurance companies, where they exist, are merely passive movers of money to the provider institutions, and fail to make use of their potential to convey the necessary incentives.

Limited freedom of choice for the consumer

According to the legislation the consumer is free to choose the insurer, thus in effect also choosing the insurer's contracted provider. This freedom of choice is important not only as a key to increased consumer satisfaction, but also as a spur to insurer and provider competition. In practice, however, consumer freedom of choice is constrained by the limited availability of insurers in many of the regions. Even where there are many insurers, division of the population into "sectors" or "spheres of influence" of insurance companies in effect precludes consumer choice. In these situations, freedom of choice in effect means little more than freedom to choose a physician within a polyclinic. Under an incentive system which rewarded doctors for the quality of services rendered or for their workload, even this choice should have some positive impact on service quality. However, as doctors continue to be paid by salary for the most part, their only reward for being preferred by patients is an increased workload with no corresponding financial remuneration. Therefore any potential benefits of increased competition due to free consumer choice are lost.

Regulatory weakness

Extremely rapid decentralization of health care administration has resulted in a loss of the state's regulatory capacity. Whereas the Ministry of Health supported the introduction of health insurance legislation, it subsequently made no effort to address the issue of the relationships among the various actors of the system, practically impeding the development of a legal and regulatory basis for mandatory health insurance. This neglect of the reform process facilitated the ensuing massive decentralization. Further, excessive reliance was placed on the market mechanism as a panacea for the ills of the health care system, without due regard for the importance of state regulation. For example, there has been a strong reliance on a competitive structure in the absence of regulatory controls to ensure that insurance companies are fulfilling their intended roles. Similarly, there is very weak regulatory control of the mandatory insurance funds. Whereas the legislation permits insurers to contract with both public and private providers, it does not make a clear institutional or regulatory separation between compulsory and voluntary insurance, or between public and private finance at either the insurer or provider level. The blurring of these distinctions creates opportunities for exploitation of poorly informed consumers, manipulation of the benefits package financed by public contracts, and co-option of public finances by insurers and providers (37). The indistinct delimitation of the responsibilities of the actors at different levels of the government and health insurance structures, along with poor policy coordination, exacerbates the inefficient use of resources (47).

The role of politics

The introduction of new health care financing institutions led to the emergence of conflicting interests and a power struggle between the old and new structures. The Ministries of Health and Finance on the national level, as well as the regional health authorities have been consistently opposed to the establishment of insurance funds and insurance companies, which have encroached upon their administrative and financial positions, although in more recent years they appear to have accepted this as part of the new reality. The Ministry of Finance does not like the emergence of a pool of funds completely beyond its control. There has been some speculation that the failure of some regional governments to pay the insurance contributions of the non-working population is intended to deliberately undermine the insurance system so as to create arguments in favour of dismantling it. In 12 regions of the Federation the local authorities raided the insurance funds and used the illegally acquired money to finance non-health related projects such as housing and construction.

In 1994, most regional health authorities began to demand the right to take control of spending the money accumulated by the territorial health insurance funds. At the same time, however, some regions were positive toward the reform, and support was greater in regions with stronger financial and administrative capacity. In 1995 and 1996, there were efforts by top medical officials to revise the health insurance legislation so as to curtail the power of the newly established insurance institutions. Proposals included abolishing the MHIFs' autonomy and bringing them under government jurisdiction and eliminating private insurers from public financing. Due to successful lobbying by the new insurance pressure groups representing both private insurers and MHIFs, these efforts were blocked in Parliament. On the other hand some regions (for example, Kursk and the Republic Marii El) decided not to abide by the federally mandated insurance system and prevented private insurers from participating in financing.

The dismissal in 1996 of the Minister of Health, who opposed the health insurance system, marked the end of attacks on the insurers and health insurance funds.

Reform legislation weakness

The architects of health care reform believed that under-funding lay at the heart of the problems of the Soviet health care system, and hoped that introduction of a new source would increase the total funds available. This, it was believed, would pave the way for the solution of other problems. In laying the stress on under-funding, they may have ignored the importance of cost-effective organization, cost controls and efficiency-promoting mechanisms. In addition, the reform architects relied heavily on the belief that market-oriented

reforms would solve the system's efficiency-related problems, not recognizing that a strong economic, regulatory and institutional environment, together with strong political leadership are prerequisites to the successful introduction of the envisaged radical change.

Samara: an example of innovative reform (44)

Samara has a population of 3.3 million, and is the largest industrial centre of the Volga area. It was one of the three regions taking part in the NEM in the late 1980s. Even as a result of the NEM, Samara had seen some positive results of its reform efforts: the average length of stay in hospitals fell by 7%, the number of "unnecessary" hospitalizations fell by 13%, emergency ambulance calls fell by 12% and the number of hospital beds dropped by 5500.

In 1996, the Samara oblast passed "The Concept for Development of Health Care in Samara for the years 1996–2000", containing the following objectives:

- modernization of the mandatory health insurance system;
- priority to primary care and training of general practitioners;
- rationalization of health care delivery, encouraging patients to seek secondary care only when necessary;
- development of forms of property, including private practice;
- modernization of health care administration, including measures for quality control;
- increased resource effectiveness.

Samara adopted the federal health insurance model in 1993; it has since achieved 100% coverage for its population, and in the first two quarters of 1999, 100% of insurance contributions had been collected. This was the result of two initiatives: the concerted effort of Samara's territorial MHIF to collect all contributions from enterprises, and a decision in 1998 by the oblast Duma to take away responsibility for paying contributions on behalf of the non-working population from the rayons and make it a protected line item in the oblast budget. Samara is in fact the only subject where the pooling function foreseen by the 1993 legislation is actually undertaken, and where the contribution of the non-working population is fully paid. According to a by-law, this contribution is calculated as total cost of health care minus the contributions of the working population.

Its success in collecting all mandated revenues through mandatory health insurance has meant that Samara not only has been able to provide the federal Guaranteed Benefits Programme to its citizens, but has also increased the benefits list.

Its ability to provide an enhanced benefits package stems also from efforts to improve the cost-effectiveness of service delivery. In August 1995 Samara once again began paying hospitals and polyclinics in accordance with the principles of the NEM. Polyclinics are paid on a capitation basis for the population in their catchment area, and are also responsible for referring patients for inpatient care and covering all inpatient costs, i.e. they have in effect become budget-holders. If their payments for inpatient care are less than the capitation-based payments, they may keep the difference; if on the other hand inpatient costs exceed the capitation-based payments, they must themselves make up the difference. This payment mechanism has unquestionably led to cost savings in hospital care: whereas during the Soviet period inpatient care absorbed 80% of resources, this percentage has now dropped to 54%.

This of course raises the question of whether some patients are being denied access to necessary inpatient care on purely financial grounds. Most doctors interviewed for purposes of this study insisted that this did not occur; however, in one instance it was admitted that some patients are asked to pay for diagnostic tests or inpatient care even when these have been referred.

Most of the polyclinics in Samara have developed day-care facilities, which are held to have significantly contributed to reducing inpatient care, and outpatient surgical facilities are being developed.

Efforts are also directed toward the development of general practice. The regional medical university opened a department of general practice in 1994, and an estimated one third of the Russian Federation's 1500 general practitioners are in Samara. General practitioners are encouraged to work in groups of three in general practice offices: a family doctor, a gynaecologist/obstetrician and a paediatrician.

Samara is the only subject in the Russian Federation which has passed legislation on private practice (1999), which is permitted psychiatrists and physicians specialized in treating "social diseases" as well as drug and alcohol addiction.

Physicians in private practice may participate in the mandatory health insurance system, and state physicians are encouraged to offer services on a paid basis within state facilities (hospitals and polyclinics). Some privatization has facilitated a limited amount of competition, though patients still do not enjoy freedom of choice of insurance company or provider. While state facilities do offer services on a private basis, privatized facilities are as yet few in view of high start-up costs.

Physicians working in public facilities are still paid according to the rigid salary scales that apply to all doctors within the federation. However, the

opportunity to provide paid services provides them with a mechanism to legally increase their incomes, as well as an opportunity to compete with each other for the patients who are able to pay. A portion of the proceeds from private payments may be kept for capital investments, and the difference between the facilities offering paid services and those that do not can be seen immediately, with the former having more favourable facilities and equipment.

Samara's innovative approaches appear to have addressed some of the issues which much of the rest of the Russian Federation is struggling with, but they also raise some important questions. It is possible that Samara is creating a two-tier system of health care, with the higher income groups enjoying higher quality care and better access to services, and the lower income groups remaining with second-rate services and problems of access. The practice of allowing and encouraging paid services within public facilities on such a large scale can be especially dangerous in this regard, as it may prompt doctors to pursue service provision to paying patients at the expense of those attempting to receive services free of charge. It is also worth noting that even though the mandatory health insurance system has succeeded in collecting all mandated contributions, the financial resources still do not seem adequate to fully cover all promised health care benefits, hence the opportunity for the development of paid services.

On the other hand, Samara has progressed farther than most, if not all, other regions in the Russian Federation in implementing a reform which appears consistent with the health insurance legislation of 1993. Moreover, it should be noted that the risks noted above are due to the lack of funds, and not to any inherent flaws in the new system.

Future directions in health care financing in the Russian Federation

As the discussion above illustrates, implementation of the health insurance legislation has encountered a series of unforeseen difficulties, and the results have fallen short of expectations. Recognition of these issues over the years has produced numerous discussions and proposals for a new reform of the financing system to address the shortcomings.

In 1997, there were two competing proposals being discussed in the parliament. According to one of these, by V. Starodubov (at that time Deputy of Minister of Health, and later Minister of Health until 1999), all the insurance companies would have been eliminated and the health insurance funds placed under the control of the regional and federal health authorities. This proposal would have essentially scrapped the new system and returned to a variant of

centralized, tax-based health care financing. The other proposal, developed by Y. Goryunov (member of the state Duma), was in favour of strengthening market relations by reinforcing the roles of insurance companies, other non-governmental institutions in the areas of licensing, accreditation and inspection, as well as private practice. It would also have enforced the regulation that insurance contributions for the non-working population be paid from local budgets (50). While the proposals were debated in the parliament in 1998, they were eventually abandoned.

In 1999 a working group was set up, composed of representatives of the Ministry of Health, the Federal MHIF, Ministry of Taxation and some other ministries and federal departments. The purpose was to discuss the Governor of Samara Oblast's proposals to increase employers' contributions on health insurance and lower taxes allocated to regional health budgets. The objective was to increase the proportion of funds allocated to the MHIFs. This initiative did not have any practical results, however.

During the last two or so years there have been discussions about reorganizing social and health insurance and possibly merging them. In addition, preoccupation with the issue of insurance carriers and their role, if any, in a newly reformed financing system, has continued to be discussed and debated. One point of view which appears to be quite popular among many health officials and employers is that the MHIFs and particularly the insurance companies are unnecessary in the health care financing system. They are accused of being passive movers of financial resources that unnecessarily burden the system with administrative costs. On the other hand, supporters of the system argue that it is not possible to make a fair assessment of a system that has yet to be fully implemented.

It may be noted in this connection that most people in the Russian Federation do not know what mandatory health insurance is, or who is responsible for it; thus they have no opinion on the subject and no objections to its continued operation (51).

In 1999 a draft law entitled "Law on compulsory health insurance" passed a first hearing in the State Duma, but was then defeated. This law would have diminished the importance of insurance carriers within the statutory financing system, offering regions the option to eliminate them altogether if they so wished. However, the insurance lobby opposed the draft law and succeeded in stopping it.

Discussions on the future course of the system intensified and produced a legislative draft with several variants, debated in 2001 and early-2002, the most important of which are the following:

1. Territorial health insurance funds are currently accountable to regional health authorities. The law proposes to create a centralized system of social and medical insurance by making the territorial funds regional divisions of the federal fund.
2. The federal government would pay contributions for the entire non-working population from the federal budget. Thus the federal fund would be financed through two sources: insurance contributions of the working population, and federal budget contributions for the non-working population.
3. The system would keep the role of the insurance carriers, and establish additional conditions intended to foster competition among them. These conditions would include:
 - free choice of insurance carrier by all citizens
 - stringent requirements for insurance carriers, including presentation of an operational plan, justification of particular provider choices, etc.
 - specification of volume of care in contracts with providers.

The ideological orientation of the third variant is opposed to the first two, as it favours the liberal, market-oriented view that places insurance carriers in a foremost position in the reformed system. The government has appeared to favour this variant, which may have a greater likelihood of being passed as legislation. Key concerns under consideration, most of which the new draft legislation attempts to address, include the following:

- the fund pooling mechanism
- how to cope with excessive decentralization
- new regulations for health insurance companies
- selective contracting
- prospective methods of payment
- the problem of severe under-funding: cost-sharing, etc.
- how to revitalize planning procedures in view of excessive reliance on market mechanisms.

More recently, two additional issues have entered the discussions: one involves the possibility of introducing federal budget contributions to match those of the regional budgets for the non-working population; and the other concerns the possible involvement of the Pension Fund in making contributions on behalf of pensioners.

It should be stressed, nonetheless, that work on the draft law is progressing slowly, due to criticisms from a number of directions. There are those who argue, as noted earlier, that the present system operates in the interests of

insurance companies and not patients, and that this must be addressed in a reform of the financing system. Others note that there is no clear legal basis for the management of public funds (the social insurance contributions collected by the MHIFs) by private bodies such as the private insurance carriers. Still others point out that there are contradictions between the rules of the Civil Code and the rules governing the operation of the mandatory health insurance system. Others argue that it is not appropriate that a single law attempts to regulate simultaneously both mandatory and voluntary health insurance, and that a separate law is needed to deal with the latter. There are numerous opinions on the subject, and it is likely that it will be some time before a consensus is reached on the most desirable course for the future of the financing system.

Health care benefits and rationing

Benefits package

The Russian Federation inherited from the Soviet Union a legacy of guarantees for a wide range of social services, including the citizens' right to free medical services which was formulated in general terms in the Soviet Constitution. There was never a defined package of services; rather, citizens were guaranteed a full range of services offered by the medical facilities to which they had access. In practice, equality among citizens was compromised by differential access and quality of services from region to region and according to one's position in the political hierarchy.

The guarantee of a full range of free health care services has not changed with independence, but rather has been confirmed through the new Russian Constitution and the new health care financing law. According to the health insurance legislation of 1991, amended in 1993, the statutory health care system guarantees the population a comprehensive range of health care services. Coverage is universal, based on citizenship and tied to residence of a region or district. The obverse is that in the absence of established legal residence, one is technically without secured health care services.⁵¹

According to Article 22 of the 1991 Health Insurance Law, the basic package of the new mandatory health insurance system would be worked out by the Federal Ministry of Health and approved by the Council of Ministers. Regional governments can work out their own programmes which, however, have to

⁵¹ It may be noted that receiving a residence permit is not an easy task in the Russian Federation; to do so one must have a job and permanent address, and approval by a number of municipal authorities.

meet federal standards of both quantity and quality. The 1993 amendments to the 1991 legislation did not change these stipulations.

The first basic package was approved by the Council of Ministers in 1992 through an Enactment entitled “On measures for implementation of the Law of the RSFSR ‘On Health Insurance of the Citizens of the RSFSR’”. Further basic packages were subsequently defined, and all specify the same minimum federal programme including the following general categories of care:

- emergency care
- primary medical and social care
- preventive and diagnostic treatment in polyclinics
- convalescence, and monitoring and rehabilitation of children, teenagers, invalids, war veterans and groups with veterans’ privileges
- referred hospital care.

The above includes what is referred to as the “minimum volume” of medical care (i.e. all medically justifiable care) in 29 medical specialties covering a standard range.

Inpatient drugs are included in the basic package, but in line with prevailing arrangements under the Soviet system, the cost of pharmaceuticals prescribed to outpatients must be paid for by the patient out-of-pocket. This holds true whether the prescription is made in a specialist clinic or is from a “general practitioner”, unless the patient falls into one of the exempt groups (children, veterans, diabetics, etc.).

Other legislation elaborating upon the levels of entitlement includes the Ministerial Order 146 of June 1993 which specifies the rights of the working population to the basic package of care and reiterates the range of care which is covered in the 29 medical specialties.

The first major step taken by the federal government to review its commitment to free health care occurred in 1998 with the “Programme of the state guarantees ensuring free health services provision to the RF citizens”, resulting in the Guaranteed Package Programme. This does not actually change the benefits structure, however it does attempt to provide tools which will allow the commitments to care to be balanced with resources. The objective is to specify the total amount of funds required to meet the costs of providing free health care services, as well as to determine how the funds are to be collected and disbursed. The Guaranteed Package Programme further determines the types and volumes of free care that are to be delivered, in effect reaffirming the entitlements already in place.

The Guaranteed Package Programme states that the levels and types of free care are to be determined by the Ministry of Health in consultation with the Federal MHIF. It is stipulated that the services included in the programme are to be funded by health care budgets of all levels of administration and MHIFs, each of which will be responsible for a specified sub-set of services in the Guaranteed Package. Indices of volumes of free medical services are to be developed as the basis for identifying the respective expenditures of federal, regional and municipal budgets, and federal and territorial MHIFs. The programme is to be reviewed annually. Furthermore, agreements arrived at annually between the Ministry of Health, the federal MHIF and the regional health care authorities (Tripartite Agreements) are to be used to discuss (a) equalization fund distribution across the regions; (b) the federal government's responsibility to fund targeted programmes (diabetes, tuberculosis prevention, immunization, medical technologies development, etc.); and (c) regional quotas for free treatment in federal clinics. In exchange, the regional authorities agree to approve and adopt territorial Guaranteed Package Programmes which may include additional free services, but must minimally meet the levels stipulated by the federal programme, as well as the obligation to pursue necessary structural transformations in their health care systems.

The initial calculations were based on the assumption that a portion of hospital care would be replaced by outpatient services, and local authorities were instructed to enforce hospital closures and bed reduction in institutions that failed to show cost-effectiveness. An 18.5% reduction target in hospital utilization was set, which would result in cost savings permitting a 27% increase in public outpatient care costs in 1999 and 35–40% increase in later years. It was estimated that under these assumptions, public funding in 1999 would be sufficient to cover 75% of the planned volume of services, i.e. a deficit of about 25%. However according to estimates of the actual deficit in recent years, this varies between 40% and 65%, with seasonal and geographical variations (52).

The territorial Guaranteed Package Programme is currently operating in most of the subjects of the Russian Federation (38). However, experience has shown that the mechanism for the agreements has not been reliable, and often the outcome has depended on the political circumstances influencing relations between the centre and the regions. Only a few of the regions have attempted to use the programme as a restructuring instrument involving a move away from inpatient care.

In January 2000, recommendations entitled "On the territorial Guaranteed Package Programme providing free medical services to citizens of the Russian

Federation” were approved by the Ministry of Health and the Federal MHIF in collaboration with the Ministry of Finance. These recommendations define the purposes, principles, structure and order of the territorial programmes, and establish norms of volumes of such care and their costs.

The free medical care and pharmaceuticals as stipulated by the Guaranteed Package Programme are listed below (by source of finance):

Free services to be covered by government budgets:

- urgent medical care
- ambulatory, polyclinic and hospital care provided to patients with socially significant diseases, including:
 - skin and venereal diseases
 - tuberculosis
 - AIDS
 - mental problems
 - drug addiction
 - pregnancy and delivery abnormalities
 - some types of conditions of children and infants
 - dispensaries monitoring healthy children
 - specialized pharmaceutical care and prostheses
 - some types of expensive medical care.

Free services to be covered by the mandatory health insurance funds:

- ambulatory, polyclinic and hospital care provided to patients with:
 - contagious and parasitic diseases, excluding venereal diseases, tuberculosis and AIDS
 - cancer, endocrine system diseases, skin diseases
 - nutrition abnormalities, nervous system diseases
 - blood diseases, immune system pathology, heart and circulatory diseases
 - eye, ear and respiratory diseases
 - digestive system pathology, all types of injuries and poisonings
 - bone and muscle diseases
 - some types of inborn adult pathology
 - some other diseases.

Per capita indexes, defining health care costs per person, are to be developed by regional authorities using federally determined methodology, and will be

used to determine the allocation of resources in order to cover expenditures on all freely provided services.

There is provision for a wide degree of regional variation as long as the care available does not fall below the specified minimum federal standards. There are increasing disparities across regions, and services that are readily available in some areas may not be on offer in others.

Exclusions

There are also services which are explicitly excluded from the guaranteed package:

- cosmetic surgery;
- homeopathic, alternative, or 'non-professional' therapies offered by practitioners with no medical qualification;
- dental services except basic provision for children, veterans and other special groups;
- medical prostheses including dentures (except for veterans and other special groups);
- rehabilitation or convalescence in institutions other than those approved by the Ministry of Health;
- educational activities and health promotion literature from non-Ministry of Health-approved health centres training in emergency procedures and nursing;
- pharmaceuticals for outpatients.

There is also recognition of the right of medical staff to determine the most appropriate treatment and, therefore, to refuse to provide treatments specified by patients who have referred themselves. This has removed one of the more onerous entitlements of the population as guaranteed under the Soviet constitution, although in practice treatment is not usually refused.

The rationale for these exclusions is mixed. The cases of homeopathic therapy and rehabilitation outside the mainstream health care system reflect concerns about the scientific evidence supporting the treatments. In the case of cosmetic surgery, dentistry, the provision of outpatient drugs and prostheses, these simply mirror precedents established in the Soviet era. Most of services covered in 1990 continue to be included, and revising the definitions has done little to exclude measures such as spa treatments and massages that many more affluent countries decline to fund.

Where treatments are not offered, patients are now at liberty to purchase them. Although this begins to raise equity issues, on the whole the care guaranteed under the basic package is so comprehensive as to preclude any serious concerns about access.

Far more worrying is the fact that the system continues to be greatly overstretched due to insufficient health care resources in the face of guaranteed availability of practically the full range of health care services to all citizens. The 1998 programme of guaranteed benefits continues to guarantee free health care while not addressing the problem of under-funding. The effort to balance health care resources with the actual cost of medical services through the Guaranteed Benefit Package has not produced any practical results because of unwillingness to alter the principle of free health care.

Not only has there been no effort to reduce the package of free benefits, but in fact, a government decision of July 2001 actually increased the free services included in the benefits package for the outpatient care sector. Thus, in effect, hospitals and polyclinics are under the obligation to provide all services according to the legally specified basic package, while nobody is obligated to pay in full for the cost of these services. Statutory funding (from the budgets and health insurance) in real terms has failed to catch up with 1991 levels, and is insufficient to cover health care costs, resulting in an increasing tendency to cover the gap with out-of-pocket payments. Available resources are directed to pay the salaries of health care staff, while the remaining activities are partially financed or not financed at all. The reasons for this imbalance between social guarantees of the state and their public funding lie in the extreme political difficulty of reducing the social service guarantees and introducing cost sharing, and the weaknesses of pressure groups in the health sector compared to other sectors (for example, the military, oil, railroads) (47).

Rationing

The core problem underlying the benefits package, which is the great political difficulty of devising a positive list of services which is not practically all-inclusive, extends throughout Europe and beyond. A negative list, or a list of exclusions is easier to establish, though in this case it is very difficult to avoid irrationalities (i.e. a lack of logical consistency in the choice of services which are excluded). Unavoidably, with limited resources, ad hoc rationing results. In the absence of formal rationing guidelines, providers tend to make decisions using a variety of informal mechanisms. Unofficial waiting lists, under-the-table payments and the practice of requiring patients to pay for the necessary 'raw materials' for tests, i.e. x-ray film or chemical reagents, all play a part in de facto rationing. These approaches imply that the worst off may get excluded,

but anecdotal evidence suggests that many doctors try to compensate, asking patients with money to purchase more materials than they need and using the surplus supplies to treat poorer patients. Although this ad hoc extension of the tax system to the hospital itself may partially protect the poorest people, it certainly does not resolve the issues of arbitrary rationing decisions and the inevitable inequities.

Complementary sources of financing

According to the official statistics, most health care in the Russian Federation is financed through a mix of budgetary and insurance sources. Table 1 and Table 2 present the amounts and shares of financing contributed by each source in the last decade.

Table 1. Main sources of finance, trillion roubles (since 1998, billion roubles)

Source of finance	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Federal budget	0.1	0.6	2.3	3.9	4.3	9.8	5.7	10.1	16.2	23.1
Regional health budgets ^a	0.4	4.8	17.4	37.1	51.9	6.3	58.7	92.9	136.5	158.3
Of which:										
Budget contributions for mandatory health insurance of non-working population	–	0.0	1.2	4.1	5.6	6.5	7.0	10.9	17.9	23.8
Mandatory health insurance (contributions for working population)	–	1.0	4.2	9.0	13.9	18.3	20.0	33.1	51.1	59.6
Private contributions to voluntary health insurance ^b	0	0.1	0.4	1.2	2.2	3.4	3.8	7.2	12.8	–
Household payments for medical services ^c	–	0.1	0.6	2.9	5.6	9.3	11.4	17.4	27.5	37.8
Household payments for pharmaceuticals	–	–	2.1	8.1	12.2	19.8	26.3	51.7	70.1	–
Corporate payments for medical services	–	–	0.3	0.2	0.6	2.1	2.6	2.6	–	–
TOTAL	–	–	26.9	61.2	88.5	126.6	124.7	207.8	–	–

Sources: Goskomstat of the Russian Federation, Health economics. N 7, 2002. Special issue. National health accounts (in Russian).

Notes: ^a Including contributions to mandatory health insurance for non-working population;

^b These contributions are included in household's payments for medical services and in corporate payments for medical services; ^c Not including under-the-table payments.

Table 2. Main sources of finance, % of total^d

Source of finance	1992	1993	1994	1995	1996	1997	1998	1999
Federal budget	11.3	8.9	8.6	6.4	4.9	7.7	4.6	4.9
Regional health budgets ^a	88.7	75.3	64.7	60.6	58.6	53.1	47.1	44.7
Budget contributions or mandatory health insurance of non-working population	–	0.5	4.5	6.7	6.3	5.1	5.6	5.2
Mandatory health insurance (contributions for working population)	–	–	15.6	14.7	15.7	14.5	16.0	15.9
Private contributions to voluntary health insurance ^b	0	0.9	1.5	2.0	2.5	2.7	3.0	3.5
Household payments for medical services ^c		1.6	2.2	4.7	6.3	7.3	9.1	8.4
Household payments for pharmaceuticals	–	–	7.8	13.2	13.7	15.6	21.1	24.9
Corporate payments for medical services	–	–	1.1	0.3	0.7	1.7	2.1	1.2
TOTAL	100	100	100	100	100	100	100	100

Sources: Goskomstat of the Russian Federation, Health economics. N 7., 2001. Special issue. National health accounts (in Russian).

Notes: ^a Including contributions to mandatory health insurance for the non-working population; ^b These contributions are included in household payments for medical services and in corporate payments for medical services; ^c Not including under-the-table payments; ^d The data in Table 1 for 2000 and 2001 are insufficient to allow calculation of percentages for these two years.

The two tables include most but not all sources of health care financing. Estimates of under-the-table payments, which are considered to be a fairly prominent source of revenues, are not included (these will be discussed in detail below). Furthermore, only a portion of financing by the various ministries and enterprises offering parallel health care services is included (see below). Finally, the tables do not include federal financing transferred to the regions and spent in various social sectors at their discretion (presumably an extremely small portion of total health care financing).

As Table 2 indicates, the federal budget share is small and declining, amounting to just under 5% in 1999. In subsequent years there was a considerable increase for health care in the federal budget, reflecting the recent spirit of recentralization and efforts to address child health and “socially important diseases” such as tuberculosis.

Table 3 shows how federal budget funds are allocated. The bulk goes through the Ministry of Health to pay for training, research, public health activities,

large investments and tertiary level (highly specialized) care. The portion allocated to “other bodies” includes funding for the Russian Academy of Sciences and for the parallel health care system. However, this does not completely cover the financing of the parallel system, as some of the ministries finance their systems through extra-budgetary federal funds not included in the official statistics. It is therefore extremely difficult, if at all possible, to obtain an accurate figure on the full size of the parallel health care system.

Table 3. Federal budget health care financing, %

	1999	2000
Ministry of Health	81.5	79.4
Other bodies	18.5	20.6
TOTAL	100.0	100.0

Source: Ministry of Finance of the Russian Federation.

The regional health budgets constitute about 45% of health care financing, but have also declined significantly since 1992. Regional government budget funds may be allocated for two purposes: to pay for certain health care services directly (as in the pre-reform system, which continues in many regions, and/or in accord with the specifications of the Guaranteed Package Programme); and to pay for the insurance contributions which must be made on behalf of their non-working populations. There are wide differences in the ways regional governments choose to spend their budget allocations for health care.

The relative share of the federal and regional government budgets together has been falling steadily over time. The total budgetary sources constitute roughly half of total financing.

The mandatory health insurance system contributes a relatively small portion, which has been quite steady at about 15% since the inception of the system. The decreases in budgetary sources have been matched by a steadily increasing out-of-pocket share, partly for payment of services, which increased more than 5-fold to 8.4%, and especially payments for pharmaceuticals, which more than tripled, reaching one quarter of the total by 1999. As patients have always been responsible for payment for outpatient pharmaceuticals, this latter increase is due to very rapid increases in pharmaceutical prices. Voluntary health insurance is also rising, but as yet contributes only a small portion of total financing.

It should also be noted that budget contributions for the non-working population, which as a share of the total fell in 1999 to 5.2% since 1995, constitute about one quarter of total contributions available to mandatory health

insurance. (The contributions made by the working population through the health insurance system constitute 16% of total financing, and the contributions made on behalf of the non-working population by the regional health budgets constitute about 5%.) This is highly inadequate to cover the health care costs of the non-working population. Amounting to 55.7% of the total population,⁵² the non-working portion incurs health care costs that greatly exceed those corresponding to the working portion, who are as a rule younger and healthier (53). It will be recalled that a number of regions do not pay their contributions for the non-working population at all or do so only in part. This is one of key factors behind the problem of under-funding of the health care system.⁵³

These developments are also clearly depicted in Table 4, showing the financing sources of the mandatory health insurance system. After peaking in 1995, the share of budget funds contributed on behalf of the non-working population fell steadily until 1998–1999, after which it began rising again.

Table 4. Sources of finance of mandatory health insurance, %

Financing source	1994	1995	1996	1997	1998	1999	2000	2001
Contribution revenues	66.0	60.7	61.3	62.0	63.7	67.9	71.9	66.7
Budget funds for non-working population	19.3	27.4	25.2	22.1	22.4	22.4	25.2	26.6
Other (deposits, penalties, fines, etc.)	14.7	11.9	13.5	15.9	13.9	9.7	2.9	6.7
TOTAL	100	100	100	100	100	100	100	100

Source: Goskomstat of the Russian Federation.

A series of surveys investigating Russian household drug and health care expenditures, undertaken by the Institute of Social Research,⁵⁴ found that in 1998 out-of-pocket payments for health care services were substantially greater than the amounts officially reported by Goscomstat. If the figures in Table 2 are recalculated using the new estimate of private payments, the following shares of the different financing sources result (Table 5):

⁵² Data are for 2000 (Goskomstat of the Russian Federation).

⁵³ Additional factors involve the low rate set for payroll contributions (3.6%), as well as low levels of federal budget spending, at least until recently.

⁵⁴ The Institute of Social Research is an independent, non-profit organization (NGO). The study in question was sponsored by the Boston University Project of Legal and Regulatory Reform in the Health Sector.

Table 5. Percentage of main sources of finance using estimates of private expenditure made by the Institute of Social Research

Source of finance	1998, billion roubles	1998, %
Federal budget	5.7	3.6
Regional health budgets	58.7	36.7
Contributions for mandatory health insurance of working population	20.0	12.5
Private contributions to voluntary health insurance ^a	3.8	2.4
Household payments for medical services	32.3	20.2
Household payments for pharmaceuticals	37.0	23.1
Corporate payments for medical services	2.6	1.6
TOTAL	160.0	100.0

Source: Table 2, Institute of Social Research data, Shishkin S. Russian Health care finance reform. Moscow: Teis, 2000, p. 143. In Russian (www.iet.ru).

Note: ^a Here (unlike Tables 1 and 2) private contributions to voluntary health insurance are not included in household and corporate payments for medical services.

Total private sources add up to 47.3%, or nearly half of total financing. This is far more than is generally presumed, and certainly far more than would be expected for a health care system premised on free health care for the entire population. A major reason for the far higher estimate of private expenditures here is that these figures include estimates of under-the-table payments.

Out-of-pocket payments

The insurance scheme as it operates in the Russian Federation for the most part does not include provisions for cost-sharing. The only officially sanctioned charges for mainstream hospital or ambulatory services are for:

- dental care
- routine ophthalmological services (eye tests, etc.)
- most medical aids and prostheses
- outpatient drugs
- those other services excluded from the basic package.

Charging for dental care, for prescriptions for patients treated in the ambulatory setting and for dental prostheses were all standard Soviet practice. In the case of pharmaceuticals, there are a number of groups of patients who are exempt from payment.⁵⁵ In accord with the official rules, there has been no significant growth in the number of services for which patients are expected to

⁵⁵ These include war veterans, tuberculosis patients, diabetics and another 28 categories of patients who are exempted from charges on an agreed list of 96 essential drugs under Ministerial Order No. 157 of July 1994.

pay within the mainstream setting. In spite of the official rules, however, there has been appreciable growth in the amount of patient participation in the financing of health care during the 1990s. In part this is due to inflation in the pharmaceutical costs as the private sector has taken on an increasing role in importing and distributing them.

In addition, the increase in out-of-pocket payments has been due to the forced participation of patients in covering that portion of costs which statutory funds are unable to cover. Providers of nominally free health care services, unable to cover their costs through public funds, charge for services which they are legally required to provide free of charge. The government, unable to provide the necessary financing, is forced to accept these legally questionable practices.⁵⁶ This leads to situations of great inequality, as patients may either receive a service free of charge, or may have to pay for it in full, depending on the type of care provided or where it is provided. In cases of hospital care, especially surgery, the cost paid for out-of-pocket may be in excess of a monthly or even an annual salary (42). Aside from such semi-legal charges for services, there are also some payments to physicians and others that are wholly under-the-table, as discussed in the section *Under-the-table payments* below.

The series of family surveys on Russian household drug and health care expenditures undertaken by the Institute of Social Research provides estimates of out-of-pocket spending that differ widely from official figures. According to the January 1998 survey, total out-of-pocket payments, including envelope payments, amount to 47%, or nearly half of total health care financing (see Table 5). The study showed that pharmaceuticals and medical devices absorbed 62% of the total (official plus unofficial) out-of-pocket spending, followed in importance by outpatient services and then hospital services (43). Whereas hospital services are much more expensive than primary-level care, they are used less frequently, thus accounting for the lower amount spent on them.

Another series of family surveys provides an indication of the size of out-of-pocket fees (26). In 2001, approximately 10% of those who sought medical help reported paying for it. Of these, about half paid “officially in the cashier’s office” in amounts ranging from 2 to 3000 roubles, and about 56% paid “money or gifts to the medical personnel” in amounts ranging from 10 to 3000 roubles. Among hospitalized patients, 15.4% paid for the hospital stay; of these 65.3% paid officially, while 51.3% paid “money or gifts to the medical personnel”.

The statistics reveal some of the inequities in financing that result from out-of-pocket spending on pharmaceuticals and health care services. The health-related expenses of the poorest people as a fraction of their income is three

⁵⁶ It is interesting to note that no one has chosen to challenge this procedure in court, probably reflecting the passive acceptance by Russians of their administrative system.

times greater than that of the richest people, even though the poorest visit outpatient facilities less often, stay more briefly in hospital, and at times do not purchase required drugs because of the cost (51). One in ten respondents claimed that a household member did not receive recommended hospital care because of the cost. Half of households reported that a family member could not afford a recommended drug at least once in the course of 1998. In over 20% of households a family member did not get a recommended cardiovascular drug because of the cost. Furthermore, it must be noted that out-of-pocket payments as a fraction of income are higher in rural than in urban areas.

The share of payments going to private providers was much higher than the share of households that obtained private services. For example, payments for private dental care amounted to 60.7% of all payments for dental care, whereas only 19.8% of household visited private dentists (however, the 1999 survey shows that the share of payments for private dental care has decreased). Similarly, while 15.3% of hospital care payments were made to private hospitals, only 0.4% of households purchased private hospital care. This clearly indicates that even with the prominence of under-the-table payments, privately provided care is far more costly than publicly provided care (43). Poor people can clearly not use paid services as they cannot afford them. Since paid services often exist because free services are in short supply, it follows that poor people often end up being deprived of their constitutional right to health care.

The growth of official and unofficial private payments is due to the imbalance between the promise of free health care and the reality of severe resource constraints. According to WHO's index of "fairness in financial contribution", the Russian Federation ranks 185th out of a total of 191 countries (54). These increasing inequities are leading to a growing realization that a revision of the constitutional promise of free health care is imperative. In view of the severe shortfall in funding and the state's inability to meet its commitments with the public resources available, discussions have begun of shifting a portion of statutory health care costs onto the consumer, as a means of increasing the funds available to health care, raising consumer cost-consciousness, and ironically, also increasing equity. Ordinarily the imposition of co-payments tends to increase inequity in health care financing as it disproportionately affects lower income groups. However in the case of the Russian Federation, the prevalence of legally questionable and under-the-table payments is thought to contribute far more to creating inequities; it is therefore more than likely that the imposition of co-payments would lessen the inequities of the current system.⁵⁷

⁵⁷ Clearly, increased equity through the imposition of co-payments can result only if the co-payments replace a substantial portion of gratuities. In a worse case scenario, co-payments would co-exist with unchanged levels of underground payments.



One of the issues dealt with by the 1997 “Concept of health care and medical science development in the Russian Federation” is cost sharing for the health care services guaranteed by the basic package. It does not, however, provide normative or legislative mechanisms that would allow for implementation of cost sharing. In more recent years this issue has become a priority according to official statements, but there appears to be unwillingness to discuss concrete actions to introduce cost-sharing. In an economic programme developed in 2000, co-payments for health care services were seriously considered, but the government did not legalize them. In a presidential address in 2001 the problem posed by the prevalence of large unofficial payments was noted, but with no mention of possibly legalizing co-payments. At present it is considered unlikely that cost-sharing will be legalized over the near term, for political reasons, however the issue has been raised publicly and there is broader awareness. Results of a sociological survey undertaken by Tacis show that a portion of the Russian population in Moscow would be willing to contribute their own resources to health care financing (53).

Some administrative bodies, in opposition to federal laws, have already taken the initiative to legalize certain co-payments. Examples include the Health Department of the Perm District, which has established fixed charges for outpatient visits and each day of hospital stay; the Kaluga District, which is considering the imposition of co-payments for their guaranteed health care services; and the Republic of Karelia, which withholds 80% of retirement income of hospitalized patients for payment of services received.

Under-the-table payments

In the Soviet era, health care personnel routinely supplemented their incomes through the widespread practice of accepting gratuities. The full extent of this was unknown. Attempts to collect figures were hampered by officials’ reluctance to acknowledge the practice, and by the difficulty of quantifying payments that could be either in cash or in kind. However, according to a study conducted at the Soviet Sociological Institute in the 1980s, the “black” portion of the health care economy amounted to about 17% of the total budget of the health care system. More conservative estimates of the value of out-of-pocket payments for health care services put them at between 7% and 10% of health expenditures. Whichever figure reflects the truth most closely, it is clear this was a significant source of finance, particularly the payment of doctors and nurses.⁵⁸

⁵⁸ Anecdotal evidence suggests the bulk of these payments subsidized the income of staff, with very little going to purchase supplies or other medical goods.

Under-the-table payments today should be seen in the wider context of corruption in the Russian Federation. According to a two-year study on corruption funded by the Danish government and the World Bank and undertaken by the Russian think tank INDEM, Russians pay \$36 billion per year in bribes, an amount that comes to more than half of 2002 government spending (55). Of this amount, \$2.5 billion involves “casual corruption” including payments for nominally free services.⁵⁹ Health care was found to be the sector absorbing the largest share of these bribes, amounting to over \$600 million.⁶⁰ The study found that at least 12 million Russians do not seek medical treatment they need because they cannot afford to pay the bribe.

Under-the-table payments therefore unquestionably continue to be a major source of funding for health care. The great mismatch between the practically all-inclusive entitlements on the one hand, and the limited official resources on the other, do not allow the system any chance of survival in the absence of widespread unofficial payments.

The results of the surveys conducted by Institute of Social Research (in conjunction with the Boston University Legal and Regulatory Reform Project) extend to the under-the-table portion of out-of-pocket expenditures on drugs and health care. The total amount of payments made unofficially by households in December 1997 for pharmaceuticals and health services amounted to 15.5% of all out-of-pocket spending. In December 1998, consumers were shown to be spending slightly more in absolute terms on unofficial payments (35.9 roubles in 1998 compared to 34.6 roubles in 1997). However, as a share of total out-of-pocket expenditures this dropped in 1998 to 11.5% because of a corresponding increase in total private health spending. This amount of unofficial payments corresponds to double the officially reported legal payments (51).

The proportion of unofficial payments made in the private sector is much smaller than in the public sector. The bulk of funds paid unofficially is spent for hospital services; in fact an estimated one third of all payments for inpatient care are made under-the-table. Most of the payments are made to doctors, and smaller amounts to health officials who arrange for hospitalization, nurses and other staff (51).

A significant number of unofficial payments are made for dental services; these were estimated to absorb 29.3% in December 1998, and went mostly to privately practising dentists. This is due to the desire on the part of providers to avoid payment of income tax, and can benefit both patient and provider if the recorded fee is lowered and the “saving” in taxes shared between patient and provider.

⁵⁹ The largest part, of about \$33.5 billion, includes bribes by businesses.

⁶⁰ Health care was followed in importance by education.

Pharmaceuticals and public outpatient clinics absorb the smallest amount of unofficial payments.

It is also interesting to note that under-the-table payments for inpatient care tend to be greater in rural areas than in urban, probably due to inferior quality of care in rural facilities. This is consistent with a broader trend showing that out-of-pocket payments in general tend to be higher in rural areas, as noted earlier (51).

Voluntary health insurance

Voluntary health insurance was first authorized in 1991, with further regulatory legislation the following year.⁶¹ It may be offered to individuals or to groups, for example the staff of an enterprise, and allows the population covered to obtain additional services beyond those included in the basic package. It is offered exclusively by private insurance companies (normally joint-stock holdings) which operate for profit, but there is no bar to non-profit organizations entering the field. According to the 1993 mandatory health insurance legislation, voluntary insurance may be offered by private insurers who are part of the mandatory health insurance system.

Voluntary insurance plays only a very small part in health care financing in the Russian Federation. Its contribution was estimated at about 3.5% of total health care financing in 1999 (see Table 2). According to the survey results of the Institute of Social Research, only 5% of the households surveyed purchased voluntary health insurance, mostly for children. The 1998 survey showed that respondents were not very interested in voluntary insurance, and the survey of the following year showed that it had become even less popular. In general, it tends to be purchased only by the rich and by small numbers of employers for their staff (in addition to mandatory insurance contributions). Foreign firms in particular tend to provide private insurance for their expatriate employees.

Private insurance firms have tended to concentrate on the top end of the market and to offer add-on services to supplement the basic package of free medical care. Their focus has been on providing better conditions and hotel services and on securing access to more prestigious institutions. Companies tend, then, to draw up contracts with the clinics and hospitals that previously formed part of the closed system, which were better resourced even in the Soviet era. They are thus able to guarantee their clientele access to better facilities and to higher calibre staff without having to bear the full cost of this provision (in other words, they are subsidized by public funds). The benefits

⁶¹ Law "On organization of insurance business in the RSFSR" of November 1992 (No. 4015).

accruing from deals with insurance companies therefore go almost exclusively to those parts of the system which are already most privileged.

There are plans to revisit the laws on voluntary health insurance, with a view to improving the regulation of the system, extending coverage and encouraging take-up. The 1997 "Concept of health care and medical science development in the Russian Federation" asserts the need to develop voluntary insurance, but there have been no further initiatives since.

External sources of funding

External sources of financing consist of loans or grants made by bilateral or multilateral organizations. The extent to which the Russian Federation has benefited from such assistance is limited. External sources have never made a major contribution to health care financing and what external aid there was after the collapse of the Soviet Union has now declined. Much of the international assistance currently channelled into the country is in the form of technical expertise and support and is focused chiefly on capacity-building, including training and support for the development of key policies, hence is not significant in terms of health care provision to patients in the short term. The long-term impact of the support given for initiatives on health care reforms, primary care, mother and child health and capacity building (training, policy development etc.) remains to be seen.

Health care expenditure

Due to incomplete reporting of financial flows, no one really knows the magnitude of financial resources allocated to the health care system in the Russian Federation. In addition, a lack of those indicators widely used in OECD countries makes international comparisons on health care expenditure problematic. Core areas of concern are the unrecorded budgets of the parallel health system, uncertainties of the precise amount spent in the oblasts now exercising independent control, and the significant and substantially unrecorded out-of-pocket payments for services. In addition, little is done to record the amount of money raised by the sale of services within the hospital and polyclinic system. Even those amounts spent out-of-pocket under official auspices (in particular expenditure on pharmaceuticals) are difficult to quantify.

Further difficulty in making reliable estimates comes from rapid inflation, which only came under control after the 1998 default, and changes in governmental approaches to record keeping. Attempts at indexation have proved difficult, but compared to benchmark expenditure levels at the time of the Soviet

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Union break-up, real spending has fallen, resulting in inadequate provision to meet basic needs within the system.

The parallel health care system, consisting of the numerous administrative bodies that provide services to their employees, is estimated to absorb under 20% of the federal health care budget, though it additionally absorbs unrecorded extra-budgetary funds.⁶²

As a result of these omissions and uncertainties, estimates of health care expenditure as a share of GDP vary widely. According to the WHO health for all database, this was 2.9% in 2000, as shown in Fig. 8 and Fig. 9.⁶³ The first of these, trends in health care expenditure over time, shows Russia consistently below all other listed countries, with an expenditure-to-GDP share approximately one third the average of the European Union and also below the NIS average. In addition, there have been wide fluctuations in the years prior to 1995, with the spending share varying between 2.2 and 3%. Fig. 9 similarly reveals the low position of Russia compared to other member states in the European Region of WHO.

However, the figure provided by the health for all database is a considerable underestimate of true spending on health care, as it includes only public financing sources (budgetary plus health insurance) but excludes the parallel services, which are of course also publicly financed. Additional missing components are official private payments, including private insurance payments and unofficial private payments.

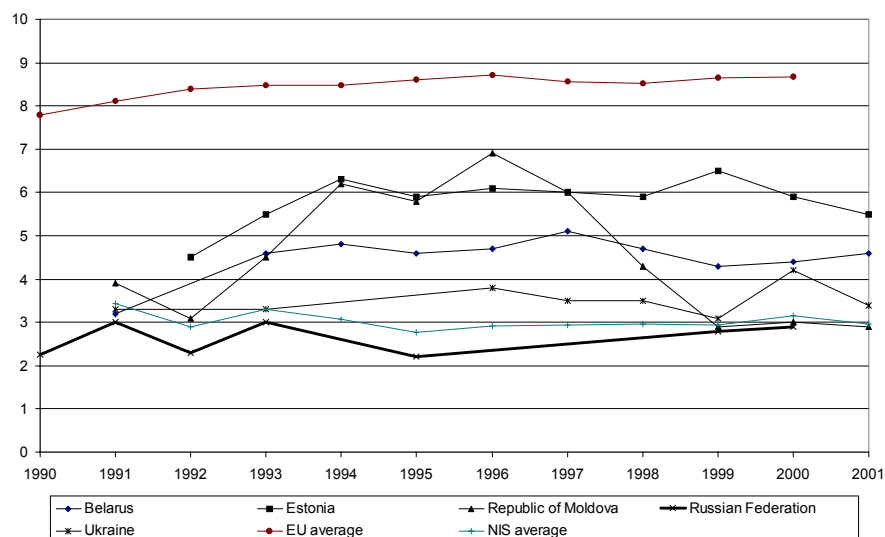
Goskomstat statistics (Table 6) put total health care expenditure at 4.6% of GDP in 1999. The World Health Report of 2000 (54) estimates the total public plus private spending share in GDP to have been higher, at 5.4% in 1997, based on an estimate of a 23.2% share of private spending in total health care spending, implying a public spending share in GDP of 4.15%, and a private spending share of 1.25%. This estimate of private spending is very low, compared to an estimate from a December 1997 survey of 3000 Russian households (43), according to which the total private share of expenditures (official plus unofficial) is about 47% (see the section *Complementary sources of financing* for a full discussion). If these figures are used, it follows that the total health care expenditure share of GDP would be between 6.5% and 7%, or substantially higher than what most sources report.

The numerous differing estimates of health care spending as a share of GDP are indicative of the difficulties in making accurate calculations, and reflect the differing assumptions going into them.

⁶² See the discussion under *Complementary sources of financing*.

⁶³ It should be noted that there is a gap in the WHO health for all statistics, as there are no data for the period 1996–1999 (see Fig. 8).

Fig. 8. Trends in health care expenditure as a share of GDP (%) in the Russian Federation and selected countries, 1990-2001



Source: WHO Regional Office for Europe health for all database

Table 6. Trends in health care expenditure in the Russian Federation, 1994–1999

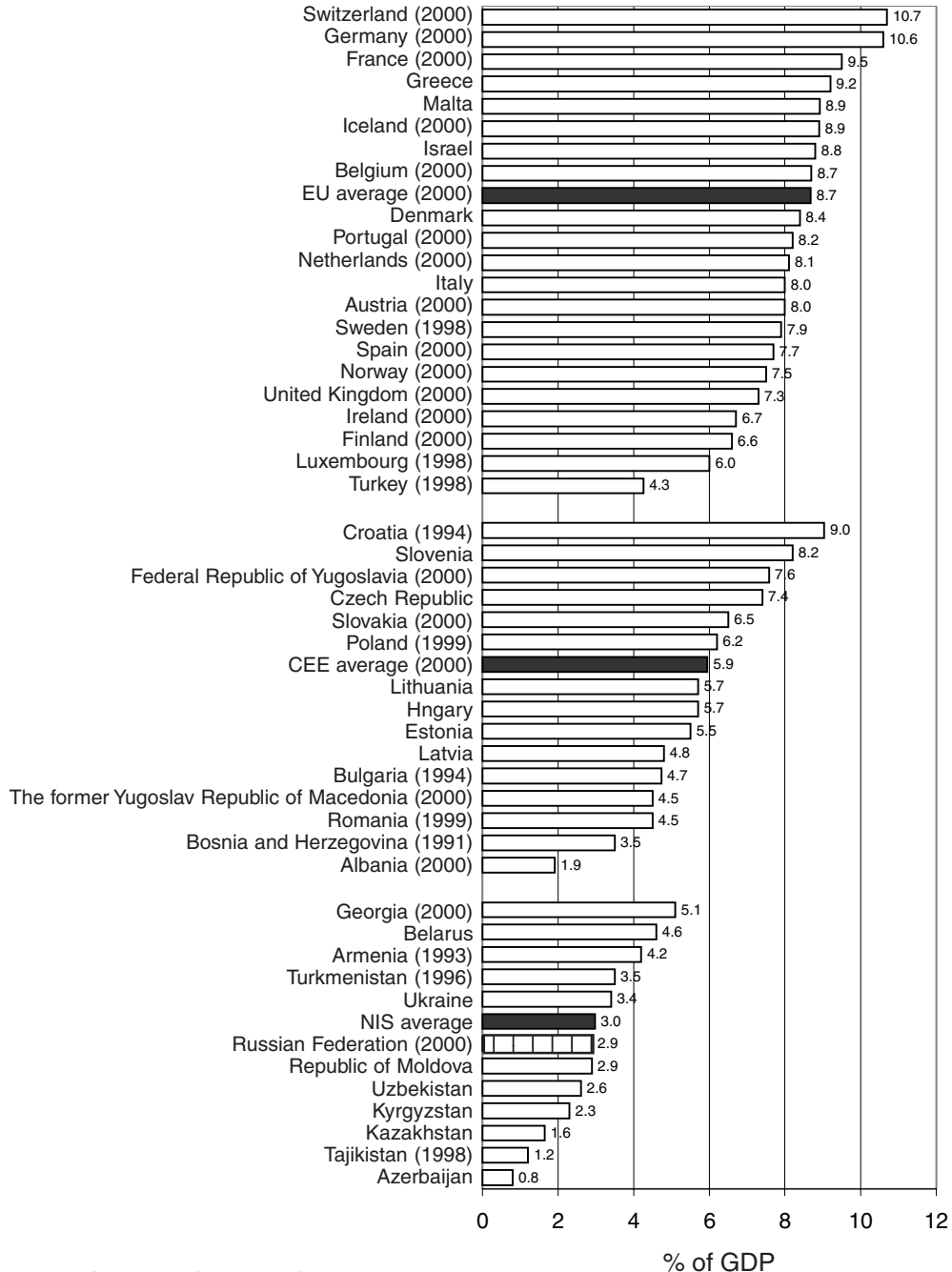
Total expenditure on health care	1994	1995	1996	1997	1998	1999
Value in current prices(trillion roubles, since 1998 – billion roubles)	26.9	61.2	88.5	126.6	124.7	207.8
Value in constant prices(trillion roubles)	26.9	21.9	22.6	26.9	24.1	25.1
Value in constant pricesUS\$ PPP, billion	29.2	23.8	24.5	29.2	26.2	27.2
Value in current prices, per capita (US \$PPP)	197.4	161.1	166.3	198.8	178.8	186.4
Share of GDP (%)	4.4	4.0	4.1	5.1	4.6	4.6
Public as share of total expenditure on health care (%)	88.9	81.7	79.2	75.3	67.7	65.5

Sources: Goskomstat of the Russian Federation and *Ekonomika zdavookhraneniya* N. 7, 2001 (Health Economics No. 7, 2001).

Table 6, showing the development of health care expenditures in the period 1994–1999, reveals that it plunged, in real terms, in 1995, recovered to its 1994 level by 1997, and then fell somewhat in the next two years. Clearly, the difficulties were greatly aggravated by the financial collapse of 1998, which took a great toll primarily on the budget component of health care financing, as detailed below.

While it is exceedingly difficult to arrive at an accurate figure, it is quite certain that public funding has dropped in real terms since the break-up of the Soviet Union. Table 7, showing the real (deflated) development since 1991 of

Fig. 9. Total expenditure on health as a % of GDP in the WHO European Region, 2001 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

Notes: CEE: central and eastern Europe; EU: European Union; NIS: newly independent states.

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total public spending, as well as the relative budget and health insurance shares, shows that real public spending never recovered to 1991 levels. Total public spending, while increasing in real terms in 1993, partly due to the introduction of mandatory health insurance, subsequently fell precipitously, so that by 1999 it stood at only two thirds of the 1991 level. This huge drop is due mainly to the decline in budgetary spending, which by 1999 had fallen to approximately half its 1991 level.

It therefore follows that the far smaller decline in real terms which has been witnessed in total health care expenditure (public plus private) shown in Table 6, was due to a simultaneous large increase in private, out-of-pocket spending to compensate for the fall in the public share.

It is also interesting to note that whereas budgetary spending dropped in 1998 due to the financial crisis, health insurance spending does not appear to have been affected. This would lend support to the argument that health insurance financing is insulated from economic fluctuations, and therefore more stable than budgetary financing.

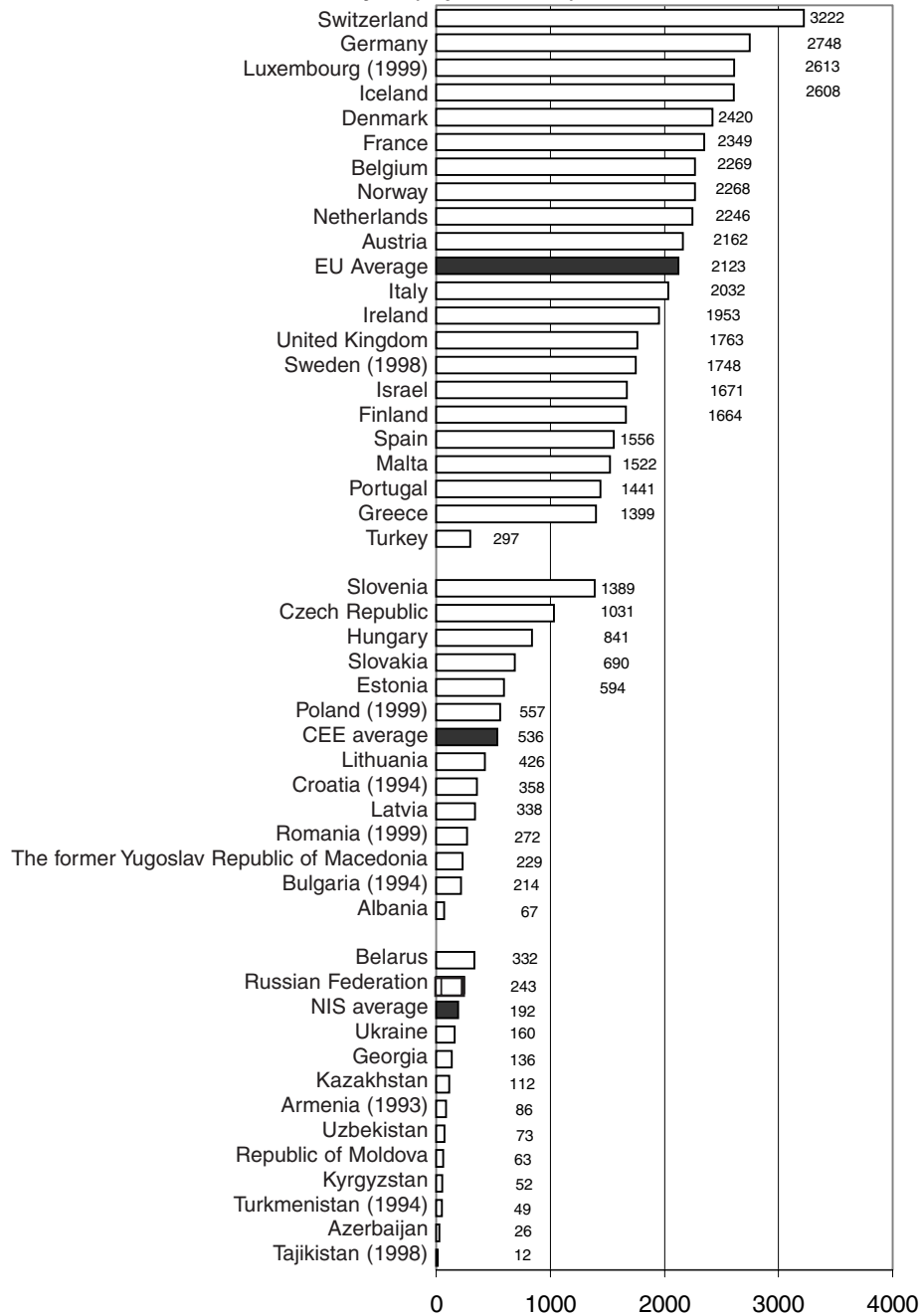
Table 7. Development of public health care expenditures in real terms (1991=100)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total public	100	80	108	98	72	71	81	67	67	71
Budget	100	80	91	81	59	57	65	51	51	55
Mandatory health insurance	–	–	17	17	13	14	16	16	16	16

Source: Shishkin S. Russian Health care finance reform. Moscow: Teis, 2000, p. 93. – In Russian (www.iet.ru). Assessment is made on the base of the Goskomstat data with use of index-deflators published after the end of each year (1992 – 17,2; 1993 – 10,2; 1994 – 4,1; 1995 – 2,8; 1996 – 1,4; 1997 – 1,2; 1998 – 1,1; 1999- 1,6; 2000 – 1,4).

In spite of the significant drops in real spending, annual per capita spending in terms of US \$PPP is probably higher than in the official statistics in Table 6, which likely underestimate the true value of private, out-of-pocket spending. WHO's health for all database estimates this to have been very low at US \$PPP 209 in 1999, though as noted earlier, this refers only to public sources of finance (excluding the parallel system). The World Health Report of 2000 more realistically puts it at US \$PPP 251 (1997 data), though this is also based on a likely underestimate of private expenditures, and in all likelihood does not include spending by the parallel health care systems. Whatever the case, even if the most liberal adjustments are made for the contribution of out-of-pocket spending, per capita spending on health care still would remain very low by western European standards, as Fig 10 suggests.

Fig. 10. Health care expenditure in US \$PPP per capita in the WHO European Region, 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database. US \$PPP

Notes: CEE: central and eastern Europe; EU: European Union; NIS: newly independent states.

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Table 8. Shares in total health care expenditure of the federal budget, regional budgets and mandatory health insurance, %

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Federal budget	11	9	10	8	6	10	7	7	8	9
Regional budgets	89	76	73	74	74	71	69	68	66	66
Including budget contributions for mandatory health insurance of non-working population	–	0	5	8	8	7	8	8	9	10
Contributions for mandatory health insurance of working population	–	15	17	18	20	19	24	24	25	25
Total	100	100	100	100	100	100	100	100	100	100

Source: Calculated on the basis of data of Goskomstat.

Table 8 shows the structure of total public health care expenditure. Both the federal and regional budget shares have been declining steadily throughout the 1990s. The contributions made by the regional budgets for the non-working population have been steady since 1995. The slack has been taken up by contributions of the working population. Only in 2001 has there been a small increase in the regional budget share paid on behalf of the non-working population

In conclusion, it must be pointed out that reform has not succeeded in raising the originally hoped-for finances through mandatory health insurance. As Table 8 indicates, expenditures of the health insurance component in 2000 represented exactly one fourth of total public expenditures. The original intention was that health insurance would be responsible for about two thirds of health care financing.

The fact that health sector personnel continue to be paid relatively low salaries (under the Soviet system doctors earned 80–90% of the wage of an industrial worker), goes some way to protecting the purchasing power of the health budget. However, the privatization of pharmaceutical, energy and food supplies has given rise to dramatic increases in the prices of these inputs. Prices for particular goods are comparable to those in countries with far higher per capita GDP, and this places further strain on health expenditures.

Clearly, it is all but impossible to make definitive statements about health expenditure in the Russian Federation when so much of the money spent is not formally recorded, nor is it possible to make accurate comparisons over time. However, it is clear that the health sector faces real difficulties in securing sufficient resources to continue to function, especially in the most deprived

regions. The shortfall in official financing is increasingly being made up for by unofficial payments, with a highly deleterious effect on equity. Moscow, St. Petersburg and other urban centres appear to be managing relatively better, while rural areas are experiencing the real stresses of the new order. Although there was always some inequity in the Soviet system, there was some redistribution of funds which to a degree equalized per capita spending throughout the regions. Under the new system inequalities appear to be widening.

Table 9 provides an indication of the extent of inequalities in terms of interregional differences with respect to health care spending per capita.

Table 9. Regional differences in average per capita expenditures on health care, 1996

	Degree of deviation from average	
	More, % of average	Less, % of average
55 regions		From -1.7 to -82.3%
33 regions	From +0.5 to +148.4%	

Source: Tacis, Review of Russian Health Care Finance System (38).

It can be seen that in 55 of the regions per capita expenditures are below the national average, while in 33 regions they are greater than average. Per capita spending in the lowest region is less than one fifth of the average, while spending in the highest region is two and a half times the average.

Moreover, it appears that these inequities are increasing over time. Whereas in 1992, the ratio of lowest to highest per capita spending was 1:4.3, in 1998 this had become 1:7.6 (38).

Structure of health care expenditures

The Soviet system traditionally focused on inpatient secondary and tertiary care at the expense of outpatient primary and preventive medicine. This was a legacy of the days when the provision of large numbers of beds was seen as the most appropriate response to the risk posed by infectious diseases. The overprovision of beds was then perpetuated by funding mechanisms which linked hospital budgets to bed numbers, thus creating perverse incentives for hospital doctors to keep open and fill unnecessary beds.

The intention of the original reform programme was both to increase quality and patient choice but also, significantly, to address the imbalance between hospital and primary medicine. Policy-makers assumed that the devolution of funds to insurance companies would create incentives for those companies to spend as efficiently as possible. To the reform planners this implied shifting resources into primary care and preventive medicine. However, insurance

Table 10. Estimated health care expenditure by categories, as % of total expenditure on health care, 1998

Category ^a	1998
1. Inpatient care (%)	49
2. Outpatient care (%)	16
3. Preventive care (public health) (%)	8
4. Pharmaceuticals (private) (%)	22
5. Public investment (%)	5
TOTAL	100
of which, public (%)	66

Source: Scheta zdravookhraneniya Rossii (Health accounts in Russia, 1994 – 1999, Moscow, 2000).

Note: ^a Items 1 and 2 include public and private expenses; items 3 and 5 only public; item 4 only private.

companies have tended to fall back on traditional patterns of provision and to perpetuate the imbalance between the secondary and primary sectors. Thus, the percentage spent on inpatient care is largely static, despite statements by planners and policy-makers that they would encourage a shift to primary care and preventive measures.

Attempts to shift care to an outpatient mode have also suffered in the face of patient preferences. Traditionally it was perceived that the least qualified and least able doctors went into primary care while those who became outpatient specialists in polyclinics were only one rung higher in the pecking order.⁶⁴ The best doctors were believed to go into hospital medicine and, in consequence, patients continue to push for hospital referral rather than accept ambulatory care.

The Soviet system also inadvertently encouraged patient preferences for hospital admission through its prescription costs policy. Inpatients received pharmaceuticals free of charge while outpatients were expected to pay for drugs unless they were exempted. This created financial penalties for those treated in an ambulatory setting, particularly as inpatients were also eligible for rent rebates.

This policy continues and has all the more impact now that pharmaceuticals are supplied through the private sector and are becoming increasingly expensive. Patients are ever more likely to benefit financially from hospital admission despite the extra strain this places on the finances of the system as a whole. Rising drug costs are a feature of health care expenditures in their own right and take up an increasing proportion of all spending year to year. This picture

⁶⁴ This was one of the drawbacks of the Kemorovo model which had polyclinic doctors acting as fundholders. Their lack of authority in the eyes of patients and of other doctors undermined their ability to be effective as budget holders.

is likely to get worse as western European companies market products directly to consumers.

As with data on the levels of spending as a percentage of GDP, it is difficult to make clear statements about the apportioning of expenditure between different categories. There are clear trends however. The proportion of spending on capital investment and renovation has declined dramatically from a high point in the 1970s, when building and expansion were taking place. Building programmes have ceased almost altogether, and there has also been a marked decline in spending on equipment. This is a ticking time bomb, as regular maintenance cannot be perpetually postponed without an eventual collapse of the ability to provide even the most rudimentary levels of care. Pharmaceuticals are taking up a greater share of the budget, largely as the result of rising costs and an opening up of the market to imports.


Table 11. Structure of health care expenditures of regional government budgets, 1994 – 1996

Expenditure category	1994	1996	1998	1999
Salaries and wages, taxes	35.4	27.4	32.0	33.9
Nutrition	5.2	5.6	5.3	5.4
Pharmaceuticals, supplies	10.8	11.7	13.3	13.7
Capital investments	18.7	7.4	9.0	10.5
All other	29.9	47.9	40.4	36.5
TOTAL	100.0	100.0	100.0	100.0

Source: Tacis, Review of Russian Health Care Finance System; Ministry of Finance of the Russian Federation.



Health care delivery system



The Russian Federation inherited a health care system dominated by the Semashko model and the particular history of the Soviet Union. Planners and policy-makers were heavily influenced by a very real fear of infectious diseases, by a belief in the primacy of the industrial worker, and by a commitment to pro-natalist policies and mother and child health which were to secure the next generation of workers and citizens.

The fear of infectious diseases was a result of the epidemics that raged through the Soviet Union after the Civil and Great Patriotic Wars. Creating enough hospital beds to isolate sufferers from infection had unfortunate consequences, however. It led to the over-provision of beds and created a long-term imbalance in the structure of health sector spending. In addition, it led to an underestimation of the role of non-infectious disease. The attempt during the Brezhnev era to provide annual health checks only exacerbated this tendency. On the positive side, the fear of epidemics was to a large extent responsible for the development of the san-epid network, which was highly effective in monitoring disease outbreaks and played a positive role in wider public health issues. It did, however, encourage neglect of noncommunicable diseases and left the system unprepared for the demographic and epidemiological shift in disease patterns from the 1970s onwards.

The commitment to the worker had many positive consequences, including the development of health and safety standards and early attempts to introduce monitoring of environmental conditions. It also saw the creation of a network of work-based clinics providing on-site primary care. However, there was perhaps a tendency to commit resources to the industrial workforce out of proportion to real health needs. Curative and rehabilitative “rest homes” were, and continue to be, included in mainstream health services provision. While

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this is not bad in itself, these areas are excluded from many western systems because of cost and because they are not considered a genuine part of health care provision. The Russian Federation would, however, find it difficult to withdraw such services now and therefore has an expensive inheritance to maintain.

This to some extent typifies the Soviet legacy to the Russian Federation. While the enormous achievements of the Soviet era should not be underestimated, the new state is saddled with the maintenance of a frequently expensive and cumbersome system. What is more, it must struggle to meet the very high expectations of its population under severe resource constraints.

Structure of the Soviet health care system

The Soviet health service infrastructure delivered care through a hierarchy of facilities on specific administrative levels. The basic administrative unit at the bottom of the hierarchy was the “*uchastok*” which, in rural areas, covered a population of approximately 7000 to 30 000. Their primary care needs were met by the health post, which was often staffed by nurses or feldshers. Any problems that required more complex help would be referred to a rural health centre, hospital or ambulatory, which would normally employ a general physician/internist or therapist (first level internist/general physician) and a first-level paediatrician in addition to nursing staff. These centres provided a mixture of primary and routine secondary care and often had a small number of inpatient beds (20–25). More complex cases would be referred to rayon polyclinics or hospitals. These were district-level facilities offering specialist secondary services on either an outpatient (polyclinics) or inpatient basis (hospitals). These fed into the oblast or regional polyclinics and hospitals, which in turn could refer to republican-level or All-Soviet centres of excellence.⁶⁵

The urban population was in principle covered in the same way except that the network of primary care givers was made up of doctors working out of polyclinics. Like the rural health posts, they were meant to deal with the basic needs of the population and to refer upwards to rayon or oblast polyclinics or hospitals, which in turn could refer on to tertiary facilities. However, the provision of ambulatory secondary care was slightly more complex in the urban setting. In addition to housing *uchastok* doctors, each polyclinic tended to employ key consultants to offer specialist outpatient services. Furthermore, primary carers often shared the same building as rayon polyclinics where a

⁶⁵ Cases that clearly required complex specialist attention could be referred directly to the oblast or tertiary level without passing through all the intermediary stages.

full range of specialist outpatient clinics were held. The physical proximity of primary and secondary providers meant that patients often referred themselves directly to specialist clinics. In larger towns or cities patients could access oblast level clinics as easily, and there were also polyclinics exclusively for women and specialist paediatric polyclinics. All this further undermined the gatekeeping principle, blurring the boundaries between primary and secondary care.⁶⁶

The links between primary and secondary care in polyclinics and hospitals were also problematic. Whereas the structure of the system was appropriate for the development of such links, in practice it did not occur. Ambulatory care was offered through the polyclinic, in isolation from the provision of inpatient care in hospitals. This meant that patients admitted from a polyclinic to a hospital and then discharged back to the outpatient clinic often experienced a lack of continuity of care. The varying criteria used by doctors in the different settings and the failure to communicate also allowed inappropriate referrals to take place, while poor coordination encouraged the duplication of services in both parts of the system. Ultimately ongoing and follow-up care, which ought to have been within the domain of primary care, remained in the secondary and specialist sector.

In addition to the primary and secondary facilities based on residence, health care was also made available through the work- place. Large enterprises supported *Medsanchasts* or work-based clinics to provide primary care on-site, and sometimes smaller undertakings combined resources to set up a polyclinic. Although it was rare for there to be inpatient facilities, these were offered in some of the large collective farms and it was not unusual to find specialist outpatient clinics as part of the care package (56). Employees were entitled to care both at work and from their home address but, again, coordination between centres of care was poor and there was duplication of services.

Finally, public health surveillance was through the network of san-epid stations which reported upwards to the Ministry of Health (see the section *Public health services*). They played an important role in collecting epidemiological data, managing outbreaks of infectious disease and regulating sanitary and environmental conditions. They were also part of the distribution and delivery network for immunization programmes and were responsible for ensuring compliance in primary health care centres and in the schools delivery system.

The profusion of care-giving institutions and the complexity of the links between them has continued in the Russian Federation. The number of facilities

⁶⁶ A portion of the gratuities paid to providers often corresponds to a fee for permission to bypass the formal first contact level.



has changed relatively little since Soviet times and polyclinics continue to offer primary care and specialist outpatient services side-by-side. The reform of the financing mechanism has yet to prompt rationalization of the system or a redefinition of the boundaries between primary and secondary care.

Primary health care and public health services

The *uchastok* (or micro-district) provides the basic unit of primary health care. As in the Soviet era, this means that in rural areas patients are covered by health posts staffed by feldshers and/or midwives and in urban areas they present to the primary care physician in the local polyclinic. There is also the same hierarchy of clinics and hospitals at the rayon, oblast or republican level to which complex cases can be referred.

First contact level

Rural health posts/feldsher-midwife stations cover a population of about 4000 and offer immunization, basic health checks and routine examinations, as well as care during pregnancy and for the newborn. They are also able to treat minor injuries and make home visits, but cannot prescribe. Staff (i.e. feldshers/midwives) are normally trained for two years beyond the basic nurse training, are employed by the local government body and supervised via the nearest health centre or polyclinic.

Health centres cover a number of *uchastoks* or larger rural populations of 7000 people or above. They are staffed by a therapist, a paediatrician and sometimes an obstetrician or gynaecologist, as well as nursing staff and midwives. They offer a range of primary care services, including immunization, screening, treatment of minor ailments and supervision of chronic conditions, as well as prescribing, sickness certification and twenty-four hour cover. Health centres tend to have a number of beds and are able to carry out inpatient deliveries and perform minor surgery. Many of the beds, however, are used for social care and tend to be occupied by the frail and elderly rather than the acutely ill. Staff are employed by local health committees who also own the facilities, and again there is no effective patient choice because of the limited size of the staff team and the distances between health centres.

Urban polyclinics serve areas divided into *uchastok* of about 4000 people; every polyclinic covers several *uchastok* depending on the administrative

division. Several polyclinics correspond to a municipal hospital. Polyclinics house a number of therapists and auxiliary staff who provide the range of cover associated with general practice including screening, first line treatment of acute and chronic illness, and ongoing care of chronic cases. Doctors normally have approximately 1700 patients on their list. In small towns paediatric generalists may also share the same polyclinic facilities, although they cover only 800 patients on average. Patients are assigned a doctor on the basis of their postal address. As in the Soviet era, patients have a technical right to change their doctors, but this requires the approval of the head of the polyclinic and is not widely exercised. The fact that doctors continue to be allocated without choice undermines confidence in the primary health care system and explains why there are so many self-referrals to secondary, ambulatory care. The situation is exacerbated by the fact that under the Soviet system there was no special training for *uchastok* physicians and generalist care was regarded as the least prestigious end of medicine.

In addition to housing therapists, polyclinics tend to employ three to four specialists depending on their size and profile. The specialties most commonly represented are obstetrics/gynaecology, cardiology, rheumatology and oncology. These doctors provide secondary outpatient care only, although the boundaries between primary and secondary care become confused as patients self-refer for specialist consultations.

Independent dispensaries Apart from the providers of primary health care listed above, there are independent dispensaries in urban areas that offer an equivalent of the care available through rural health posts/centres, ambulatory clinics and accident and emergency centres attached to hospitals. Some primary care also takes place within the specialist (secondary) care setting, both outpatient and inpatient, as a result of failure to coordinate care or to hand over follow-up of cases effectively. Further health promotion and disease prevention activities are listed under public health services. Roughly three fourths of dispensaries, polyclinics not attached to hospitals, as well as the outpatient departments of rayon hospitals are owned and managed by rayons.

Special focus polyclinics In towns, cities and large settlements throughout the country, there is a network of children's polyclinics where generalist paediatricians and specialists in ambulatory paediatric care mirror the normal polyclinic patterns of provision but treat only children up to the age of 19. Likewise there are polyclinics devoted exclusively to women (and in particular to gynaecological and obstetric services) in areas large enough to sustain them.

Enterprise polyclinics Some *Medsanchast* facilities survive and through their own doctors provide the staff of enterprises with the standard package of basic primary provision, although with an increased emphasis on occupational health.

There are also work-based polyclinics with outpatient specialists and a very few examples of inpatient beds attached to industry. These clinics are a legacy of the Soviet focus on the industrial worker. Previously, both local government health committees and the enterprises themselves contributed to the costs involved. However, the position of employers has been compromised by the need to make payroll contributions on the monthly salary of all employees, so that they are unlikely to continue to fund special provision of health services. Thus polyclinics continue to operate in the economically stronger enterprises, while the smaller ones are increasingly losing interest.

Health professionals at the first contact level

Most doctors in practice now qualified in the Soviet era and so tend to be associated with the negative image of primary medicine based on general practice. *Uchastok* doctors are therapists (or first category specialists in internal medicine) who are not highly respected and are declining in numbers because of the belief that they will eventually be replaced by general practitioners. The introduction of a two-year postgraduate training programme for GPs in 1992 means that new entrants to general practice are now specialists in their own right and are significantly better trained than those of the previous generation. This is expected to raise standards and enhance public confidence in the primary care system. The role of nurses was also underdeveloped and nurses continue to act as little more than doctors' aides. Plans to enlarge their clinical and patient management input are being developed.

An estimated 1500–2000 GPs have trained in the past 5 years (57), including both new doctors and retrained doctors, but fewer than 1100 have entered the system as GPs. There are wide variations in estimates of the number of GPs actually practising, and this may be due to counting only those in family practices as opposed to including those in polyclinics. The reasons for the limited popularity of this specialty is that the opportunities for receiving envelope payments may be more limited and the salary scales confine GPs to very low levels of remuneration. Further, GPs encounter hostility on the part of other specialists who still do not understand that general practice is a specialty in its own right. Because retraining to qualify as a GP has been set at six months,⁶⁷ the specialists believe that general practice does not qualify as a real specialty. In addition, specialists feel threatened with eventual displacement by the GPs. On the whole, the public perceives the issue in the same light as the specialists.

⁶⁷ Whereas it takes two years after basic medical training to train as a general practitioner, one who has already trained as a specialist in something other than general practice needs six months to re-train as a general practitioner. Further, GPs are required to attend a one-month recertification course every five years.

In part, the public's perception has been influenced by a confusion between the terms "general practitioner" and "family practitioner". Whereas in international terminology these two terms are synonymous, in the Russian Federation a general practitioner is held to be one who covers all specialties for adults except paediatrics and gynaecology. A family practitioner, by contrast, is thought to be one who covers all specialties, including gynaecology and paediatrics. Thus there tends to be an equation in people's minds between general practitioners and therapists who are not particularly well respected. Training for general practitioners to date seems to be geared more toward the concept of "GP" as defined narrowly above, even though this is in contrast to the official position of the Ministry of Health endorsing the concept of GP in the sense of "family practitioner" (i.e. covering all specialties).

In support of the development of primary care based on general practice, a Ministry of Health order in 2000 defined training requirements, rights and obligations of general/family practitioners. It further specified the legal, organizational and financial mechanism upon which family medicine is to be based.

In the context of primary care development, there are plans to place general practitioners in polyclinics to replace therapists, while gynaecologists and paediatricians will continue working in specialist polyclinics. The objective is to use the existing volume of polyclinics and ambulatories as primary care settings to the maximum extent, while development of new facilities should be the exception rather than the rule.

The 1993 legislation "Fundamentals of RF legislation on citizens' health protection",⁶⁸ as well as the 1993 health insurance legislation, stipulated patients' free choice of physicians. However, this has yet to be carried out in practice. The lack of free patient choice is an important factor behind the common practice of self-referrals to higher levels of care.

Gatekeeping was part of the Soviet system of primary care, but it did not work in practice. However, there are some rayons in the Russian Federation where it is partly functional today; these include the Samara oblast, St. Petersburg, Chuvashia, Kemerovo, Tula, and Tver. An incentive to promote the practice of gatekeeping in St. Petersburg has been allowing doctors to claim part of the savings from insurance companies. In Samara, *ushastok* doctors were re-trained as general practitioners, though the skills are not considered high enough. Some were made fundholders, thus providing them with the incentive to keep patients at the primary care level.

⁶⁸ Adopted July 1993 (No. 5487-1).

During the Soviet period, a network of specialized interregional facilities served people from neighbouring rayons, with a corresponding payment mechanism that compensated the facilities for treatment of the patients. Rayons could thus specialize in the provision of different services, as inter-rayon facility sharing allowed a comprehensive range of services to be offered. However, with the implementation of the new financing mechanisms, the payment system has broken down. This gives rise to an “atomization” of the health care system, as each rayon or oblast tries to provide the full range of services on its own, resulting in inefficiencies and duplication of facilities.

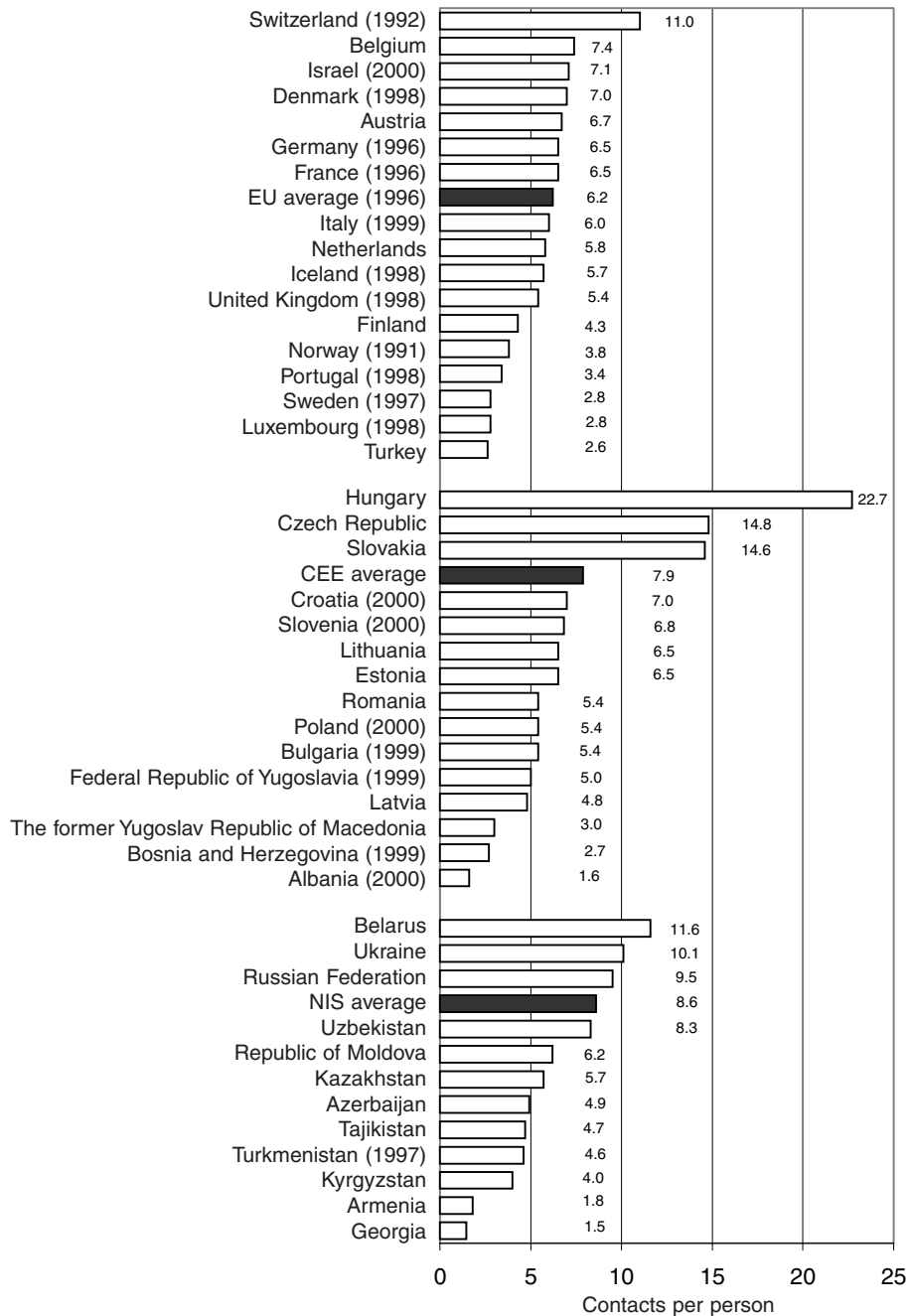
With the exception of certain changes introduced through new financing mechanisms and drastic decentralization, the primary care system is strikingly reminiscent of the Soviet model despite the reforms. There has not been a real shift in responsibility for managing care through the health insurance funds, their branches or private insurers, or for budget holding to individual GPs. General practitioners cannot realistically set up single-handed practices in the public sector, and the conversion of polyclinics into group practices has taken place only in experimental pilot projects. The health insurance system, on the other hand, due to its only partial implementation and the absence of appropriate incentive mechanisms, has not succeeded in changing the structure of provision in favour of primary care and prevention.

The reform of health care financing was seen as an opportunity to shift more responsibility for promotion and prevention activities into the primary care sector and onto the first contact doctor. For example, insurance companies could create financial incentives for GPs to extend their routine screening and to carry out other preventive measures, including counselling patients on health behaviour. However, this appears to be just another example of over-reliance on market-oriented financing mechanisms to solve problems that are beyond the scope of financing alone. Over and above the technical issues, there is a serious question about how well these issues are understood even by the medical community, much less the broader public. According to a 1997 survey, only 6% of doctors believed that prevention should be given greater priority than curative care, and only 3% supported general practice as a new form of primary care provision.⁶⁹ However there is a general perception in the health care community that there has been an improvement since then, with more doctors in favour of prevention and general practice.

Compared to other European countries, outpatient contacts with physicians in the Russian Federation tend to be rather high (see Fig. 11). In 2001, there were 9.5 such contacts per person, compared with 8.3 for the NIS as a whole and 6.2 in the EU. Within the NIS, the Russian Federation is surpassed only by

⁶⁹ Filatov, discussed in E. Tkatchenko, M. McKee, A. D. Tsouros, *Public health in Russia* (58).

Fig. 11. Outpatient contacts per person in the WHO European Region, 2001 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

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Belarus and Ukraine. This high figure actually represents a decline since 1985, when according to Ministry of Health data outpatient contacts per person were 11.1.

An estimated 30% of initial contacts are referred to higher levels of care, compared to 8–10% in the European model of general practice, reflecting the difficulties faced in efforts to develop a PHC culture. Over and above having to create a pool of doctors specialized in general practice, and having to overcome the prejudices of the patients (and doctors) who have little confidence in generalists, another key issue is the general practitioner's or PHC physician's place of practice. There are plans to develop family practice within polyclinics, where general practitioners will be working parallel to specialists. Clearly, care must be taken to deal with the problem that constant and easy access to specialist care will entail.

Primary care providers, then, are normally employed directly by the institutions in which they work and indirectly by local government. Their institutions may or may not enter into contracts with local insurance companies to compensate them for the volume of services they provide to an insured population but, in addition, all will receive significant core funding from local government. In areas where the insurance mechanisms are not operational the funding for primary care comes from tax-based revenues, just as in the Soviet era. In other areas insurance companies contract with polyclinics and remunerate them for visits completed, preventive measures taken and treatments administered. However, these payments are in addition to the tax-funded support of the system. They allow chief doctors to pay bonuses to efficient staff or to enhance their working conditions but are not the determinant factor in a facility's survival. Only small amounts of primary care are offered privately, either on a fee-for-consultation basis (in independent polyclinics or in the parallel system) or through voluntary insurance schemes.

Notwithstanding the similarities to past practice, there has been a shift in the perception of primary care by policy-makers, who have formally recognized the importance of the sector in providing cost-effective and appropriate treatment. A number of regions are experimenting with new approaches to primary care delivery.

In St. Petersburg efforts are directed toward developing PHC in the polyclinic setting, and there are efforts to implement a new understanding of public health, along with innovative programmes in geriatric care. In Tula, experiments are underway with different models for urban and rural areas, with individual practices in their own premises, and GPs in polyclinics. There are an estimated 120 practising GPs, each of whom has taken over a large proportion of former visits to specialists, and an HMO has been developed. In Dubna, efforts have

been made to strengthen continuity of care; protocols have been introduced to improve the links between primary and secondary care; quality assurance-based on evidence-based medicine as well as prevention and health promotion measures are being pursued.

Patient satisfaction with services tends to be quite low. Surveys on patient satisfaction frequently do not make a distinction between primary and secondary care; this issue will therefore be discussed in the section *Secondary and tertiary care*.

Public health services

The san-epid network was responsible for core public health services during the Soviet era. It was made up of a series of facilities (sanitary-epidemiological stations) reporting upwards from the rayon to the oblast, from the oblast to the republican level, and ultimately to the Ministry of Health of the USSR. This system of accountability had the benefit of ensuring uniform standards (at least in theory) but the disadvantage of inhibiting links with local government bodies. Its core duties included delivering immunization programmes through its local branches, controlling of outbreaks of infectious diseases, collecting epidemiological data, monitoring and regulating sanitation, hygiene and environmental health, and disaster relief.

Responsibility for health promotion, health education and prevention largely belonged to the Ministry of Health until 1991. Since then the ministry has retained some health education functions, and the san-epid system has taken on responsibility for implementing federal, regional and local regulations for health promotion and disease prevention.

During the Soviet period, prevention and promotion activities were also partly undertaken by medical and recreational facilities owned by industrial plants. These facilities, which were exclusively available to the respective workers, provided a variety of on-site medical and occupational care, rehabilitation services, sanatoria and vacation benefits.

Responsibilities of the san-epid system currently include the following:

- communicable disease prevention and control
- immunization
- hygiene of children and teenagers, health and nutrition in kindergartens and schools
- food safety
- radiation safety
- occupational disease prevention

- environmental health
- epidemiological control and analysis
- control of working conditions
- health education and promotion of healthy lifestyles.

Physicians working in the san-epid system undertook a designated “hygiene” stream during their undergraduate training in the medical universities. This was somewhat less popular than streams training future medical specialists, so those following it were often the least able students. Physicians in the san-epid system now undergo a postgraduate training programme. Two thousand specialist doctors graduate per year. There are more than 26 000 doctors working in the system, 63 000 medium level staff and about 130 000 people in the entire service (59).

The san-epid system performed an important role prior to the 1960s. It was able to deliver basic interventions, such as immunization and vector control, to dispersed populations. It has not, however, been able to adapt to changing circumstances. Many laboratories are obsolete, thus unable to respond to increasingly important complex infectious agents (e.g. antibiotic resistant or requiring special laboratory conditions). The methods used to investigate outbreaks are also largely obsolete, based on laboratory investigation rather than epidemiological investigation using case-control studies and modern surveillance systems. The system’s laboratory focus has also left it with very few staff trained in modern public health and poorly prepared for its new tasks in relation to noncommunicable diseases.

The scientific isolation of Soviet medical science during the 1970s and 1980s prevented access to Western developments in both methods of treatment and the concept of evidence-based medicine. As a result, many widely-used interventions are ineffective and those that are effective are often unused.

In the 1980s, although epidemiological data continued to be collected and analyzed, they were no longer published because of what they conveyed about the deterioration of Soviet society. As a result, health professionals were denied the data along with an appropriate forum and authority to conduct discussions. The central authorities treated noncommunicable diseases as “social diseases”. The policy response was to step-up the provision of routine check-ups, and to increase hospital bed numbers, thus it failed to address the epidemiological transition that was occurring (7). No efforts were directed toward reducing risk factors for non-infectious diseases, and this approach continues to the present day. In particular, with the exception of the 1985 anti-alcohol campaign – initiated mainly because of the consequences of widespread drinking on industrial output – there has been almost no attempt to tackle the high toll of premature death due to alcohol (31).

Russian Federation

In response to alarm caused by news of the poor health condition of children, the Ministry of Health in 2002 ordered the *dispensarization* (checking) of all children 0–18 years old, a population of about 33 million. All children are examined by a nurse, paediatrician, neurologist, psychologist, orthopaedic expert, ophthalmologist, ear specialist, speech specialist, etc. This approach reflects the old notion of tackling problems through the medical model. It cannot deal with the root of the problem, which includes lack of adequate medical care when children need it, poor nutrition, poor growth monitoring, accidents, violence, alcohol, smoking, narcotics, etc. Once the check-ups have been done, there is very little follow-up, not least because of a lack of money following the expensive *dispensarization* exercise.

The san-epid system is now responsible for conducting epidemiological studies of diseases at the regional and federal levels, and there have been meetings to review this topic at the central level. However, in practice a lack of good will and resources prevents these functions from being carried out. There are nonetheless a few local examples of good practice, such as in Sverlovsk and Perm oblasts. It is hoped that their work will eventually feed into management and decision-making.

Environmental protection is the responsibility of the san-epid system jointly with the Ministry of Nature. The san-epid system specifies the levels of hazardous substances in the environment and the ministry specifies and monitors standards on the rational use and renewal of natural resources (40). However, a lack of skills and resources, in concert with low level corruption, has limited the measures' effectiveness.

In view of the rapid deterioration in the health status of the population beginning in the late 1980s, one of the first legislative acts that was introduced in 1991 was the Law on the Sanitary-Epidemiological Wellbeing of the Population. This law stated the rights and responsibilities of the population in the sphere of health and health care, determined the obligations and responsibilities of all health care providers (both public and private), and proclaimed the general requirements for ensuring sanitary and epidemiological wellbeing, without indicating how these might be achieved.

In 1992, the National Centre for Preventive Medicine (NCPM, a research institute under the Ministry of Health) initiated an attempt to improve the technical, organizational, and scientific capacity for health promotion and disease prevention. This involved epidemiological database building, demonstration programmes at the regional level, process evaluation and dissemination (60). The NCPM acted as a linking agent among regional, national and international agencies and professional organizations involved in the prevention of noncommunicable diseases. As a result of these initiatives,

partnerships have been established with health agencies in Canada, Sweden and the United States but, so far, little has been achieved.

In 1994 a policy document was prepared in collaboration with the NCPM's Canadian partner (Health Canada) entitled "Toward a Healthy Russia: Policy for Health Promotion and Disease Prevention: Focus on Major Noncommunicable Diseases". A second document, prepared in 1997 in collaboration with the American partner was entitled "Towards a Health Russia: Policies and Strategies for the Prevention of Cardiovascular and Other Noncommunicable Diseases Within the Context of Public Health Reforms in Russia". These two documents formed the basis for the the Ministry of Health's "A Concept of Strengthening the Health of the Russian Population", which attempted to define health policy needs and intentions, but without presenting specific targets or strategies for the health care system. It will be recalled that 1994, when the first policy document was developed, and later 1998, were extremely difficult times of economic crisis for the Russian Federation, and this, combined with concurrent decentralization, made the formulation and execution of effective health care policy rather difficult. The most serious problem, however, appears to be that the state did not then and does not now have a clear understanding of how to proceed with respect to public health issues and health system development.

Throughout the 1990s, the WHO Regional Office for Europe had been strongly advocating a health for all policy as an important tool for member states' health development policies. In Moscow a high-level policy seminar was organized in 1997, headed by the Regional Director of WHO, but did not get far, possibly due to a change of the Minister of Health at a crucial moment. Since then, WHO's efforts on health policy in the Russian Federation have been focused on assisting the Tacis preventive health project in selected regions.

In spite of the policy documents noted above, and the formal statements on the importance of confronting the health (and demographic) crises, the actual political commitment to improvements in the health of the population appears to be lacking. A survey of Russian literature concludes that while it is officially recognized that reforms to improve the public health system are imperative, reform goals are poorly defined and the proposed strategies are not appropriate to achieving the goals. There is a lack of clarity about the meaning of public health, and on how health care reforms can be linked to improvements in the public health system, with a common perception that health care providers, and primary care development (often simply placing general practitioners in polyclinics) in particular, can fulfil the role of a public health system (58).

Nonetheless, a number of initiatives have been undertaken in collaboration with various partners (for example European Union Tacis programme, the Soros



Foundation, the World Bank, etc.) with a view to developing capacity in the areas of health promotion and prevention. One of the most pressing requirements is for staff trained in modern public health. The Soros Foundation and the Government of Israel have been especially active in providing training for young health professionals who are now forming the nuclei of training programmes in Moscow, St. Petersburg, Tver and Chelyabinsk. In addition, St. Petersburg has benefited from its participation in the Brimhealth initiative led by the Nordic School of Public Health (61).

In 1999 new legislation, “On Sanitary-Epidemiological Wellbeing of the Population”, was adopted. In accordance with this law, efforts are being made to establish a single san-epid service. A number of Ministries, including Defence, Internal Affairs, Justice, Presidents Administration, Emergency Federal Security Service, Railway Stations, Borders, and others, had their own parallel san-epid systems, operating independently and responsible for epidemiological and hygiene issues within their own area of jurisdiction. Under the 1999 law, all these separate systems were to come under the federal, centralized state service, but this has yet to occur.

Immunization and screening are delivered through local polyclinic doctors, although there are also some school-based delivery routes. Routine immunization by polyclinic paediatricians and school programmes are coordinated and monitored by the san-epid network, which may account for the high level of coverage currently reported for measles (98% in 2001 as shown in Fig. 12). There have been improvements in vaccine quality in recent years, and the pediatric system of care is working relatively well and was one of the least disrupted sectors during the crisis years. However, the quality of the immunization statistics is questionable, given the very large and growing numbers of street children.

Most family planning and antenatal services are currently included in primary care provision.

The 1980s campaign against heavy drinking lapsed, however the san-epid system began preventive functions with smoking and alcohol in 1996, though the programmes are small scale and not particularly visible, thus ineffective. There is a gap in health education, which is only partly filled by the external assistance programmes that are helping to address substance misuse and sexually transmitted diseases, HIV and AIDS. In particular, harm reduction programmes such as needle exchange and advice on safe sex have been almost entirely donor-driven, with the Open Society Institute (Soros Foundation) and subsequently the UK Department for International Development, playing the main roles.

Fig. 12. Levels of immunization for measles in the WHO European Region, 2001 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

Russian Federation

A number of programmes on the prevention of noncommunicable diseases, including hypertension, diabetes and oncological disease have been developed and are being implemented.

Rates of smoking are extremely high among men and are increasing rapidly among young women, especially in cities, in large part reflecting aggressive marketing by transnational tobacco industries (21). A ban on tobacco advertising introduced in early 2002 has largely been ignored (62).

Several of these programmes are implemented on a national level. For example, the 1993 Presidential Programme on the Children of Russia aims at the development of a set of mechanisms to help invalids, orphans, children of refugees, children who live in the far North, children who have been affected by the Chernobyl accident. The programme also involves some activities in current problems in child health care, prevention of street children and delinquency, development of social services for children, organizing summer vacations.

Other federal programmes include: Safe Motherhood, involving social support during pregnancy and delivery; Children of the North, making check-ups possible for children in the far North; Anti-HIV/AIDS; and Hypertension.

The regions are responsible for their own programmes, and most have them in the following areas: HIV/AIDS; sexually transmitted diseases; hepatitis; preventive programmes for hypertension, diabetes, asthma, and others. There are many donor programmes supporting some of these activities: the Open Society Institute (Soros Foundation), USAID, DFID (UK), CIDA (Canada), Taxis (EU), the Nordic countries, and others. WHO and the World Bank also support these initiatives.

Secondary and tertiary care

The network of secondary and tertiary facilities combines hospitals, hospital outpatient clinics and specialist ambulatory centres based in polyclinics. The infrastructure inherited from the Soviet era remains largely intact, despite some bed and facility closures, and it is still organized on a territorial basis. The basic units that provide secondary care are as follows:

Uchastok hospitals/health centres: these are small 20–50 bed units in rural areas offering fairly basic inpatient cover, often with a staff team of a single surgeon, therapist and paediatrician. Much of their work falls into the primary or social care categories, but some straightforward surgical procedures may be carried out and uncomplicated chronic and acute cases may be treated.

Rayon (district) hospitals: each rayon, whether rural or urban, is served by a district or rayon hospital with between 100 and 700-odd beds. They are intended to meet the secondary and inpatient care needs of 40 000 to 150 000 people and offer a full range of general medical and surgical specialities. They also provide paediatric, obstetric and gynaecological care unless they are in the same catchment area as a dedicated children's or women's hospital.

Rayon (district) polyclinics: every rayon also provides an outpatient care centre with a full range of specialities to treat those who do not require hospitalization. Rayon hospitals may also run outpatient clinics to provide some follow up care. Coordination between the two outpatient systems and between the primary and secondary sectors is not always satisfactory.

Oblast (regional) hospitals: Each oblast has a hospital that accepts referrals of complex cases from rayon hospitals and polyclinics. All specialities and sub-specialities are represented and the qualifications of staff and the care offered are more sophisticated than at the rayon level. The oblast hospital also serves as the teaching unit of the local medical school.

Oblast polyclinics: Specialist outpatient services are also provided at the oblast level. These are distinct from the follow-up outpatient clinics provided by hospitals, and again there are issues of the coordination and continuity of care.

Special focus hospitals and polyclinics: These are devoted to paediatrics with a full range of specialities and sub-specialities offered. There are also hospitals (and polyclinics) exclusively for women, although these tend to specialise in obstetric and gynaecological care only. They will take referrals of more complex cases from lower down the system, both for inpatients and outpatients.

Enterprise and other Ministry hospitals and polyclinics: Enterprise polyclinics offer some specialist or secondary outpatient services. Very few enterprises offer inpatient facilities although there are some beds, often on former collective farms, that admit patients, albeit for fairly rudimentary care. Those enterprises that are economically sound finance their facilities exclusively out of their own resources, and in some cases provide high quality care. According to the health insurance legislation, even enterprises with their own parallel system were intended to contribute to the health insurance system for their employees, who would be covered by the insurance system and the enterprise system. However, many enterprises facing severe financial pressures have closed down their facilities. The parallel health care systems of the various ministries also tend to concentrate their secondary care services in the outpatient setting. The Ministry of Defence, which provides medical facilities for the Army, is the major exception, offering a full range of secondary care other than obstetrics and gynaecology and supporting its own hospitals. There are also other examples of inpatient secondary, and indeed tertiary, care offered by

ministries in what was the closed system. Most of these institutions now contract out a portion (usually small) of their services to the health insurance system for the use of the corresponding services by the broader public.

Federal hospitals and polyclinics offer the most complex care at large and highly specialized hospitals or polyclinics, mostly in Moscow. These are often associated with research institutes in their respective fields and offer highly sophisticated secondary and tertiary services.

Day-care hospitals: These emerged at all levels during the 1990s, and are units attached to hospitals and polyclinics, where an entire procedure is done in one day.

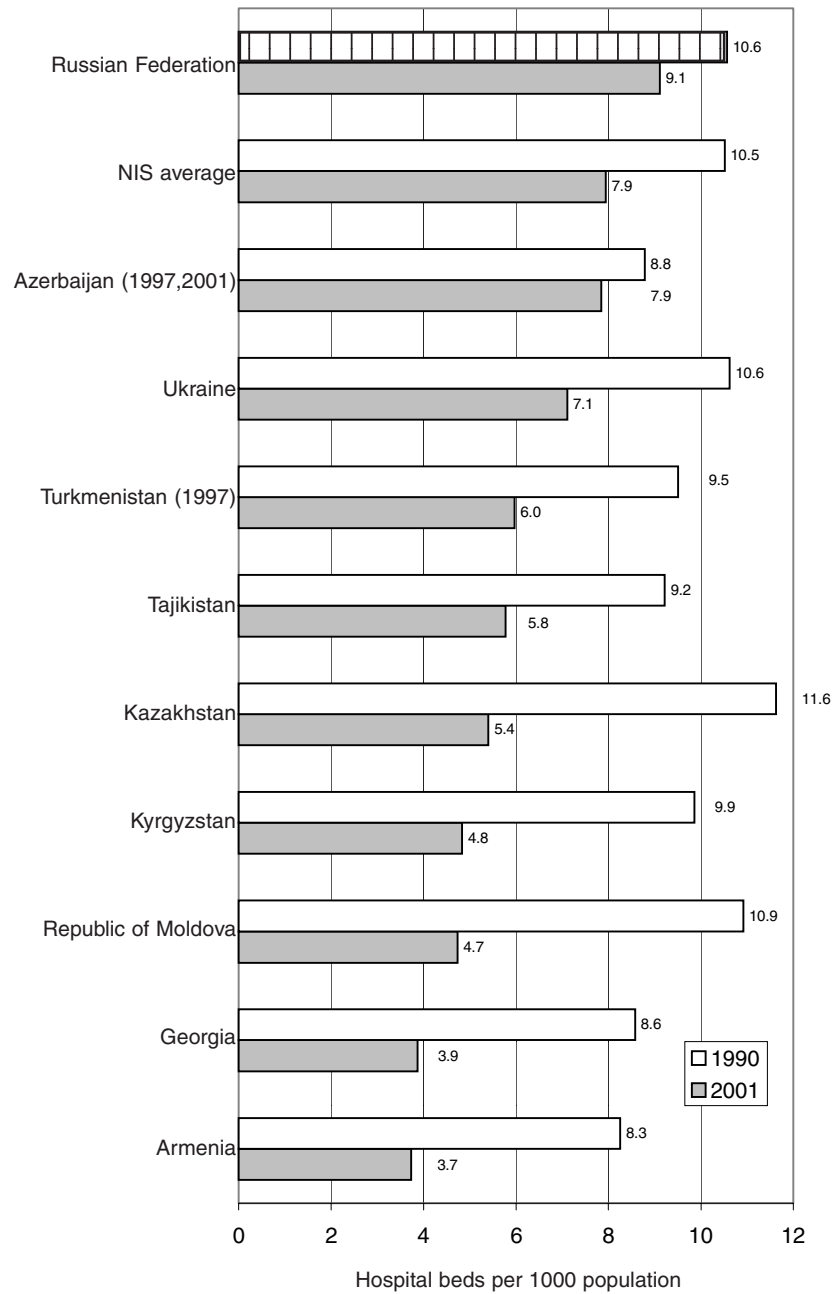
Curative and rehabilitative sanatoria: Rehabilitation, a Soviet tradition, is an integral part of the health care system. Curative and rehabilitative sanatoria made it possible to adapt the workers to particular conditions, distract them from drinking, or treat particular disorders, and in serious cases to prevent invalidity. Treatment includes physical exercise, massage, acupuncture, etc. by specialized nurses under the direction of doctors. Some oblasts have specialized hospitals.

All the above remain in public ownership, with title vested in the appropriate administrative tier of government. Staff contracts are with the employing institution and are ultimately underwritten by the local health committee. Both inpatient and outpatient facilities are expected to receive a subsidy from general taxation – passed through local government structures – and to enter into contracts with insurance funds for the treatment provided. The way this works in practice varies enormously across the country. There are areas where insurance schemes do not function and play no part in financing secondary provision and others where they are believed to contribute up to 80% of hospital or polyclinic costs. The contribution of under-the-table payments is also believed to be enormous.

There is an emerging legal private sector but it is very small. The facilities include fee-for-service polyclinics, offering a mixture of primary and secondary care, private diagnostic facilities, and a very few private hospitals. The majority of paid services are commissioned through voluntary insurance schemes and managed by private insurers rather than by individuals. The clinics and hospitals of the parallel system absorb most of such private care provision.

There is considerable over-provision of secondary and tertiary care in the Russian Federation, particularly of inpatient facilities. As can be seen in Fig. 13, in 2001 the Russian Federation had 9.1 beds in acute hospitals per 1000 population, which is the highest of all the NIS countries in the figure. In fact, as Table 12 indicates, acute hospital beds per population in the Russian Federation are higher than every other country in the European Region, and

Fig. 13. Hospital beds in acute hospitals per 1000 population in the newly independent states, 1990 and 2001 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.

NIS: Newly independent states.

Russian Federation

amount in fact to more than double the average of the European Union. Yet acute beds-per-population have actually been declining in the Russian Federation since 1980, as shown in Fig. 14. However, they would have to decline at a much faster rate in order to approach the levels found in most other countries.

The annual hospital admission rate of 21.6 per 100 population in 2001 (Table 12) is the highest of all the NIS and most of the CCEE and western European countries.

The average length of stay is also the highest of all the countries in the European Region with the exception of Azerbaijan, and significantly higher than the countries in western Europe. As Table 13 indicates, this shows a steady downward trend since 1985.⁷⁰

Despite the very large number of hospital beds, the occupancy rate of nearly 86% is on the high end of the countries shown in Table 12.

The high bed-to-population ratio and utilization rates are due in part to the lack of social care provision and the use of acute hospital beds for long stays by the elderly and the chronically ill. They also reflect the long-term impact of tying hospital income to bed numbers, thus creating a perverse incentive to expand bed capacity and then fill the beds.

Policy-makers and planners at the centre are acutely aware of the burden of over-provision in the health sector. They are also aware that the tendency to use the available capacity leads to longer average stays and higher recurrent costs. The Ministry of Health does not, however, have the authority to close those facilities under the authority of regional and local government. Rather, it was hoped that the introduction of health insurance would influence the balance between modalities of care. A shift to contracting, using case payments, would certainly be one mechanism to reduce length of stay. Similarly, contracts were expected to create incentives for day-case surgery and for broader cost containment policies, but the mandatory health insurance mechanisms are not functioning as originally hoped. Thus, bed closures tend to be an ad hoc response to a funding crisis rather than part of a systematic review of local provision. Furthermore, closing beds may not result in savings if staff are not cut simultaneously. Yet staff redundancies have not occurred to any significant degree.

It should also be noted, though, that bed reduction must also take into account the vast size of the country, with its large sparsely populated areas, particularly in Siberia. For example, the Tyumen region covers the territory of several European countries, yet has a population of 3 million, with urban areas

⁷⁰ It should be noted that the data in Table 12 and Table 13 are not directly comparable, as the first refers to acute hospital data and the second to all-hospital data.

Table 12. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2001 or latest available year

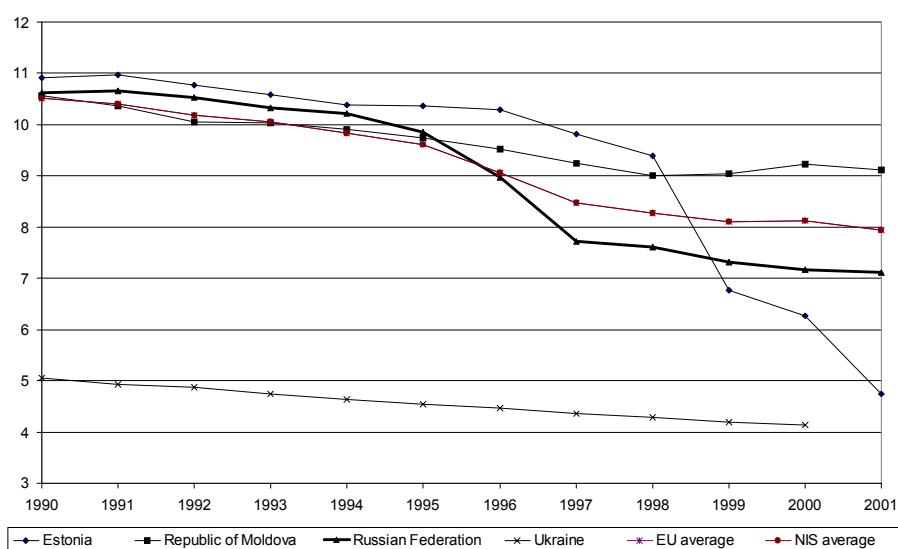
Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Andorra	2.5	9.4	6.7 ^b	70.0 ^b
Austria	6.2 ^a	27.2 ^a	6.3 ^a	75.5 ^a
Belgium	5.8	16.9 ^b	8.0 ^b	80.0 ^c
Denmark	3.3 ^b	17.9	5.2 ^a	83.5 ^a
EU average	4.1 ^a	18.9 ^b	7.7 ^b	77.4 ^c
Finland	2.4	19.7	4.4	74.0 ^f
France	4.2 ^a	20.4 ^b	5.5 ^b	77.4 ^b
Germany	6.4 ^a	20.5 ^a	9.6 ^b	81.1 ^a
Greece	4.0 ^b	15.2 ^c	—	—
Iceland	3.7 ^e	18.1 ^f	6.8 ^f	—
Ireland	3.0	14.5	6.4	83.8
Israel	2.2	17.8	4.1	93.0
Italy	4.0 ^a	16.0 ^a	7.0 ^a	75.5 ^a
Luxembourg	5.6	18.4 ^g	7.7 ^c	74.3 ^g
Malta	3.5	11.2 ^a	4.3	75.5 ^a
Netherlands	3.1	8.8	7.4	58.4
Norway	3.1	16.1	5.8	87.2
Portugal	3.3 ^c	11.9 ^c	7.3 ^c	75.5 ^c
Spain	3.0 ^d	11.3 ^d	7.6 ^d	76.2 ^d
Sweden	2.4 ^a	14.9	4.9	77.5 ^e
Switzerland	3.8 ^a	16.3 ^c	10.0 ^a	85.0 ^a
Turkey	2.1	7.6 ^a	5.4	58.8
United Kingdom	2.4 ^c	21.4 ^e	5.0 ^e	80.8 ^c
CEE				
Albania	2.8 ^a	—	—	—
Bosnia and Herzegovina	3.3 ^c	7.2 ^c	9.8 ^c	62.6 ^b
Bulgaria	—	14.8 ^e	10.7 ^e	64.1 ^e
CEE average	5.4	17.8	8.3	72.3
Croatia	4.0	13.9	8.9	85.5
Czech Republic	6.3	18.9	8.6	70.5
Estonia	5.1	17.9	6.9	62.3
Hungary	6.4 ^a	24.2	7.0	76.9
Latvia	5.8	18.6	—	—
Lithuania	6.3	21.7	8.0	76.3
Slovakia	6.7	18.8	9.2	70.9
Slovenia	4.2	15.9	6.8	70.5
The former Yugoslav Republic of Macedonia	3.4	8.2	8.0	53.7
NIS				
Armenia	3.7	4.7	9.6	31.6
Azerbaijan	7.9	4.7	15.5	25.7
Georgia	3.9	4.3	7.4	82.0
Kazakhstan	5.4	14.7	11.3	96.5
Kyrgyzstan	4.8	13.9	10.8	87.6
NIS average	7.9	19.1	12.5	85.0
Republic of Moldova	4.7	11.9	10.3	70.7
Russian Federation	9.1	21.6	13.2	85.8
Tajikistan	5.8 ^d	8.9	13.0	54.5
Turkmenistan	6.0	12.4 ^d	11.1 ^d	72.1 ^d
Ukraine	7.1	18.7	12.5	89.5
Uzbekistan	—	—	—	84.5

Source: WHO Regional Office for Europe health for all database.

Notes: ^a 2000, ^b 1999, ^c 1998, ^d 1997, ^e 1996, ^f 1995, ^g 1994, ^h 1993, ⁱ 1992, ^j 1991.

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Fig. 14. Hospital beds in acute hospitals per 1000 population in the Russian Federation and selected countries, 1990-2001



Source: WHO Regional Office for Europe health for all database.

Table 13. Inpatient utilization and performance in the Russian Federation, 1985 – 2000 (all hospital data)

	1985	1990	1995	1998	2000
Hospital beds per 1000 population	13.5	13.8	12.6	11.9	11.6
Admissions per 100 population	24.4	22.8	21.2	21.0	21.9
Average length of stay in days	17.0	16.6	16.8	15.8	15.4

Source: Ministry of Health statistics.

concentrating 30 000 to 100 000 residents. In such situations, hospitals with an average capacity of fewer than 300 beds should continue to function. Closure or conversion of small hospitals should be undertaken only in large urban areas.

It is quite clear, therefore, that the health insurance system has done little to promote the originally envisaged structural changes in the system. Inpatient care consumes 65% of public health care resources, and has been increasing, whereas in Western countries inpatient care accounts for about 40% of health care resources and has shown a downward trend (47). There has been little if any change in the direction of increased day hospitals, outpatient surgeries, and free-standing diagnostic centres. It has been estimated that rational use of hospital resources could lead to a reduction of hospital costs by as much as 40–50%. However, it is most unlikely that market incentives, even if operational, could achieve such a transformation on their own.

In addition to inappropriate payment mechanisms, the lack of cover for outpatient drugs in the basic benefits package is a major factor contributing to the continuing structural imbalance. There are also social and cultural issues combining to exacerbate conditions. People have become accustomed to the norms established in the Soviet era, and regard a two-week stay for an appendectomy as entirely normal. There is resistance to early discharge policies, which are felt to reflect a decline in standards. There are also widespread beliefs – some based on fact – that it is particularly difficult for patients to cope in Russia if they are sent home early. Factors cited include the need to queue for food, the difficulties experienced by people in shared apartments, and winter weather conditions. The elderly in particular seem to expect to be able to admit themselves for long stays, which are viewed in part as opportunities to rest and recuperate. The small number of nursing homes or sheltered accommodation offers few if any alternative means of meeting social need.

There have been discussions between the Ministry of Health and local government authorities of a possible shift of beds to the social care sector. Estimates suggest that up to 20% of existing beds could usefully be redesignated as long-stay or social care beds. However, it is unclear how this agenda might be advanced within the reformed funding framework.

The process of introducing change will therefore be complex. There are hopes that, in time, insurance companies will seek a more rational use of resources and use contracts and a range of financial incentives to change provider behaviour. It is also hoped that provision will be made for meeting social need from welfare rather than health system budgets and that patient culture and the expectations of service users will change gradually as new approaches become established. Restrictions on access created by tighter definitions of the basic entitlement and a strengthened gatekeeper role will also make the substitution of outpatient care for inpatient care both feasible and acceptable, especially if complemented by enhanced quality and efficiency on the part of primary care providers.

Patient and staff satisfaction with health care services

The condition of hospitals and polyclinics is often poor. The collapse of the capital investment programme has meant that the fabric of buildings is deteriorating rapidly. Maintenance tasks cannot be carried out and equipment is now frequently both outdated and in a poor state of repair. Forty-five percent of hospitals lack shower and bath facilities; 15% of rural hospitals lack running water (63). This leads to dissatisfaction on the part of patients and staff, particularly doctors, who find the constraints on professional practice imposed by physical conditions extremely frustrating.

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Patient surveys have tried to measure dissatisfaction and its causes but have not distinguished clearly between attitudes to primary and secondary services. They do however suggest high levels of dissatisfaction with the current state of the system as a whole. A 1995 public opinion poll interviewed 1400 respondents from 17 regions of Russia and showed that only 14% were satisfied with medical services. The most frequent complaints were about high drug prices, low skills and qualifications of doctors, inconsiderate attitudes of staff and long waiting time to see a physician. Another opinion poll of 1000 people in Moscow revealed extensive support for privatization in the health sector. Fifty percent of respondents were in favour of transferring health care facilities to private ownership, 35% were against, and 15% were undecided. Given the population's general unfamiliarity with privatization and its consequences following 70 years of communism, support for private ownership should perhaps be interpreted as a measure of dissatisfaction and a call for change per se, rather than a clear mandate for health sector "privatization". It is interesting that the practice of under-the-table payments was not cited as a cause of dissatisfaction. Anecdotal evidence suggests that this is in part because it is so widespread as to seem normal and unworthy of comment. It has been suggested that some of the support for private health care is related to patients' perceptions that paying a single fee to a private provider would be cheaper than paying a whole series of tips and gratuities for poor quality care in the public sector.

Measures of citizens' satisfaction with public versus private care reveal the following with regard to preferences: nearly 30% of interviewees in 1997 believed that public dental care is superior to private dental care, compared to 11.5% who preferred private dental care; and 37.4% preferred public services (other than dental) compared to 9.6% who preferred privately provided services. Only one third of respondents unconditionally preferred privately provided care. These results clearly indicate the preference on the part of the Russian population for publicly provided services. However, these results were strongly biased by the lack of personal experience of many respondents with private provision. When these individuals were excluded from the sample, the results were reversed, and a high preference was shown for privately provided services (43).

Yet another study conducted in January 1997 (All-Russian Central Institute for Public Opinion Studies) showed that 61% of respondents preferred "mainly free-of-charge" services, which in the Russian context also means "publicly provided services".⁷¹ Hence it is possible to understand the reluctance shown

⁷¹ This need not be the case of course, as it is possible to have private providers contracted with public purchasers, who therefore provide services that are free of charge to the patient even though the provider is in the private sector. It was the intention of the 1993 legislation to develop this type of arrangement in addition to the public provider-public payer one, however it has not developed to any significant degree.

by the government to introduce co-payments, even though services remain only nominally free (43).

When asked why households visited private providers, the answers were as follows:

- 30% because the services were not available through statutory provision;
- 25% because of dissatisfaction with the professional qualifications of physicians at public facilities;
- 20% because of reported ignorance and lack of sensitivity of personnel at public facilities.

According to the same survey, part of the negative attitude to private provision is due to the low income levels prevailing for a substantial portion of the population. In 1997, 20.8% of the population, or 30 million people, lived below the subsistence level. Many Russians are unable to afford pharmaceutical drugs, and the affordability of care has decreased substantially in the lower income groups, indicative of the ongoing stratification of the country.

The conclusions of these studies can be summarized as follows:

- Private sector provision has occupied a certain niche and satisfies the needs of the small group of people who can afford it.
- Privately provided health care services compensate, though only a little and selectively, for the shortage of public provided care.
- Many Russians have lost their access to health care due to the absence of a uniform standard for pharmaceutical supplies, free provision of care, and lack of realistic guarantees.
- There is a growing gap between social groups with respect to health care access and quality, aggravating the country's social problems.

Dissatisfaction is also very widespread among health care personnel and focuses particularly on salaries. These were always low relative to industrial workers, but since 1991 they have been eroded further, failing dramatically to keep pace with hyperinflation. Poor working conditions, payment arrears,⁷² poorly maintained facilities, outdated equipment, and the severe shortages of medical supplies and pharmaceuticals were also cited as causes of dissatisfaction.

⁷² Payment arrears continue to be a problem, however less recently than in earlier years. According to surveys, at the end of 2001, 25% of working-age people were owed back wages, and of these 73% were owed back pay for two months or less. As recently as end-2000, 30% of working-age people were owed back pay (26).

Social care

Most community care services at the end of the Soviet period were under the Red Cross, financed by voluntary contributions and some state donations. With the economic crisis following the collapse of the Soviet Union, the lack of resources caused this system to disappear. Following curtailment of Red Cross activities, some of its initiatives were taken over by the Ministry of Social Affairs. However, due to severe under-financing, few activities in community care managed to survive.

Community care services are therefore very limited in the Russian Federation. The health care system continues to carry the burden of many of Russian society's social needs. Long-term inpatient care for the chronically ill, the elderly and those with psychiatric illness continues to be carried out within the acute sector. Nor are there adequate strategies for the care or support for people with mental or physical handicaps, which results in inappropriate use of medical facilities by special needs groups.

Social services in the Soviet era were relatively underdeveloped and they have yet to match the scope of those in European countries. There are no day centres, nor is there a formal system of providing helpers to allow people to continue to live independently in their own homes. This holds true for those with a mental or physical handicap.

A very small number of 'homes' for the elderly are provided through the welfare budget, but these are woefully inadequate in terms of both accommodation and availability. Since 1993, there has been an attempt to establish nursing homes for the elderly and chronically ill; although the model is successful, demand for spaces far outstrips supply. Long-term provision therefore tends to be offered through the geriatric beds of mainstream hospitals. The Soviet-era financing mechanisms allowed institutions to be remunerated for filling this role. It is unclear how the introduction of the insurance package and contracting will impact on this situation.

The care of the mentally ill was also generally through the use of acute psychiatric beds, although there were small numbers of chronic beds designated for long-stay patients with lower levels of medical input. The facilities for those with mental and physical handicaps did include long-stay "homes" but these were normally under the charge of a doctor and failed to provide adequate non-medical care.

There is no private sector in social care to date. All provision is publicly owned and continues to rely on the mixture of local government and insurance-based funding that prevails in the area concerned. Because most care takes

place in the acute setting, access is through medicalized routes. There is no formal mechanism to prioritize cases if services are oversubscribed. Rationing is informal and opaque and may rely on unofficial waiting lists or under-the-table payments by patients or family.

The Ministry of Health has plans to coordinate with local governments in order to facilitate a shift of beds to the provision of long-stay or chronic care. It is hoped that nurse-led models of care will be introduced and that convalescent and nursing homes will be included in the new sector. It is estimated that as many as 20% of beds could be usefully redesignated in this way. How to assign financing for this shift has yet to be determined.

In recent years there have been efforts to develop hospices at the regional level for geriatric patients, orphans and invalids.

Human resources and training

The Soviet Union traditionally had high numbers of health care personnel by international standards, and this continues to be so for the Russian Federation. This reflects the Soviet approach to health care provision, which was to provide large numbers of health centres, clinics and hospital beds with relatively high staff-to-bed, or staff-to-facility ratios. Since doctors and nurses were considered to be “non-productive elements” of society they were cheap to employ, and hospital and clinic directors had few incentives to control staffing levels. This situation has been slow to change. In absolute numbers, the Russian Federation today has roughly 600 000 active physicians.

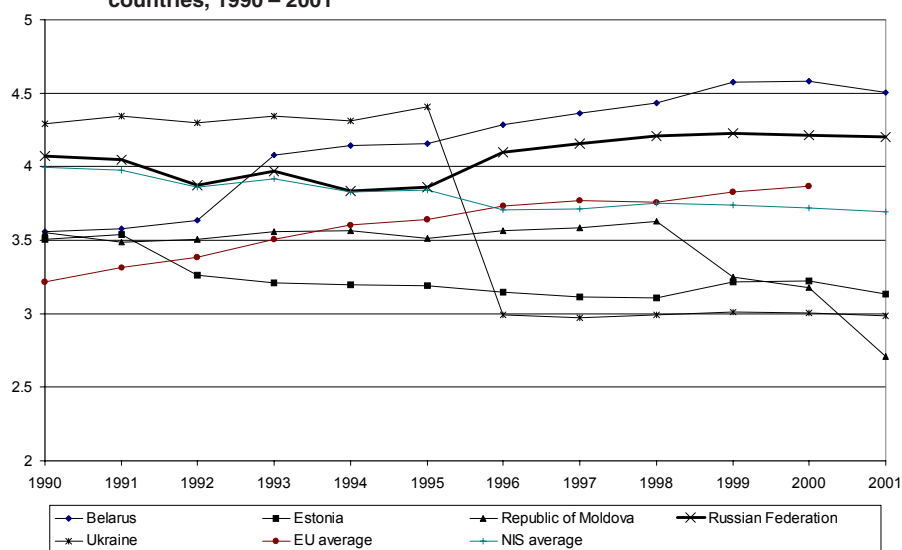
Fig. 15, showing trends in physician numbers over time, reveals several interesting points. First, doctor numbers per population in the Russian Federation are significantly higher than the average for the EU throughout the period shown. Second, the Russian Federation and the NIS average followed an almost identical downward pattern between 1990 and 1995, after which there followed a marked divergence, with the NIS figures continuing the downward trend and the Russian Federation sharply swinging upward. This pattern followed by the Russian Federation can also be seen in Table 14.

Fig. 16 allows a comparison of numbers of doctors among most of the countries of the European Region. In 2000 the Russian Federation was surpassed by only two countries in the NIS (Georgia and Belarus) and three countries in western Europe (Greece, Italy and Monaco).

The number of nurses is also relatively high when compared to CEE and western European averages, excluding the Nordic and Benelux countries. According to WHO Regional Office for Europe health for all database, there were 7.9 nurses per 1000 population in 2000 (see Fig. 16 and Table 14). Fig. 17 and Table 14 show a sudden drop in nurse numbers in 1991, after which there is a barely perceptible declining trend. High nurse numbers can, of course, be an asset as well trained nurses support strong primary and community care. However, in the case of the Russian Federation – where nurses are little more than doctors’ aides – there can be a legitimate question about the necessity of so many nurses.

There are also a relatively large number of pharmacists and dentists, but as they are increasingly operating outside the public sector only suggestive figures are available.⁷³

Fig. 15. Physicians per 1000 population in the Russian Federation and selected countries, 1990 – 2001



Source: WHO Regional Office for Europe health for all database

The decline in the numbers of medical personnel in the first half of the 1990s can be accounted for by several factors: In part it was due to the adjustments of previous data to exclude non-Russian parts of the former Soviet Union that are now independent and had had slightly higher ratios of doctors-to-population than Russia itself. Some is due to an exodus of those nearing

⁷³ Pharmacist numbers are not shown in Table 14 from 1994 onward as they are highly unreliable.

Table 14. Health care personnel in the Russian Federation, 1985 – 2000

Number per 1000 population	1985	1990	1992	1994	1996	1998	2000
Active physicians	3.87	4.07	3.87	3.83	4.09	4.21	4.19
Active dentists	0.26 ^a	0.28	0.29	0.30	0.31	0.32	0.32
Nurses	8.22	9.99	8.32	8.24	8.24	8.21	7.95
Midwives	0.87	0.89	0.76	0.64	0.66	0.62	0.51
Active pharmacists	0.30	0.34	0.23	–	–	–	–
Physicians graduating	–	0.14	0.16	0.17	0.17	0.17	0.10
Nurses graduating	–	0.34	0.34	0.34	0.34	0.36	0.40

Source: WHO Regional Office for Europe health for all database (13).

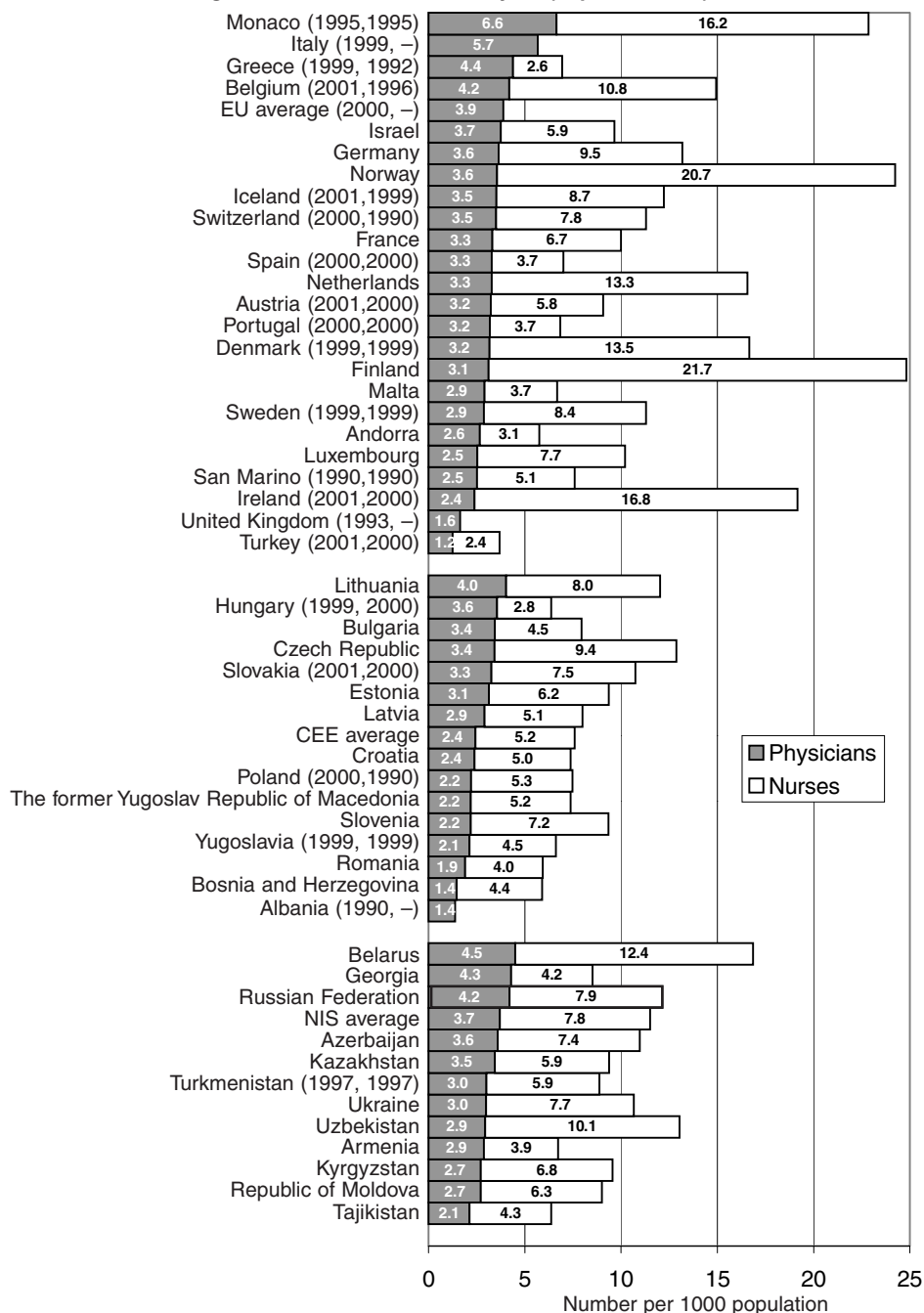
Note: ^a1996 data.

retirement age who felt more inclined to retire than to adjust to changes in the system. There were also some cuts in staff when small rural facilities closed in the face of overwhelming financial pressures, and various enterprise-based clinics shut down as industry ground to a halt. A number of these have re-opened since the economy has stabilized, and staff appear to have been reinstated.

Part of the drop in numbers of doctors was also the result of Soviet attempts to address overstaffing issues in the mid and late 1980s by reducing the admissions to medical schools, giving rise to a drop in the number of new doctors in the early 1990s. Along with natural wastage, this created a drop in total staff numbers not directly attributable to the changing circumstances of the Russian state. At the same time, there were more students entering medical schools in the early 1990s, partly because of the inability of the centre to impose university admission limitations upon the regions. Therefore, the number of doctors entering the workforce in the second half of the decade exceeded that of the previous high point in the 1980s. It is noteworthy that the number continued to increase until a sharp drop in 1999, which continued in 2000. Numbers of graduating nurses, on the other hand, were stable in the first half of the 1990s, and then began to increase in the second part of the decade.

Given the poor rates of pay, poor working conditions and high levels of dissatisfaction reported by the medical workforce, the apparent popularity of the medical and related professions requires some explanation. Anecdotal evidence suggests that those applying to join both medicine and nursing are struck by the prestige of their respective professions and believe them to be well respected despite complaints by consumers about the system as a whole. They also express a desire to enter 'caring' occupations. It is clear that although official levels of pay are low, medical students expect to command reasonable salaries. Interestingly, the majority of students continue to express a desire to

Fig. 16. Number of physicians and nurses per 1000 population in the WHO European Region, 2000 or latest available year (in parentheses)

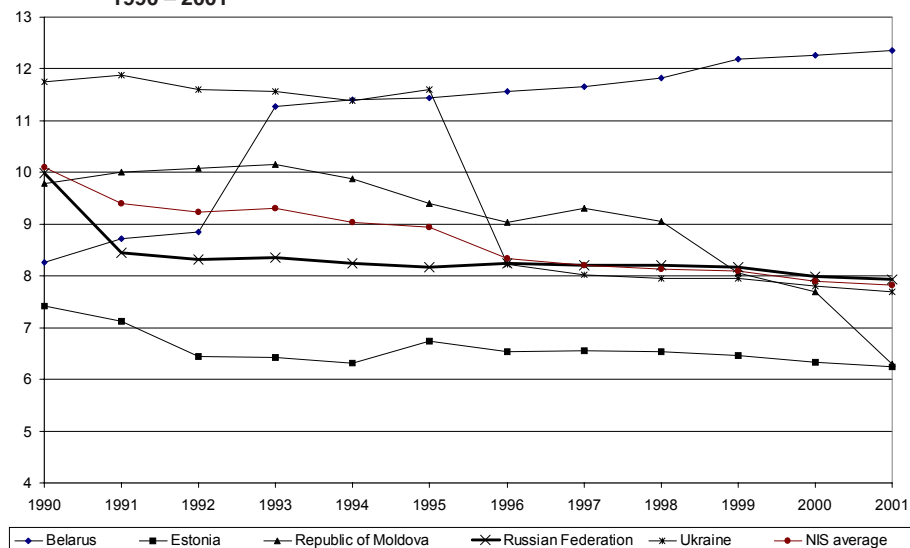


Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

Russian Federation

Fig. 17. Nurses per 1000 population in the Russian Federation and selected countries, 1990 – 2001



Source: WHO Regional Office for Europe health for all database

specialize, particularly in high-tech medicine, despite the hopes of planners and policy-makers that primary care will become increasingly important.

To qualify as a doctor one needs six years of general medical education and two years internship to become a specialist, as is the case of most doctors. The number of specialties recognized within the Russian Federation is higher than in much of the rest of Europe, with over eighty branches of medicine listed as specialist areas of practice. The number of doctors recognized as specialists is also high, in part because of the proliferation of specialties and in part because the Soviet system, with its specialist ambulatory services, encouraged secondary and specialized care. The Soviet Union undervalued generalists and primary care physicians, but the need to shift the emphasis to the primary sector has now been recognized. With this has come recognition of the importance of training for general practitioners. A two-year training programme was introduced in 1992, making general practice a speciality in its own right. In addition to enhancing the skills of family doctors, it should raise their status.

Previously one could be sent somewhere to work prior to the internship, but this is no longer possible.

Nurses in polyclinics and hospitals are little more than doctors' aides and have a small role in clinical work. The only instances of nurses taking a part in patient management and treatment decisions is in the feldsher-midwife model

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where, following additional training of one to two years, nurse-practitioners are able to take on the first-call primary care role. Teaching of nurses was formerly carried out by doctors; recently nurses have also undertaken this role. A number of faculties have been developed for highest nursing education in medical schools.

Management skills and related training are also being addressed coherently for the first time. There is now a Faculty for Health Care Management in the Moscow Medical Academy, which offers postgraduate training for hospital managers. As in Soviet times, the chief doctor of a hospital or clinic acts as the de facto chief executive officer, taking responsibility for staffing decisions, budgets, maintenance of facilities and negotiations with third party payers (both local government and insurance funds). Until recently senior doctors were assumed to have the financial and personnel management skills to carry out this range of duties effectively and very little training was offered. Now, with support from international partners, programmes are being developed which will provide more concrete skills for managers in health services. There is not yet full coverage nor are management skills included in the undergraduate syllabus, but the process of developing management capacity is under way.

It is too early to assess the effectiveness of initiatives to adapt human resources and training to the new challenges facing the Russian health system. The syllabus for undergraduate studies has only undergone relatively minor readjustment, that is, removing political components and increasing the coverage of noncommunicable diseases, and the expectations of medical students do not seem to have encompassed the new priorities of policy-makers. There are moves to reduce the number of specialities, but little progress has been made in restricting access to training in narrow specializations.

Pharmaceuticals and health care technology assessment

The structure of the pharmaceutical industry and distribution network have changed quite radically in the course of the past decade. Before the break-up of the Soviet Union, domestic production levels covered a substantial portion of domestic pharmaceutical consumption, with the balance made up by imports from Central European countries. The break-up of the Soviet Union caused massive disruption to pharmaceutical production, however, and whole areas of production were confined to newly independent states (Russia, Belarus and Ukraine, and to a lesser extent Kazakhstan and Kyrgyzstan). The industry that remained within the Russian Federation (as elsewhere in the former Soviet

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Union) was largely out-dated and poorly maintained. With the rapid transition to a market economy, a number of factors combined to make pharmaceutical production unprofitable and cause a drastic decline in production levels: sharp increases in the price of raw materials, energy and transport; disruption of cooperative links between plants; severe resource constraints; lack of customs barriers on imported substances; increased competition from imported products; and tax privileges for suppliers from abroad. As substance production within the Russian Federation dropped by 60% in the period to 1997, local producers increased prices dramatically, making them uncompetitive compared to imports. The volume of production dropped by a factor of five, according to a report entitled "The State of Production and Realization of Medicines in the Russian Federation in 1998" issued by the Ministry of Economy and the Ministry of Health. By 1997, 120 pharmaceutical factories, 21 plants involved with substance production and 42 research institutes synthesizing immuno-biological preparations were working at 25–50% of capacity, with 70–90% of equipment nearing the end of its useful life (64).

In the meantime, the volume of imported substances and finished pharmaceutical products increased dramatically. By 1997, 93% of producers were relying on imported substances with the proportion of imported products rising to 65% in the late 1990s. Whereas in 1999 domestic production rose to 44.4%, in 2001 it fell once more to 33.6%. At the same time, consumer prices of pharmaceuticals increased dramatically. While production collapsed, domestic producers raised prices to international levels with the result that domestic output measured in US\$ increased by 150% in the four years to 1997. In February 2002 retail prices increased by 10% compared to the same period of the previous year.

In 1997 domestic pharmaceutical production showed some improvement, and profit margins of the top companies were very satisfactory. The total value of domestic production in 2001 accounted for \$916.1 million, representing a 4.5% increase from the previous year. Some producers have initiated modernization and installation of new production facilities. An estimated 70% of pharmaceutical producers have been privatized. By 1997, pharmaceutical consumption had reached 70% of pre-reform levels.

The major pharmaceutical purchasers are the federal, regional and municipal authorities, hospitals and polyclinics, pharmacies and consumers. The role of the federal government as purchaser, while declining, is still significant because of the volume needed to carry out its nationwide programmes (e.g. the Diabetes, Mother and Child, and Vaccination and Prevention Programmes, etc.). Following independence, when the centralized purchasing system was abolished, regions developed their own procurement systems. Pharmaceuticals used by

hospitals are purchased by territorial mandatory health insurance funds or through the hospital budget. Since the early privatization stage following the breakdown of the Soviet Union, the insurance funds began contracting *pharmacias*⁷⁴ (drug supply agencies) to supply hospitals with the needed drugs. Efforts are being made to achieve economies of scale by eliminating the older practice of hospitals purchasing their own drugs. Increasingly, insurance funds buy drugs on the basis of tenders, with *pharmacias* as one class of bidder, along with private wholesale/distribution companies, which often win the bid.

The system of pharmaceutical distribution is characterized by a high degree of fragmentation. There are about 3500 pharmaceutical wholesalers. Fewer than 30 of these offer nationwide coverage, some with vertically integrated structures, and some providing their own manufacturing capability either within Russia or the CIS, or their own pharmacy network in larger cities. About 10% of wholesalers are importers, while the remaining 90% either deal exclusively with domestic drugs or re-sell drugs imported by the other wholesalers.

Wholesale distributors can be classified in four groups: (a) *pharmacias* (see above) which supply their regions with drugs for use in public facilities and also function as private wholesalers to the retail pharmacy sector, as well as municipal chains of pharmacies and clinics, usually managed by carry-over employees from the old system; (b) privatized formerly state-owned companies, also managed by former state employees; (c) new, profit-driven private companies, some of which have become nationwide vertically integrated structures; (d) international companies with western-style operations, all based in Moscow, many of which run their own pharmacy networks.

The Russian Federation has an estimated 16 000 to 19 000 pharmacies, of which 23% belong to regional governments, 60% to municipal authorities, and 17% are private. There are also about 50 000 pharmaceutical kiosks. The number of retail outlets has been growing very rapidly.

Pharmaceuticals are provided for inpatients by the hospital, while outpatients must purchase them from pharmacies. While inpatient prescription costs are meant to be covered from the hospital's budget or through the case payment made by the insurer, most inpatients have to purchase their own drugs, and it is estimated that 80% of inpatient pharmaceutical costs are paid for out-of-pocket. This reflects, for the most part, the financial constraints facing hospitals. With the exception of core drugs needed to meet public health requirements (i.e. insulin, vaccines, and TB prophylactics), hospital directors acquire the bulk of the pharmaceuticals used through commercial channels and must therefore pay market rates for goods supplied. Under these conditions, inadequate hospital

⁷⁴ These enterprises are often referred to as being public; in actual fact they are shareholding enterprises in which the government holds a share, sometimes a minority share.

budgets and frequent irrational drug prescribing lead to shortages within hospitals even when drugs are available in the private sector.⁷⁵ The inability of federal, regional and local authorities to pay for supplies to hospital providers in a timely manner is, in turn, an additional reason for the relatively poor financial performance of domestic pharmaceutical producers, which supply hospitals but then have difficulty collecting payment.

At the retail level geared to outpatients, some pharmacies were sold to the private sector immediately after the establishment of the Russian Federation. Most pharmacies initially remained formally state owned, but due to a lack of public funds began to operate on private finances. At the same time, completely new private pharmacies emerged. These “private” enterprises now operate on a for-profit basis, purchasing drugs directly from importers or drug companies and selling them on. Notwithstanding their new status, they are obliged to supply drugs free of charge to vulnerable groups and then to apply to local government for the reimbursement of costs. Many are reluctant to comply with this requirement because of the delays in securing refunds. Most areas still have a state-owned pharmacy which should guarantee provision, but these outlets often experience difficulties obtaining stock. State pharmacies stock about 500 to 700 items, in contrast to private pharmacies which stock over 2000.

While the availability of drugs has increased through imports, drug affordability has fallen and many Russians are unable to purchase needed medications (43,65). It appears that overall access to prescribed medications is improving. However, a series of surveys conducted since 1994 show that the percentage of respondents able to get all their prescribed medications was 62 in 1994; 70 in 1995; 75 in 1996; and 78 in 2000 (65). In spite of the improvement, over one in five patients are still unable to obtain their prescribed medications. Whereas unavailability of drugs and lack of money have been the two most important reasons cited over the years for this inability, lack of money has become increasingly important; this was the reason given in October 2000 by 66% of urban inhabitants (compared to 20% in 1994) and 70% of rural inhabitants (compared to 25% in 1994) who were unable to obtain their prescribed medications. Most medications are still obtained from state pharmacies (74% in urban areas and 84% in rural areas in October 2000), but commercial pharmacies are increasingly important as pharmaceutical outlets. Of all the respondents who were able to get some or all of their medications, 15% were permitted a full discount (65).

⁷⁵ The high costs of pharmaceuticals, however, do create incentives for hospital managers to monitor the type and quantity of pharmaceuticals provided. Chief doctors in some areas now review prescribing patterns of medical staff in an attempt to achieve a balance between clinical need and cost.

According to other 1998 survey results, half of all surveyed households responded that at least once in the course of a year a household member was unable to afford a recommended drug, while over 20% of households had a family member go without a recommended cardiovascular drug (43). (For more information see the section *Out-of-pocket payments*.)

It is important to distinguish between actual demand for pharmaceuticals, determined by the population's needs, and solvent demand, which is based on the ability of would-be purchasers (public authorities, health insurance funds, and consumers) to pay. Actual demand in the Russian Federation is influenced by the large proportions of the population comprising pensioners, the chronically ill, and those living in areas with poor air quality (an estimated 85% of the population), as well as by the high rate of infectious diseases. Solvent demand differs substantially by region, depending on local economic conditions, the finances of the regional and local authorities, and the income levels of the citizens. In the Russian Federation solvent demand is clearly lower than actual demand.

Consumption of pharmaceuticals therefore tends to be relatively low. In 1996, per capita consumption was said to be 33% that of Germany and 20% that of the United States (64). Furthermore, it was estimated that only 60% of the country's drug requirements were being met. These low levels of consumption relative to Western countries make the Russian market extremely lucrative for foreign pharmaceutical companies, many of which have been aggressively advertising, to the confusion of both consumers and prescribing physicians. The number of drugs registered for sale increased from 5000 in 1992 to 12 000 in 1998. Currently the State Register contains 140 000 products, many of which are new to doctors. Such extreme liberalization of pharmaceutical products makes control impossible. By comparison, most western European countries manage well with a few thousand products on their drug formularies. Many of the pharmaceuticals being sold in the Russian Federation today have no proven pharmacological value whatsoever. Although there are such available sources of drug information as the national drug formulary, and the drug information compendium for all registered products produced under the auspices of the Ministry of Health, in many cases the most readily available information comes from commercial sources.

Hospitals similarly do not always have access to necessary information on drugs. The general public, unused to commercial pressures during the Soviet era, is now influenced by advertising, which reinforces the traditional cultural expectation that each consultation should lead to a drug prescription. The absence of any regulation of drug advertising has led to alarming practices: for example, codeine-based analgesics which should be sold only on prescription

have been the subject of intensive television advertising and can be purchased at pharmacies and kiosks. Although drug advertising regulations are in place now, their enforcement is still insufficient. Further, the insufficiently developed quality assurance and regulatory system has allowed the market to be infiltrated with drugs that are restricted or prohibited elsewhere, or drugs with little or no proven therapeutic usefulness and imports of dubious quality from the Far East or eastern Europe (66). Prescribing doctors pay more attention to price and availability than quality.

The Association of International Pharmacological Producers held a meeting in Moscow in 2002, where it was estimated that counterfeit drugs in the Russian Federation accounted for about 12% of the prescription market in 2001, costing legitimate manufacturers about US \$250 million per year. Laws against counterfeit drugs are weak, and penalties are light or non-existent. Counterfeit drugs cannot be confiscated and destroyed, and often find their way back into the market. Amendments made to legislation to deal with these issues have been pending in the Duma since 2001.

Regulation of the pharmaceutical sector has changed with decentralization and while this has brought some positive results, it is also less coherent than that of the 1980s. Responsibilities are divided between the Federal and regional levels. The Ministry of Health makes an overview of federal regulatory issues and monitors controlled drugs and imports of federal licensees, while local authorities oversee the local distribution network including pharmacies. Pharmaceutical manufacturers are subject to inspection by the Ministry of Health and Ministry of Technologies, Science and Industry for manufacturing standards, and by the san-epid network for sanitary conditions.

Drug prices are regulated by several mechanisms. At the federal level the Ministry of Health registers manufacturers' products and prices. After this, mark-up limitations are introduced, intended to hold down retail prices of pharmaceuticals. These limitations specify the allowable percentage of mark-up for both wholesalers and retailers. According to federal legislation, the maximum mark-up over the manufacturer's price is 25%, and retail prices should not exceed wholesale prices by more than 30% for drugs included in the list of essential drugs (the limit is slightly higher for other drugs). In practice, the mark-ups within these limits are the responsibility of regional authorities and therefore vary from region to region. In principle, mark-ups apply to the first importer, however, in practice there are various mechanisms by which mark-ups can be avoided for distributors further down the chain, resulting in mark-ups varying from 120 to 200%.⁷⁶

⁷⁶ Very often there are higher mark-ups for relatively cheaper drugs, and lower mark-ups for relatively more expensive drugs.

Whereas the Russian Federation generally lacks a coherent legislative basis for regulating the health care system, it does have a legislative framework and system of state control of medical goods imports, including a drug law, registration and certification, and quality control systems. According to Russian legislation, all drugs and biological products must be registered with the Ministry of Health at the federal level. Registration is undertaken by the ministry's Bureau of Registration of New Pharmaceuticals and Medical Equipment on the basis of assessments by the ministry's certifying agency, the State Inspection of Quality Control on Drugs and Medical Equipment. Gosstandart-authorized⁷⁷ laboratories may also certify pharmaceuticals. Thus there is no lack of regulation at the federal level; in fact the system is heavily regulated. There are, however, problems with enforcement, irregular updating, etc.

The federal and many regional governments have taken steps to compile lists of essential drugs in an effort to promote access, especially for vulnerable groups, and cost-effective consumption of pharmaceuticals. In April 1996, the government adopted the resolution "On a list of essential and life-saving drugs", which are recommended for supply and use in public health facilities. This was also intended to boost domestic production, as companies producing these drugs receive tax exemptions. In practice the list also included a large number of domestically produced drugs not always in line with criteria for essential drugs. Hospitals and polyclinics are encouraged to restrict themselves to the administration of drugs listed as essential, but compliance is incomplete.

Various lists of essential drugs are developed and used for different purposes: in addition to the federal government, regional governments develop their own lists, usually an expanded version of the federal one and often used for supplying the public sector and for drug reimbursement purposes. The various ministries and enterprises running their own facilities (i.e. the parallel system) develop their versions, as do the larger insurance companies. The key criteria for selection are efficacy, safety and price. However, as getting a drug on a list implies guaranteed drug sales, bribery and backdoor deals are additional factors determining which drugs get included, as is the case in many other countries.

The federal government in recent years has attempted to take measures to support the pharmaceutical industry, and in 1998 the programme "Development of Medicinal Industry in 1998–2000 and up to 2005" was adopted. It proposed the organization of domestic facilities for the production of new substances that would allow 70% of pharmaceutical needs to be covered by domestic production. However, the programme has remained unfunded by the state budget. Increasingly, individual manufacturers are raising funds for their

⁷⁷ This is the State Committee of Standards.

own development, with the longer-term goal of achieving good manufacturing practice (GMP) standards. The Russian GMP standard was approved in 1998 with a provision that implementation by manufacturers must be within five years. Although after this period non-compliant producers should in principle be closed down, there are very few manufacturers that have taken substantial steps toward implementation.

There are also attempts to encourage prescription of generic drugs. However, this is problematic for several reasons such as unreliable supply, extensive advertising and promotion of brand name drugs targetted at both patients and prescribers, as well as inadequate drug reimbursement and insurance schemes. Nonetheless, because of strong price sensitivity, the local markets are generally more receptive to generics than brand-names. There is no negative list as such.

Promotion of rational drug prescription and use has become an issue in several regions, as well as at the federal level. Tools such as national and local essential drug lists, drug formularies, and treatment guidelines have been developed and implemented in various regions. Competitive bidding has become a common tool for procurement of drugs for public sector needs and is supported by the legislative framework.

A federal centre for monitoring adverse reactions was set up in 1997 and is now a member of WHO's adverse drug reaction monitoring programme. The centre has good links with a number of regional drug information centres, however efforts are still required to establish countrywide activities.

Professional organizations such as associations of pharmacists, distributors and manufacturers are playing increasingly important roles in the regulation of the pharmaceutical sector. Substantial changes can also be observed in activities of various basic and continuing pharmaceutical education and training institutions, both public and private.

While efforts are being made to introduce the evidence-based medicine concept in the Russian Federation, there is a long way to go in this regard. The concept of pharmaco-economic evaluation of pharmaceuticals is also gradually being developed.

In early stages of decentralization several regions compensated for the lack of federal legislation by passing their own pharmaceutical legislation. This practice has gradually diminished and there is now a clear division of responsibilities between federal and regional authorities. Federal responsibilities are clearly defined by the federal drug law that covers the entire Russian Federation, while a large number of federal level regulations and decrees have been proposed as guidelines and recommendations for further adjustments by the regions themselves.



The regulation of new technology is largely in abeyance. However, this is less of an issue at the moment, if only because very little capital expenditure is being undertaken anywhere in the Russian Federation.

In theory, case payments are expected to include a component to cover the cost of routine acquisitions and equipment maintenance. Where providers want to invest in high technology or expensive equipment they are meant to apply to the insurance company or companies with which they have contracts for a grant to cover the costs. It is assumed that insurers will exercise control and only support purchases that correspond to health care needs in the area, with emphasis on primary and preventive medicine. In practice, insurance companies have neither been able to exert control nor to support capital programmes. In those areas where purchases have been made, they have been funded by local government out of tax revenues.

In those few areas that have had funding, there is no apparent control of purchasing policy. Imports are largely at the discretion of local funding bodies, licenses do not need to be issued either for the acquisition or use of new equipment, and the training of staff is left to the discretion of the suppliers. Experience indicates that when funds are available local authorities respond to the demands of secondary and tertiary physicians in highly specialized niches and invest inappropriately and without regard to long-term strategy or the stated health needs of the population.





Financial resource allocation

The system for allocating resources from third party payers through health care organizations to individual clinical providers is currently a mixture of two quite distinct approaches with separate payment mechanisms for central and local governments and for insurers. The relative importance of the two allocation routes varies from region to region. The combination of these two approaches to resource allocation was the result of an only partial reform of financing mechanisms, that left the balance between insurance contributions and local government payments varying widely from region to region, according to economic disparities and political differences.

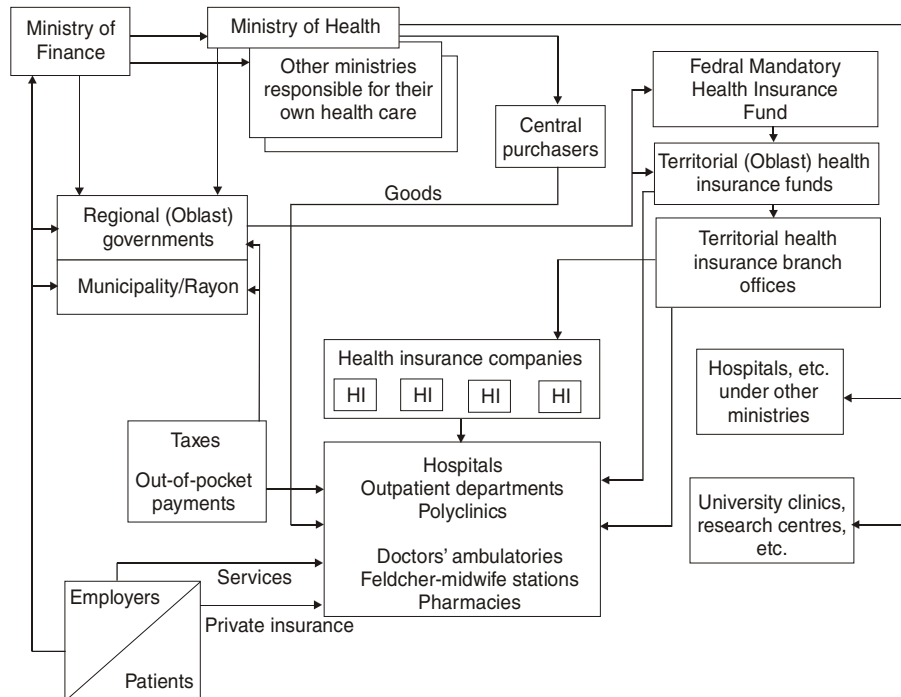
Local authorities in areas experiencing major deprivation face considerably more problems than those in economically successful regions. The efforts of the federal Mandatory Health Insurance Fund (MHIF) to offset the variations in local economic conditions are not enough to prevent growing inequities among regional health budgets. The territorial funds operate best in prosperous regions, thus adding to the inequities. The equalization fund absorbs only 5.5% of insurance revenues, little more than a symbolic amount.⁷⁸ In the face of varying constraints, local governments have adopted different strategies for the allocation of resources.

Third-party budget setting and resource allocation

A graphic representation of funding flows in the health care system is set out in Fig. 18.

⁷⁸ It will be recalled that of the 3.6% payroll tax, 3.4% goes to the territorial funds and 0.2% to the equalization fund to be used for equalization purposed across regions.

Fig. 18. Financial flow chart



Source: Computer display model of the Russian Federation, WHO Regional Office For Europe, Health Services Management Unit.

The Ministry of Health and Ministry of Finance carry out an annual budget cycle which reviews the costs of the centrally funded components of the health care system (direct ministry costs, federal facilities and support for core programmes including immunization) to be financed nationally through general taxation.

Further, the Ministry of Health and federal MHIF each year calculate the cost of the Guaranteed Package Programme for the entire country (see the section *Health care benefits and rationing* for a discussion), and make adjustments for each region based on morbidity patterns and subject to agreement by the Ministry of Finance. Based on these costs, targets are then set for each region in the form of recommendations that are not legally binding. Approximately two thirds of the targeted amount involves the Guaranteed Package Programme, with primary and secondary care provision to be financed by the mandatory health insurance system. The other third involves tertiary and specialized care, as well as regional programmes financed through the regional budgets.

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The basis for employers' contributions has been set by the federal government. The level of contribution that should be made by local authorities on behalf of the non-working population (including the elderly, children, the disabled and the unemployed) has not been set centrally, and varies widely from region to region.⁷⁹ According to the health insurance legislation of 1993, the total pool of contributions – both budget and insurance financed – should combine with local government's direct support – derived from various sources including taxes and rental income – to make up the full (notional) allocation for a region or district. In general, however, the regions pay only a fraction of the contributions that are needed to cover the health care costs of the dependent population. (See the section *Complementary sources of financing* for a full discussion of this issue.) Therefore the funds actually available to the mandatory health insurance system fall far short of what is targeted, averaging less than one third of the necessary two thirds. The regional budgets, in lieu of paying their quota on behalf of the non-working population, prefer to finance facilities directly, as this offers them greater control over their spending. The remaining one third (involving tertiary care, etc.) is paid for out of the regional budgets. Most of this goes to fund regional-level facilities, and a small amount to federal facilities.

The total amount of financing at the regional level thus depends less on the targets set by the Ministry, and rather more on the historical budgets of the institutions concerned, based on staffing, bed numbers and fixed costs; the ability of the local authorities to raise revenue; local custom and practice; and the extent to which the insurance system is working locally, given that employers are not always able to meet their obligations.

In some cases the two main financial flows are supplemented by direct contracts between enterprises and providers, as well as between insurance carriers and providers of the parallel system (whose finances are entirely separate from the Ministry of Health system). In other cases voluntary insurance schemes fund private treatments in mainstream facilities, boosting the income of the health sector. Out-of-pocket and under-the-table payments contribute significant amounts to the total health sector budget. None of these sources are detailed in the third-party budget setting process or are really open to scrutiny, but the contribution is thought to be crucial.

The regions also receive some funds from the Ministry of Finance, aggregated under social sector budgetary transfers. There is no separation of the amounts to be allocated to health care, education and other social spending. The regions' health care needs are assessed in order to specify the amount to

⁷⁹ The smallest payment per capita was 1 kopek per person per year (equal to US \$0.03 or 3 cents).

be transferred, but it is up to the regions to decide how much of these transfers will be allocated to health care and other social services. Their decisions are not monitored, thus information on the size of the allocations to health care are not compiled on the national level. Regions further transfer funds to the rayons, which are free to decide how much to allocate to each activity. Rayons also raise their own funds through taxation. The federal transfers to the regions allocated to health care and those from the regions to the rayons show up in official statistics as regional and rayon budgetary sources, even though the funds did not originate at that level.

There are also flows from the regions to the federal level. In principle there is a system of federal medical services available to regions at no cost to them, based on regional quotas. However, in practice this does not work very well due to lack of federal resources. The use of these facilities requires payment by the region or by the patient. This quota system includes 67 of the 273 federal inpatient clinics under the Ministry of Health, offering high technology services. The quotas are intended to cover about one quarter of the facilities' activity, but in practice it is much less due to the requirement to pay.

The mandatory health insurance funds collect contributions and transfer them to insurance companies on the basis of a weighted capitation formula. The insurance companies (or in their absence the branch or territorial MHIFs) enter into contracts with providers based on case payments, which are expected to create pressures for efficiency. In the event that there are no insurance carriers in a region, the MHIF contracts directly with providers. Payment methods are intended to reflect the priorities of the third-party payers and the volume of activity of providers. In practice, however, funding has tended to follow historical patterns with little concern on the part of insurance carriers for efficiency-promoting methods of payment (see the next section for a more detailed discussion).

The federal MHIF is expected to regulate financial flows and to compensate for variations in resources arising from differences in the wage base of different regions by reallocating 0.2% of all contributions. This amount is insufficient to address the existing inequities and much of the health sector routinely faces a shortfall in resources.

Payment of hospitals

Historically hospitals were paid line item budgets, based largely on bed numbers. Polyclinics received funds according to a similar formula that used a notional

number of visits in lieu of beds. These budgets were increased each year on the basis of a centrally agreed figure that covered inflation, growth, etc. There were, therefore, perverse incentives to expand facilities in order to command greater resources.

The shift to a financing system based in part on insurance mechanisms was intended to address these issues and, through insurance-based pricing pressures to create incentives for hospitals to reduce the length of stay and to use diagnostic tests and investigations more rationally. The prospective payment method was to fix the price for any particular inpatient case against a schedule of diagnostic classifications. Payments to polyclinics were to be by a variety of methods, providing encouragement to treat patients in the ambulatory setting rather than referring them on to hospitals. In addition, it was expected that hospitals and polyclinics would receive some 30% of their finances from the oblast or rayon based on their actual costs. In practice the operation of the new funding has been more complex and the payment of hospitals has varied from the original proposals.

In areas where the insurance scheme is fully operational the territorial MHIFs contract with insurance companies for the provision of care for insured populations. At the outset, a prospective per capita allowance was made by the territorial MHIF to the insurance company for each individual covered. Insurance companies then contracted with local providers (hospitals, polyclinics and/or dispensaries) for the basic package of care as set out by the Ministry of Health in association with the federal MHIF. Prices were set by territorial tariff agreement. This basic model is still in place except that, significantly, territorial MHIFs allocate the capitated funds to insurance companies retrospectively. This fundamental change came in response to fears of abuse following a review of expenditures and reserves held. It became apparent that large sums of money were unaccounted for – estimates suggest US \$100 million – and that at the very least there had been some significant mismanagement. It was felt that the root of the difficulties lay in the transfer of lump sums to insurance companies, which were inclined to invest these reserves speculatively, and not always successfully.

The insurance companies or the territorial funds (or their branches) in their absence, also pay providers retrospectively. Retrospective payments, however, completely eliminate any possibility of influencing hospital behaviour with a view to creating cost savings. The problems arising from this method of payment therefore involve two separate though closely related issues: the questionable role of the insurance companies, and the impact on the behaviour of hospital providers.

The role of the insurance companies

In those regions where they are functional, insurance companies negotiate a system of case payments, most frequently linked to a form of diagnostic related group (DRG), which specifies the appropriate length of stay, package of interventions and tests and appropriate clinical standards expected in each case for any given condition.⁸⁰ The companies are not, however, risk-bearing. They pay providers on a case-by-case, or visit-by-visit basis and bill the territorial MHIF for each item reimbursed by them. They do not seek to negotiate limits to the number of cases to be treated or to pass on to the hospital responsibility for the demand for care. There is thus a tendency to “underwrite” care for a whole local population without any formal mechanism for limiting hospital provision. Contracts are based on the basic package, but do not otherwise specify volumes of activity to be purchased.

Health insurance companies have come to be tied into a process of billing and bill processing. They now derive their profits on the basis of a percentage charge on each intervention invoiced, rather than from saving on their per capita expenditure for the population covered. There is therefore no incentive for companies to reduce the volume of care or to encourage providers to reduce costs or unnecessary interventions. The medical insurance company has become little more than a processing department handling the hospital’s invoices on commission and ensuring some minimal scrutiny of hospital standards and activity by way of added value.

The problems inherent in the issues outlined above were highlighted in a review of the insurance situation in Moscow and St. Petersburg in 1996. It was felt that the insurance companies had a blank cheque to bill above and beyond the per capita limits. The investigation revealed that the territorial funds continued to pay out on demand regardless of expense and that the insurance companies charged a flat rate fee of 8% of all invoices processed. Clearly, some new perverse incentives had been created which undermined the potential of insurers to contain costs. Rather they were encouraged to collude with providers in billing the maximum sum possible. Given that the majority of contracts were with hospitals, this had the further disadvantage of encouraging secondary over primary care. Measures have now been taken to stop this practice, although they call into question the viability of the insurance model itself.

⁸⁰ These “medical and social standards” vary between insurers, hospitals and regions often because different medical norms had evolved during the Soviet era when there was little access to international journals and little appreciation of the growing place of evidence-based medicine in other systems.

The impact on hospitals

The 1990s have seen the introduction of new payment methods for providers, though there are wide variations among the regions with respect to the various methods adopted. As Table 15 indicates, by 1997 most hospitals (58%) which were under contract with an insurance fund were using some type of case payment method; line item budgets were used in only 5.5% of the cases.

Table 15. Payment methods for hospitals (% of hospitals contracted with insurance funds)

	Line item budget	Clinical specialty	Diagnosis related groups	Bed days	Total number of hospitals
1995	12.7	7.5	50.4	29.4	100
1996	8.5	9.7	53.1	28.7	100
1997	5.5	10.0	58.4	26.1	100

Source: Sheiman, Paying hospitals in Russia, Eurohealth (67).

It should be noted that Table 15 refers only to hospitals contracted with insurance funds, i.e. it does not include hospitals contracted with insurance companies.⁸¹ However it can be safely presumed that the insurance companies have also been switching to new payment methods, in line with the innovations of the insurance funds. On the whole, approximately 80% of hospitals in the Russian Federation have contracts with either an insurance fund or an insurance company, though it is not possible to give the percentages for each.

Where new payment methods for hospitals have been introduced, they are used to pay only for those services contracted by the insurance funds or companies. On average, these are estimated to involve only about one third of hospital revenues. The remaining two thirds, coming from regional budget funds, still take the form of line-item payments based on historical patterns.

The introduction of new payment methods for hospitals has undoubtedly had a number of positive impacts. These include the development of new clinical and financial information systems; increased collection and use of data on hospital utilization, patient diagnostic groups and costs; an overall increased consciousness of cost effectiveness; and an increased interest in quality (52,67).

Nonetheless, it is also apparent that expected improvements in hospital utilization patterns have not materialized. There are two sets of reasons for this. The first is related directly to the method of payment. According to the evidence, new payment methods have not induced efficiency-promoting

⁸¹ This is because the data are provided by the federal MHIF, which has information on the territorial funds. It is a virtual impossibility to collect data on the payment methods of insurance companies on a national level, and probably even on a regional level.

behaviour among hospital providers. Whereas many countries today are experiencing declining average lengths of stay, this tends to be constant in the Russian Federation, and it has been shown that regions do not vary with respect to lengths of stay according to whether they use input or output based payment methods. The reason for this is that when setting reimbursement rates, most regions took the high stays as the reference point for diagnosis groups, thus institutionalizing inefficiency (67). The fact that payments are retrospective does not discourage the use of costly hospital services. It was also found that Moscow hospitals paying on a line-item basis had a higher bed turnover than those paying on a DRG basis. It appears that there is still a perception relating effective resource utilization to high bed occupancy (67). On the other hand, prospective payments can only work in an environment where well-functioning sanctions would be imposed in the case of non-compliance. In the absence of such sanctions, an institution could take the money and not follow up with contracting the corresponding services.

The second reason for the lack of improvement is related to the fact that the new payment methods involve only about one third of hospital revenues. This has a number of consequences. First, it does not allow the new payment methods to come into play with their full force. Second, it causes confusion and prevents a rational approach to hospital financial management and planning. Third, the coexistence of the old and new payment methods provides conflicting and contradictory signals and incentives.

There is some emerging evidence that patients have become more reluctant to use the health care system and are now bearing some of the burden of disease, in particular that of chronic illness, themselves. This reflects perceptions of the health system as ailing and inadequate and is also a response to the growing likelihood that inpatients will be asked to pay for “hotel services” themselves, bringing food, sheets, etc. from home. Under-the-table payments, too, increase the cost to patients of hospital admission and may have encouraged the apparent reluctance to attend for care in the conventional medical setting. This should reduce strain on the insurance system but is not otherwise desirable.

However, neither the exodus of patients from the system nor the practice of allowing debt to make up funding shortfalls are sustainable strategies. Planners and policy-makers are attempting to formulate further reforms that will protect the insurance principle and its incentives for greater efficiency and cost containment. In the interim, hospitals continue to provide care in line with the medical judgement of the physicians in post and without restrictions of volume. They receive funds from local government and/or insurance companies and funds through a variety of financing mechanisms. However, the value of their receipts falls short of the cost of actual services provided. While some of the

funding gap is met by semi-official and unofficial out-of-pocket payments, it is unclear how long this situation can be sustained.

Payment of physicians

In 1991, average earnings in the health services were only 75.4% of the national average. A doctor is currently paid similarly to a primary school teacher and earns little more than a nurse or feldsher. A typical surgeon in a public hospital might earn 1500 roubles a month, equivalent to US \$50, while in a state-of-the-art private hospital in Moscow a surgeon can earn as much as US \$1500 a month (68). There is no distinction between the way that doctors in the primary and secondary sectors are paid. However, there are more opportunities for specialists and those working in hospitals to further their qualifications and take on extra responsibilities, so they do tend to have marginally higher salaries.

All public sector health care personnel work on a salaried basis and most are employed indirectly by the level of government responsible for their particular institution. Employment contracts determine the rate of pay and may specify the hours or shifts to be worked, the volume of work in terms of the number of patients in the catchment area, or the range of responsibilities. Adjustments are made to reflect the attainment of postgraduate qualification, years of experience and the responsibilities of the post but do not reflect the volume of work carried out or its quality.

Since all medical personnel are effectively employed by the relevant tier of government, basic salary levels are agreed centrally. They are upgraded annually in line with Ministry of Health and Ministry of Finance estimates of what is feasible within the global constraints on the health system's budget. There is no tradition of independent trade unions representing the medical professions and striking is illegal; thus, little pressure has been exerted on the formal decision making structures.. There is, however, widespread dissatisfaction with rates of pay and a clear recognition on the part of senior policy-makers that the current situation depresses morale and has negative consequences for health service performance. Not least among these are the frequently cited phenomena of doctors making little or no effort, seeing very few patients and routinely referring patients onwards, yet receiving the same monthly income as colleagues who are committed to their patients. This undermines the motivation of productive staff.

In response to these difficulties there has been an attempt to extend the rudimentary bonus scheme begun during perestroika. In the 1980s hospital and polyclinic managers were granted the autonomy to pay bonuses out of

reserves to staff who performed well. Now that the right to generate income and retain profits has been extended, chief doctors are expected to have greater resources to commit to performance-related incentives.

The use of bonus payments is now commonplace. As much as 20% or more of any individual's monthly pay cheque may be derived from the supplementary payment, but in the absence of any formal performance assessment these bonuses have typically been awarded across the board regardless of productivity. It was perhaps optimistic to assume that the managers of hospitals and polyclinics would be able to introduce differential rates of pay, particularly given lack of formal support and the fact that the worst instances of abuse are often by senior staff, who are a difficult group to discipline. There are still hopes that the introduction of a more mixed formula for paying medical staff may be achieved, perhaps linking outputs – rather than outcomes – with reward.

The ability to influence staff through pay is further undermined by the extensive practice of under-the-table payments. While both nurses and doctors accept these payments, doctors have greater power over resources, and access to drugs, tests and hospital admissions and so are more able to supplement their official income. This amounts to an unofficial means by which doctors establish earnings differentials relative to nurses and feldshers and by which hospital doctors and specialists secure higher incomes than generalists and primary care doctors.

The private sector, although still underdeveloped in the Russian Federation, tends to use more varied approaches to paying physicians. The quasi-private, fee-for-service polyclinics which offer dental or ophthalmological care pay their staff a salary plus a share of profits. Physicians offering private consultations charge a fee-for-service and if they work out of a clinic are likely to retain 40–70% of these fees, with the remainder contributing to running costs.

The government has clearly recognized that a general upgrading of salary levels is required to resolve the issues of motivation and performance in the health care sector.



Health care reforms

Aims and objectives

By the mid-1980s the shortcomings of the Soviet system were becoming increasingly apparent and health service planners had recognized the need to address issues of oversupply of facilities, inefficiency and low morale. They introduced some reforms, in particular the pilot projects in Kemorovo, Leningrad and Samara, in an attempt to address the imbalance between secondary and primary care. These experiments looked at the introduction of market mechanisms and at ways of vesting health budgets in the primary sector, but they were superseded by events.

The break-up of the Soviet Union not only brought to the fore the problems of the old approach to health services management, but exacerbated them, creating a more urgent need for reform. The health status of the population went into a rapid decline, with falling life expectancy for both men and women. There was a huge rise in excess mortality among men from their late teens to forties, together with a resurgence of infectious diseases that had not been seen in decades and growing morbidity and mortality from chronic conditions. This trend was accelerated enormously by the strains placed on the population by the economic chaos of the 1990s. It became abundantly clear to politicians as well as planners and policy-makers that the health services, with all their waste and duplication, needed to be overhauled if they were to meet the growing needs. The expense of maintaining the levels of provision of the Soviet era became untenable in the face of an implosion of the tax base that accompanied other economic events. It also threw into sharp relief the inefficiency of the system and the poor quality of the services offered.

The political disquiet which did so much to bring an end to the Soviet system was a further factor in shaping the demand for health sector reforms. Just as perestroika and glasnost had raised expectations and heightened demand for change, the founding of the new government brought the expectation of reform on the part of policy-makers as well as general population. A key area perceived to require radical change was the high degree of state centralization. Decentralization was seen as a critical component of any reform policy, not just in order to allow greater responsiveness in decision-making at the local level, but as a symbolic means of redefining the nature of the new political era.

Since much of the impetus for the reform process centered around issues of funding, efficiency and decentralization, it was logical that the reforms themselves should address these directly. One key strand of the reforms – the introduction of national, mandatory health insurance to supplement tax based funding – was intended to link all three. In the critical financial position of the Russian Federation, payroll based insurance contributions were also seen as one of the only means of introducing additional funds into the health sector, with the advantage that they would be earmarked specifically for health care.

In addition the Ministry of Health supported reforms in the training of general practitioners, the autonomy of hospital and polyclinic managers, the payment of staff and planning and regulation. The intention was to combine a range of measures to overturn the effect of years of rigid, bureaucratic control by decentralizing management and financial responsibilities, improving the economic rationale of medical decision-making, and encouraging greater efficiency and a greater responsiveness to patient and citizen needs.

Content of reforms and legislation

The legal basis for health care reforms at the federal level is provided by a variety of legislative acts (Codes, Federal laws), Presidential decrees, Decisions and Proposals of the Government of the Russian Federation, and Orders of the Government and of the Ministry of Health and other ministries. The legal basis at the regional level is provided by legislative instruments enacted by the governments of the subjects of Russian Federation. The most important federal instruments are listed in chronological order below; it should be stressed that though extensive, this list is not exhaustive. It is beyond the scope of the present document to include regional level instruments.

It will be recalled that on 25 December 1991, legislation entitled “On changing the name of the state RSFSR” was passed, according to which as of that date the name of the Russian state should be read and written as “Russian

Russian Federation

Federation” (RF). However, the previous name of RSFSR was allowed to be used in official documents until the end of 1992. This resulted in some confusion with respect to the titles of legal documents, as during the first two years or so of independence some legal documents refer to the new state as RSFSR and others as RF. The titles of the legal documents listed below follow the official names as they appear in the Encyclopaedia of Russian Legislation.⁸² During this period there was also a change in the name of the Parliament from the Supreme Soviet of the RSFSR (consisting of two Chambers) to the Federal Assembly of the RF (consisting of the State Duma and Federation Council). After 1993 all laws are referred to as “Federal Laws”.

1991

1. Law of the RSFSR “On health insurance of the citizens of the RSFSR” of 28 June 1991 (No. 1499-1), setting out the basic framework for the establishment of a health insurance system for publicly provided health care services. This law was considered to have some fundamental weaknesses: it did not provide an appropriate institutional framework, it did not comply with the tradition of solidarity, and it involved the use of risk-based insurance. It was therefore amended and reissued on 2 April 1993 (Law No. 4741-1), and was accepted as the basis of the health insurance system.
2. Law of the RSFSR “On the sanitary-epidemiological wellbeing of the population” of 19 April 1991 (No. 1034-1), stating the rights and the responsibilities of the population, health care providers and both public and private organizations. (Last amended on 21 July 1998, Federal Law No. 117.)
3. Law of the RSFSR “On separation of the state committee for sanitary and epidemiological surveillance from the Ministry of Health” of 19 April 1991 (No. 1034), establishing the epidemiological service as a free-standing organization. (In 1996 it was reintegrated into the Ministry of Health structure.)
4. Law of the RSFSR “On local self-management” of 6 July 1991 (No. 1559-1), determining the structure and responsibilities of local self-management of rural districts, cities, and rayons (cities and villages)

⁸² Version 3.1.

and their economic and financial basis. Responsibilities of village, district, and urban administrations include, in particular, management of all establishments of public health care services within the territory, development of health promotion and prevention among the population, improvement of environmental and living conditions. (Last amended on 28 August 1995, Federal Law No. 154.)

5. Law of the RSFSR “On the budget process of rayons, cities, city rayons, towns, rural settlements and other administrative territorial units of the RSFSR” of 10 October 1991 (No. 1734-1), confirming that regional units can develop their own health budgets, without Ministry of Health approval. (Last amended on 31 July 1995, Federal Law No. 118.)

1992

6. Decree of the President of the RF “On transformation of the Academy of Medical Sciences into the Russian Academy of Medical Sciences” of 4 January 1992, establishing the Russian Academy of Medical Sciences as a separate legal entity.
7. Decision of the Government of the RSFSR “On measures for implementation of the Law of the RSFSR ‘On health insurance of the citizens of the RSFSR’ ” of 23 January 1992 (No. 41) (amended on 22 May 1992), defining the tasks of the ministries, departments and executive bodies of the subjects of the RSFSR on the introduction of mandatory health insurance; ratifying a number of the normative acts (including the basic package of care); and addressing the issue of payment of contributions from the local budgets on behalf of the non-working population.
8. Order of the Government of the RSFSR “On the basic programme of health services under Mandatory Health Insurance for the citizens of the RSFSR” of 23 January 1992 (No. 41), outlining the package of entitlement under health insurance.
9. Law of the RF “On krai and oblast councils and krai and oblast administrative bodies” of 5 March 1992 (No 2449), establishing that kraies and oblasts have the same rights as republics of the RSFSR in the spheres of social and economic development, i.e. management of land,

natural resources and property, and their own health services. This paved the way for decentralization, setting out the shift of government financing responsibilities from the Ministry of Health to the regional and local levels and guaranteeing local powers to determine levels of health care funding and provision subject to certain minimum standards. The Ministry of Health was only to retain functions such as health policy formulation, training and research, public health and other core matters.

10. Decision of the Parliament of the RSFSR “On confirmation of regulation of the federal Mandatory Health Insurance Fund” of 18 June 1992 (No. 5145-1), determining the mandatory health insurance premium rate: each employer is to pay 3.6% of the monthly wage bill for each employee. Other amendments to the health insurance law were also adopted by the parliament.
11. Law of the RF “On psychiatric care and guarantees of the rights of the citizens at the time of its provision” of 2 July 1992 (No. 3185-1). (Amended on 21 July 1998, Federal Law No. 117.)
12. Order of the Ministry of Health of the RSFSR “On the phased transition to primary health care based on the work of the general practitioner or family physician” of 26 August 1992 (No. 237), recognizing the term “primary health care” for the first time and setting out plans to extend primary care units, increase the number of primary care nurses and give them greater responsibility and provide special training for GPs.
13. Decree of the President of the RSFSR “On measures for development of public health services in the Russian Federation” of 26 September 1992 (No.1137), requiring allocation of necessary financing for public health services and construction of medical establishments and their maintenance, and developing proposals for improvements in the management of health care establishments and in the quality of medical care.
14. Decision of the Government of the RSFSR “On differentiation of payment for work for positions of health care workers within the budget sphere on the basis of a uniform tariff scale” of 14 October 1992 (No. 785).



15. Law of the RF “On organization of insurance business in the RSFSR” of 27 November 1992 (No. 4015), establishing the main principles of insurance activities in all spheres. (Amended on 31 December by Law No. 157.)
16. Law of the RF “On the insurance tariffs in the Social Insurance Fund of the RSFSR, in the State Employment Fund of the RSFSR and in the Mandatory Health Insurance Fund of the RSFSR for the first quarter of 1993” (revised quarterly) of 25 December 1992 (No. 4230-1), establishing compulsory contribution levels as a percentage of salaries for all three social insurance funds.

1993

17. Decision of the Parliament of the RSFSR “On the Federal Fund for Mandatory Health Insurance” of 24 February 1993 (No. 4543-1), making compulsory health insurance a social security measure: establishes federal and regional health insurance funds to enforce state health policy, accumulate compulsory health insurance premiums, redistribute insurance premium income between districts and regions in the interests of equity, and guarantee coverage of all citizens by mandatory health insurance.
18. Decree of the President of the RSFSR “On urgent measures for stabilization of the subsistence minimum of the population of the RSFSR in 1993” of 27 March 1993 (No. 405), concerning social problems resulting from economic reforms, requiring the use of the subsistence minimum level as the social standard or point of reference for increases in minimum wages, pensions, grants, etc.
19. Law of the RF “On health insurance of the citizens of the RF” of 2 April 1993 (No. 4741-1) amending Law No. 1499-1 of 28 June 1991 (see item no.1). The amendments provide that coverage for the unemployed, children, the elderly and others not in employment is to be provided by the respective local authorities of these population groups.
20. Decision of Government of the RSFSR “On powers of bodies of the executive authority of krajs, oblasts, independent (autonomous) territories, cities of federal importance on licensing different kinds of

activity” of 27 May 1993 (No. 492), entitling the local authorities listed to license numerous kinds of activities, for example, medical activities, trade activities, etc.

21. Law of the RF “On certification of production and services” of 10 June 1993 (No.5151-1), establishing rules for obligatory acquisition of the certificate of conformity to the requirements of necessary quality on various kinds of medical goods and services.
22. Order of the Ministry of Health of the RSFSR “On confirmation of the list of preventive, diagnostic and curative services included in the basic programme of mandatory health insurance of the population of the RSFSR for 1993” of 21 June 1993 (No. 146), specifying the Basic Programme in 29 medical specialities covering a standard range of services.
23. Law of the RF “Fundamentals of the RF legislation on citizens’ health protection” (No. 5487-1) of 22 July 1993, approved by Decree of the President of the RSFSR of 14 December 1993 (No. 2288), defining tasks of legislation of the Russian Federation concerning protection of health of the citizens, the competencies in this area of executive bodies at various levels, principles for development of a system of health protection, improvements in public health services and in the quality of health care services, protection of the rights and interests of patients and medical and pharmaceutical workers (including remuneration for their work), and responsibility in the event that harm to health of the citizens is caused. For the first time the problems of health are considered to be a state priority. (Amended on 20 December 1999 by Federal Law No. 214 and on 2 December 2000 by Federal Law No. 139.)
24. Law of the RF “On donation of blood and its components” of 6 September 1993 (No. 5142-1), making changes in the Law of 4 May 1992. (Amended on 16 April 2001, Law No. 34.)
25. Decision of the Government of the RSFSR “On measures of performance of the Law of the RSFSR ‘On modification and additions in the Law of the RSFSR On Health insurance’ ” of 11 October 1993 (No. 1018), demanding that authorities in all subjects of the RSFSR organize the work of territorial Mandatory Health Insurance Funds and approve their

territorial Basic Programmes. It also adopted instructions on methods of payment for the Mandatory Health Insurance Funds.

26. Document of the Federal Mandatory Health Insurance Fund “Recommendations on the choice of method of payment for medical services” of 18 October 1993, recommending remuneration methods for outpatient services (per capita payments, case-based payments, etc.) and hospital care (number of hospital beds, case-based payments, etc.).
27. Constitution of the Russian Federation (accepted by national referendum on 12 December 1993) establishing conditions for fulfilment of basic rights of citizens in the Russian Federation. Item 41 specifies the right of the citizen to protection of health and medical care. According to the Constitution, the State formulates policy for the fulfilment of the constitutional rights of the citizens in the area of health protection and puts it into effect by acceptance of federal laws and other normative and legal acts, and decisions of local authorities.
28. Decree of the President of the Russian Federation setting up interdepartmental commissions on health care and environmental safety, within the State Security Council.

1994

29. Order of Federal Mandatory Health Insurance Fund of 19 January 1994, recommending methods of financial accounting in the Mandatory Health Insurance Funds.
30. Order of the Ministry of Health of the RF of July 1994 (No. 157), adopting a list of essential drugs covering 96 drugs in 31 categories, and exempting certain population groups from payment.
31. Decision of the Government of the RF “On state support of pharmaceutical industry development and improvement of drug, medical technologies and related goods supply” of 30 July 1994 (No. 890), foreseeing government measures to increase financing of the pharmaceutical industry and strengthen control over production of drugs and related goods for medical purposes. (Amended on 10 July 1995, by Law No. 685.)

32. Order of the Ministry of Health of the RF “Regulation about obtaining permission to carry out professional (medical and pharmaceutical) activities” of 19 December 1994 (No. 286), outlining the rules that must be followed to receive permission for conducting professional work in accordance with the Law of 22 July 1993, No. 5487-1.
33. Federal Law of the RF “On protection of the population and territories from extreme situations of pollution due to natural and technological causes” of 21 December 1994 (No. 68).

1995

34. Federal Law of the RF “On Veterans” of 21 December 1995 (No. 5). (Amended on 18 January 1998 by Federal Laws No. 171 and 172.)
35. Order of the Ministry of Health of the RF “On the organization of health care” of 7 February 1995, concerning health services for different groups of the population.
36. Federal Law of the RF “On general principles of organization of local self-government in the Russian Federation” of 28 February 1995 (No. 154), defining the functions and responsibilities of local governments in the field of public health services. (Amended on 22 April 1996 by Federal Law No. 38; 26 November 1996 by Federal Law No. 141; and 17 March 1997 by Federal Law No. 55.)
37. Federal Law of the RF “On prevention of the spread of HIV infection in the Russian Federation” of 30 March 1995 (Federal Law No. 38). (Amended on 12 August 1996, by Federal Law No. 112 and 9 January 1997 by Federal Law No. 8.)
38. Federal Law of the RF “On social services for elderly citizens and invalids” of 2 August 1995 (No. 122).
39. Order of the Ministry of Health of the RF “On the list of essential and life-saving drugs” of 6 September 1995, requiring all pharmacies to stock all drugs specified in the list of essential drugs.

40. Federal Law of the RF “On modifications and additions to the acts of the Russian Federation for compensation by employers for harm caused to workers due to mutilation, occupational disease or other damage to health connected with performance of work” of 24 November 1995 (Federal Law No. 180). (Amended on 24 July 1998 by Federal Law No. 125.)
41. Federal Law of the RF “On social protection of invalids in the Russian Federation” of 24 November 1995 (Federal Law No. 181). (Amended on 24 July 1998 by Federal Law No. 125, and 4 January 1999 by Federal Law No. 5.)
42. Order of Ministry of Health of the RF “On privileges in drug supply for invalids and other population groups according to Federal Law ‘On Veterans’ ”.

1996

43. Decision of the Government of the RF “On confirmation of rules for providing paid medical services to the population by medical establishments” of 13 January 1996 (No. 27), outlining rules and conditions for medical establishments to provide medical care on a paid basis.
44. Decision of the Government of the RF “On confirmation of a Regulation about licensing medical activity” of 25 March 1996 (No. 350), ratifying the appropriate Regulation concerning the rules of obtaining a license by medical personnel.
45. Order of the Ministry of Health of the RF “On licensing medical activity” of 18 April 1996 (No. 148), providing measures for the implementation of the Government’s Decision of 25 March 1996. This order demands that all health authorities follow the above Decision of the government.
46. Decision of the Government of the RF “On creation of an interdepartmental Committee on Health” of 15 April 1996 (No 456), creating a committee with representatives from the Ministries of Health, Defence, Interior, and Railways, the Federal Mandatory Health Insurance Fund and others, in agreement with the Ministries of Economy and Finance to

coordinate the efforts of all concerned ministries to implement state policy in health matters.

47. Order of the Ministry of Health of the RF “On certification of doctors in general practice” of 6 June 1996.
48. Federal Law of the RF “On state regulation in the field of genetic engineering activities” of 5 July 1996 (Federal Law No. 86). (Amended on 12 July 2000 by Federal Law No. 96.)
49. Order of the Ministry of Health of the RF “On introduction of additions and changes in ‘A Regulation about payment of work of the workers of public health services of Russian Federation’ ” of 11 November 1996 (No. 372).

1997

50. Decision of the Government of the RF “On measures to prevent the spread of tuberculosis in the Russian Federation” of 7 March 1997.
51. Order of the Federal Mandatory Health Insurance Fund “On organization of work regarding letters, complaints and suggestions of the citizens of the Russian Federation” of 25 March 1997 (No. 35), demanding that all subjects follow the rules outlined in this order to reply to all citizen complaints concerning the provision of health care.
52. Decision of the Government of the RF “On import and export of medications and pharmaceutical substances” of 27 May 1997 (No. 647), adjusting customs regulations and controls for imports and exports of pharmaceuticals, for the prohibition of imports of forbidden and substandard drugs, and control of pharmaceutical manufacturing. (Additions to Clause 124 made by the Decision of the Government of 19 December 1998, No. 1606.)
53. Federal Law of the RF “On the subsistence level in Russian Federation” of 24 October 1997 (No. 134), establishing a legal basis for the definition of the subsistence level in the Russian Federation and its use as an accounting standard for the specification of minimum wages, minimum

pensions, and other measures of social protection of the citizens of the RF. (Amended on 27 May 1999 by Federal Law No. 75.)

- 54.** Decision of the Government of the RF “Concept of health care and medical science development in the Russian Federation” of 5 November 1997 (No. 1387), stating the basic goals of health care system development as outlined by the Ministry of Health: improvements in the organization of health care; consideration of the issues of financing and modernization of management; maintenance of sanitary-epidemiological wellbeing; development of medical science; improvements in the system of medical education and personnel selection, etc.

The Government ratified the plan on the implementation of this concept in 1997–1998 in order to guarantee the rights of citizens’ health and medical care, to achieve economic stability and improve efficiency of health services and medical science, and it has been extended until 2010. Another Concept, based on the above, was developed in 1997 and ratified later, defining state policy for the development of a medical industry and medical engineering.

- 55.** Decree of the President of the RF of 17 December 1997 (No. 1300), adopting the “Concept of national safety of the Russian Federation”, according to which the health of the population is determined to constitute grounds upon which the national security rests.

1998

- 56.** Federal Law of the RF “On narcotic drugs and psychotropic substances” of 8 January 1998 (No. 3), defining issues with respect to the manufacture, import, storage, sale, and use in inpatient and outpatient establishments of narcotic and psychotropic substances, and related punitive measures.
- 57.** Order of the Ministry of Health of the RF “On the development of pharmaceutical support for the population of the Russian Federation” of 23 January 1998 (No. 17), ratifying the list of essential drugs as the basis for providing pharmaceuticals within the framework of the Guaranteed Package Programme (394 pharmaceuticals in 55 categories).

58. Order of Federal Mandatory Health Insurance Fund “On observance of confidentiality with respect to the items of information which constitute medical secrets” of 25 March 1998 (No. 30).
59. Federal Law of the RF “On medicinal means” (Drugs Act) of 22 June 1998 (No. 86), providing the framework for the development, manufacture, pre-clinical and clinical testing of medications, control of quality, efficacy, safety, and trade in medicines and other activities relating to pharmaceuticals. It also makes a priority of state control of manufacturing, quality, efficacy, and safety of pharmaceuticals.
60. Resolution of the Government of the RF on “Code of the Federal Mandatory Health Insurance Fund”, of 29 June 1998 (No. 857), adopted by the Presidential Order No. 729 of 29 June 1998, strengthening the role of the federal Mandatory Health Insurance Fund in coordination and governance of the territorial funds.
61. Federal Law of the RF “On obligatory social insurance covering industrial accidents and occupational diseases” of 2 July 1998 (No. 125).
62. Decision of the Government of the RF “On confirmation of a Regulation about the Ministry of Health of Russian Federation” of 2 July 1997 (No. 659), outlining the ministry’s functions and duties.
63. Federal Law of the RF “On the basic guarantees of the rights of the child in Russian Federation” of 24 July 1998 (Federal Law No. 124).
64. Federal Law of the RF “On the budget code of the Russian Federation” of 31 July 1998 (No. 145), according to which the executive bodies at the federal and regional levels of the Russian Federation, and local self-management accept the normative acts concerning budget regulations within the limits of their competence. Clause 24, in particular, provides the right of federal legislative bodies and local self-management bodies at each level to independently carry out the budget process and to allocate budget funds at the appropriate level.

65. Decision of the Government of the RF “On confirmation of the programme of state guarantees ensuring free health care services provision for the citizens of the Russian Federation” of 11 September 1998 (No. 1096), resulting in the Guaranteed Package Programme, which defines the types and volumes of medical care to be provided to the population free of charge, and does not change the benefits structure specified in earlier legislative acts. Its innovative feature is the attempt to assure that benefits delivered match available resources. Establishes indices of volumes of care to identify expenditures at the federal, regional and municipal levels, as well as for the federal and territorial mandatory health insurance funds. The programme is to be reviewed annually. (Amended by the Decision of 24 July 2001, No. 550, increasing free outpatient care).
66. Federal Law of the RF “On immunoprophylaxis of communicable diseases” of 17 September 1998 (No. 157).
67. Resolution of the Government of the RF “On the programme of the state guarantees ensuring free health services provision to the citizens of the Russian Federation” of 9 November 1998 (No. 1096), approving the Guaranteed Package Programme. The objective is to provide the total amount of funds required to meet the costs of providing free health care services, as well as how the funds are to be collected and disbursed. It further determines the types and volumes of free care that are to be delivered.
68. Order of the Ministry of Health of the RF “On introduction of the classifier of simple medical services” of 22 December 1998 (No. 344), listing professional medical standards to be followed in order to ensure high-quality medical care.

1999

69. Order of the Ministry of Health of the RF “On the development of the organization of emergency care for the population of the Russian Federation” of 26 March 1999 (No. 100), establishing norms of operation for medical and pharmaceutical personnel of emergency care stations.

70. Decision of the Government of the RF “On measures about state controls on prices on pharmaceuticals” of 29 March 1999 (No. 347), limiting allowable mark-ups.
71. Federal Law of the RF “On sanitary and epidemiological wellbeing of the population” of 30 March 1999 (No. 52), determining basic concepts of the sanitary-epidemiological wellbeing of the population. It defines respective responsibilities of the federal level, the subjects of the Russian Federation, and the municipalities and also the rights and obligations of citizens and business entities.
72. Decision of the Government of the RF “On guaranteed provision of life-sustaining pharmaceuticals to the citizens of the Russian Federation, the most important medications, and on some preferential conditions for supplying pharmaceuticals to citizens” of 8 April 1999 (No. 393). The last part concerns vulnerable groups (invalids, veterans of war, children from 0 to 3 year of age, organ donors and some others).
73. Federal Law of the RF “On legislative foundations of social insurance” of 16 July 1999 (No. 165), establishing uniform approaches to all kinds of social insurance, including medical insurance and a uniform social tax.
74. Decision of the Government of the RF “On the Territorial Guaranteed Package Programme providing free medical services to citizens of the Russian Federation” of 26 October 1999 (No. 1194), detailing tasks of the programme in 2000.
75. Order of the Ministry of Health of the RF “On confirmation of the nomenclature of establishments of health services” of 3 November 1999 (No. 395), listing the names of health and medical establishments and functions whose activity is permitted. (Amended on 4 June 2001 by Law No. 180.)
76. Federal Law of the RF “On the tariffs of insurance contributions in the Pension Fund of the Russian Federation, Social Insurance Fund of

Russian Federation, State Employment Fund of Russian Federation and Mandatory Health Insurance Fund for 2000” of 20 November 1999 (No. 197), maintaining the insurance contribution rate of the mandatory health insurance system at 3.6 % for the entire working population (from which 0,2% is transferred to the federal MHIF).

77. Order of the Ministry of Health of the RF “Ministerial programme on general (family) practice” of 30 December 1999 (No. 463), developing the concept of the general practitioner as equivalent to a family doctor and specifying the legal, organizational, information and financial mechanisms necessary for the development of family practice.
78. Order of the Ministry of Health of the RF “On the list of medications in Lists A and B” of 31 December 1999 (No. 472), stating that medications included in List A must be kept under lock while those in List B need not be.
79. Federal Law of the RF “On entering additions and amendments to the Law of the RF ‘On social insurance of the citizens of the Russian Federation’ ” introduces stronger state regulation of the mandatory health insurance system. Some provisions of this law contradict stipulations of the Law “On basics of compulsory social insurance”.

2000

80. Letter/Instruction of the Ministry of Health of the RF “On certification of medical equipment and medical engineering” of 13 January 2000 (No. 2510/280-32), providing for the establishment of 35 bodies in 33 subjects of Russian Federation responsible for certification of medical equipment and quality surveillance, efficacy and safety of the products.
81. Recommendations “On the territorial Guaranteed Package Programme providing free medical services to citizens of the Russian Federation” approved on 17 January 2000 by the Ministry of Health and the federal Mandatory Health Insurance Fund in collaboration with the Ministry of Finance. These define the purposes, principles, structure and order of the territorial programmes, and establish norms of volumes of care and their costs. This methodology is to be used by authorities of the subjects of the Russian Federation to develop their own programmes.

82. Order of the Ministry of Health of the RF “On the representatives of the Ministry of Health of the RF in federal regions” of 30 June 2000 (No. 239). Since the administrative division of the country into seven divisions in 2000, permanent representatives of the President were placed in each of the divisions. In these divisions there are posts of representatives of different ministries, including the representatives of the Ministry of Health (often professors of Medical Universities).
83. Order of the Ministry of Health of the RF “On measures for the prevention of possible terrorist acts” of 11 July 2000 (No. 257), ordering all medical establishments to have plans concerning prevention of terrorist acts in medical establishments and procedures to be followed in the event that such acts occur.
84. Decision of the Government of the RF “On confirmation of a Regulation about the state sanitary-epidemiological service of the Russian Federation and state sanitary-epidemiological norms” of 24 July 2000 (No. 554), replacing the Decisions of 6 May 1994 and 30 June 1998. The regulation emphasizes stricter standards and demands greater responsibility for their observance.
85. Order of the Government of the RF of 31 August 2000 (No. 1220), approving the Concept of protection of health of the population of Russian Federation for the period until 2005. Contains an analysis of the health status of the population and specifies the directions that must be pursued to address the factors negatively influencing health, stressing the need to strengthen preventive measures. The most urgent measures identified involve lifestyles causing high mortality from cardiovascular diseases, external factors (accidents, poisoning, trauma), and infectious diseases.
86. Federal Law of the RF “On modifications and additions to the legislation of the Russian Federation on protection of health of the citizens” of 2 December 2000 (No. 139), introducing a provision in the Federal Law “Fundamentals of RF legislation on citizens’ health protection” (of 22 July 1993, No. 5487-1) concerning the state guarantees for provision of free medical services under the basic package of mandatory health insurance.

**2001**

- 87.** Decision of Gosstandard of Russia⁸³ “On confirmation and introduction in action of rules of certification of medications” of 3 January 2001, No. 2. The rules determine the basic principles and requirements of certification of foreign and domestic medications registered in the Russian Federation, to protect the rights of consumers and effect a uniform state policy for the provision of high-quality pharmaceuticals to the population.
- 88.** Order of the Ministry of Health of the RF “On the ministerial programme of development of nurses’ profession in the Russian Federation” of 9 January 2001 (No. 4).
- 89.** Decision of the Government of the RF “On confirmation of a Regulation about licensing medical activity” of 21 April 2001 (No. 402), determining the order of licensing of medical activity carried out by legal entities and individual businesses, and canceling a number of previous decisions.
- 90.** Order of the Ministry of Health of the RF “On organization of medical care for the population of the Chechen Republic in medical establishments of a Southern Federal Region” of 16 May 2001 (No. 161/34).
- 91.** Order of the Ministry of Health of the RF “On measures for prevention of the spread of sexually transmitted diseases” of 23 May 2001 (No. 171).
- 92.** Order of the Ministry of Health of the RF “On implementation of the Decision of the Government of the Russian Federation of 2 June 2001, No. 90 ‘On the procedure of social rehabilitation of people who suffered as a result of terrorist acts’ ” of 28 May 2001 (No. 173), providing for medical care for the victims.
- 93.** Federal Law of the RF “On the prevention of the spread of tuberculosis in the Russian Federation” of 18 June 2001 (No. 77), establishing the legal basis for policy on the prevention of tuberculosis.

⁸³ This refers to the State committee which develops and approves standards in different kinds of activity.

94. Order of the Ministry of Health of the RF “On a national calendar of preventive inoculations and calendar of inoculations under epidemic indications” of 27 June 2001 (No. 229).
95. Federal Law of the RF “On restriction of tobacco smoking” of 10 July 2001 (No. 87), defining the legal basis of restriction of smoking for the purpose of decreasing morbidity and mortality of the population, adjusting activity on manufacture, wholesale trade, retail sale and advertizing of tobacco products.
96. Decision of the Government of the RF “On the Territorial Guaranteed Package Programme providing free medical services to citizens of the Russian Federation” of 24 July 2001 (No. 550), introducing changes to the Decision of the Government of 11 September 1998 (No. 1016) establishing the volume and types of services to be provided, and providing for increases in the volume of free medical services in outpatient care.
97. Concept “On development of public health and medical science and goals for 2001-2005 and the period up to 2010” extending the Concept of 1997 to 2010 (see item no. 54).
98. Decision of the Government of the RF “On state regulation of prices of pharmaceuticals” of 9 November 2001 (No. 782).

Draft laws

Draft law “On patients’ rights”.

Draft law “On regulation of private medical activity”. The constitution of the Russian Federation and the rules of the civil code provide an opportunity for private activity in the area of health services. Private practice is in fact growing rapidly, but the absence of appropriate legislation leads to widespread underground activity and loss of tax revenues, thus making legislative regulation of this process a matter of great urgency. This draft law attempts to provide a regulatory framework for private activity in the health sector.

Draft law “On public health care services in the Russian Federation” develops more precise rules governing activities in health care provision. Consideration

is given to state, municipal and private services, with priority to increasing federal budget financing of health authorities in subjects of the Russian Federation in order to assist in covering the needs of medical and health establishments; restores vertical authority to the Federal Ministry of Health, to be enforced throughout the Federation; establishes equal opportunities for all health care establishments with respect to contracting with voluntary health insurance organizations regardless of form or type of ownership; stresses the role of state regulation of health care and outlines the scope of state health policy, emphasizing State responsibility for the health of the population. The draft passed the first hearing in the State Duma at the end of 1999. The Duma's Committee on Health is still working on this draft. The main opposition comes from the Government, which cannot afford to increase budget financing of the health system as stipulated in the Draft.

There are several proposals in a Draft law "On additions and changes in the Law "On health insurance", suggesting changes in the mandatory health insurance system. These proposals include (a) restructuring the mandatory health insurance system by changing the mode of collecting taxes; (b) making territorial health insurance funds regional divisions of the federal fund; (c) having the federal government pay health insurance contributions for the entire non-working population; (d) establishing additional conditions for the development of competition between insurers and between providers.

Legislation in the subjects

According to clause 72 of the Constitution of Russian Federation, the legislative basis for public health care services is to be jointly provided by the Russian Federation and the subjects thereof. The subjects bear a significant share of the responsibility for the health status of the population in the territories, as well as for the organization, management, and financing of services and public health care establishments, and have the right to enact legislation to be enforced within their territories.

More than 300 laws devoted to health and health care have been passed in the subjects of the Russian Federation. Some of these elaborate upon the federal laws, or provide some modification to the federal legislation in view of particular socio-economic conditions of territories, or other local characteristics. Some laws have also been passed which do not have any analogous legislation on the federal level, such as for example, "On patients' rights" in Republic of Karelia and Saratov area; "On protection of the rights of the child" in the Tula and Orel areas; "On the rights and guarantees of citizens on creation of a family" in the Ivanovo area; and "On primary medical care" in Republic of Karelia.

Health for all policy

A “Health for all policy” has not been officially adopted, although in 1997 there was a ministerial recommendation that it be officially incorporated into Russian health policy. Nonetheless, there is widespread acceptance of the principles set out by “Health for all”, and both its content and its strategic guidelines inform the health sector reform process within the Russian Federation (69,70).

A health care strategic concept was developed in 1997 and adopted by the Chernomyrdin government, but there appears to be no mechanism to implement it. Neither is there any federally established framework for action by the regions, and the Ministry of Health has not always shown enthusiasm for such initiatives as the regions have managed.

Note on legislation in the Russian Federation

As the section *Content of reforms and legislation* suggests, there has been a massive proliferation of legislative acts related to health and health care in the period since 1991. And yet this list is in fact quite selective and incomplete. It may be noted that in the 1996–1997 session alone, 79 instruments related to health and social issues were adopted (58). In the period 1991–1998, approximately 1500 new laws (in all areas) were adopted by the Federal Assembly, while in the next three years about 600 new laws were passed (71).

This extraordinary build-up of laws and other legal instruments over a relatively short period of time was prompted by the overwhelming desire to make a clean break from the Soviet past and create a legal system virtually from scratch, and in virtually every key area: civil, administrative, constitutional, financial, etc. This has led, however, to gaps, repetitions, inconsistencies, both internal and intertextual contradictions and a general lack of coherence in the laws. The legal system is too large and complex, yet also incomplete, vague, incohesive, and sometimes driven by narrow interest groups or bureaucratic pressures. Often the laws remain uninformed by the existing knowledge base, or lack the necessary implementation mechanisms or financial and administrative resources, or run into contradictions between federal mandates and regional directives (71). Thus, while addressing real problems, the laws often do not lead to their solution.

A likely corollary of a legal system which is undergoing the problems of rapid change is that there will inevitably be enormous room for maneuvering, and circumventing its rules. Perhaps this is even more so due to the Soviet legacy, where rules were so numerous and stringent that the system inadvertently fostered rule evasion for the purposes of survival (72). The situation is made

all the more difficult due to the inability to enforce compliance. Weaknesses in enforcement are compounded by the weakness of the federal centre in relation to the growing authority of the regions.

Reform implementation

The reforms to the health system of the Russian Federation are so far-reaching and the country so vast and diverse that it is not a simple matter to assess their implementation.

There has been a very real and major decentralization of power with the passing of legal responsibilities for the population's health to local government bodies and the withdrawal of the Ministry of Health from planning, regulation and management. There is now scope for local authorities to guide policy-making and customize provision to local needs. Where insurance companies operate there has also been a shift of authority to nongovernmental third-party payers. There is, however, considerable evidence that not all regions and districts are able to meet the responsibilities devolved to them. There is a lack of financial and managerial capacity that has led to a decision-making vacuum in some areas. Furthermore, a danger has emerged that the health care system may collapse into numerous segmented systems. In very recent years, therefore, there has been an effort on the part of the Ministry of Health to engage in negotiations with the regions as part of an initiative to re-assert its control.

The picture with regard to health insurance is even more mixed. The health care financing legislation of 1991 and 1993, arguably was an overly ambitious effort to overhaul the system practically overnight. It stipulated a highly complex set of new financing mechanisms based on numerous borrowed ideas, quickly assembled into a system untried and untested anywhere in the world. To further complicate matters, all this was undertaken under conditions of extreme economic crisis, political instability, with a highly incomplete and fragmentary legal system, and with limited administrative and managerial resources. Against such a background, it may be more appropriate to suggest that it is a wonder that implementation of the health insurance legislation has worked as well as it has, rather than to say that implementation has failed to live up to expectations.

The extent to which the mechanisms foreseen by the legislation have actually come into being varies. The federal Mandatory Health Insurance Fund is in place and each of the territorial MHIFs has been legally constituted. However, the inability of some employers to meet their obligations to make payroll-based contributions and especially the failure of local governments to make contributions on behalf of their non-working populations, have meant that the

income accruing to the funds varies widely and generally falls short of target revenues. Continued mixed financing mechanisms for providers (from insurance and budgetary sources) produce conflicting signals which do not allow providers to reap the full benefits of changes in financing and remuneration methods. Perhaps most importantly, resources available to the health sector have not increased as was originally hoped, and the system continues to be short of funds.⁸⁴

The role of insurance companies also differs from that envisaged in the legislation. Although it was never the intention of the reforms to set limits to the care available under the basic package, the actual mode of operation of the insurance companies has removed any incentives for them to encourage providers to contain costs and improve efficiencies. This issue is one that requires serious attention, in view of the Soviet legacy of a highly inefficient health care system that wastes already scarce resources.

Another unresolved problem is the unrealistic level of state commitments to the benefits package, in view of the dire financial constraints faced by budgetary and health insurance funding sources. The government appears to be unable to face up to the necessity of introducing cost-sharing in health care services, although under-the-table, de facto cost sharing is in place, with highly inequalitarian implications.

On a more positive note, the reforms have helped generate a sense of accountability and cost-consciousness among many of the entities and professionals in the health care system, along with the acquisition of new financial, managerial and administrative skills. In addition, there is evidence suggesting that while the implementation of the mandatory health insurance system has not increased the total amount of funds available to health care, as was originally hoped, it has likely insulated a portion of health care financing from the fluctuations of economy activity (unlike tax financing).

Various actors have contributed to the formulation of reforms and to their implementation but the Ministry of Health and the various research centres and academics who have consulted with the ministry have been the most crucial in drawing up detailed reform proposals. Doctors and other health care providers have not taken a key role in this and have been relatively powerless as a group compared to their counterparts in much of the rest of Europe. Individual doctors however, have been involved in the reforms in all spheres, from politics to policy formulation.

⁸⁴ It may be noted that relative to its level of income, health care expenditure as a share of GDP in the Russian Federation is a reasonable fraction. This is because, in general, lower income countries tend to have lower shares of health care spending in GDP, and vice versa. However, due to widespread inefficiencies, including the use of many irrelevant, non-evidence-based interventions, available resources are greatly overstretched.

Nongovernmental organizations and population or user groups have also played little part in the formulation of the reforms and are only now beginning to establish themselves. There was considerable ambivalence on the part of the authors of the health reforms and traditional providers as to the potential for involvement of such groups. However, international organizations advising on the reform process are anxious to see the nongovernmental and not-for-profit sectors actively involved.

Multilateral and bilateral inputs have tended to be at the level of offering advice and technical assistance rather than substantial resource inputs. In addition, international experience and the various existing models of health sector financing have proved highly influential in offering possible approaches to change and fuelling debate.

While there are differences in approach among key actors, there was considerable consensus at the time the reforms were first put forward. The fact that the various interest groups were prepared to put their differences aside is an indicator of how seriously the crisis in the health sector was taken. The lack of experience of private enterprise and the insecurity of the economy have combined to make unworkable parts of a plan that was perhaps overly optimistic in the first instance. There was simply not enough economic or financial stability nor enough resources to allow the reforms to succeed as originally envisaged. Equally important was the extent to which the reforms presupposed a level of managerial and technical skill in the provinces which simply was not available. How the system now responds and where the balance among the various funding mechanisms lies remains to be seen.

The success of the reforms has been further compromised by the general lack of direction of the government with regard to health care in recent years, and equally importantly, the lack of a commitment to the principle of making real improvements in the health care system.

The directions pursued by the Ministry of Health with regard to health system development still rest on the 1997 "Concept of health care and medical science development in the Russian Federation". This was a major document upon which reform was (and is) to be based. Nominally, there are four main priorities emerging from this concept:

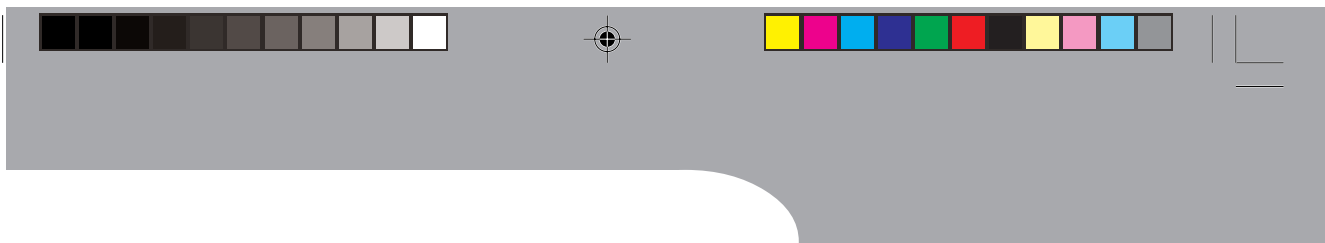
- health promotion, prevention and attention to lifestyles
- primary care development based on family practice
- de-emphasizing secondary and tertiary care
- quality of care.

However, the document is very general, does not specify targets and therefore, cannot form the basis of programme formulation and implementation. There appears to be no clear idea where the reform is headed and this prevents concrete goal-oriented actions. Ideas abound but they are too disparate, conflicting and vaguely formulated to form the basis of a realistic programme. Key obstacles to developing a coherent and pragmatic health care policy can be summarized as follows:

- Despite statements to the contrary, health and health care are not government priorities.
- The Ministry of Health hesitates to take responsibility for making a concrete plan because there are too many uncertainties surrounding economic and social policy development.
- There is a lack of sufficient technical expertise, political will and information on which to base a concrete policy.
- There is a shortage of financial and institutional resources to back up policy formulation and implementation.
- The regions have become quite autonomous and the Ministry of Health lacks the necessary authority over them to enforce a policy on a national level.

Recent efforts on the part of the Ministry of Health to reassert its control over the regions may presage a greater interest in and commitment to addressing the problems of the health care system.





Conclusions

The reforms of the health system in the Russian Federation were undertaken at a time of great upheaval and in response to pressing demands. The system is still very much in transition but some broad conclusions can be drawn.

The threat to equity posed by the breakdown of services in the areas most effected by economic crisis in the early 1990s was acknowledged by planners and policy-makers. The reforms were drawn up with a clear aim of preserving access to a basic package of care for the whole population. The assumption at the outset was that the efficiency savings that would come about from the reform process would be sufficient to cover the costs of the minimum requirements. This has not proved to be the case. Further, the insurance mechanism did not lead to an explicit priority-setting process. Rather, de facto rationing now takes place without scrutiny. There are very serious threats to equity due to growing differences in economic performance and capability across regions, with implications for the regions' capacities in services provision. In addition, as the system comes to be increasingly financed out-of-pocket and under-the-table, in the absence of a formal cost-sharing mechanism in place, equity is clearly being compromised.

Health status in the early part of the 1990s was severely affected. In the first instance this was the result of the long-term shortcomings of the Soviet health care system, which failed to anticipate the epidemiological shift or to address the huge importance of noncommunicable diseases. Even more significant was the massive downturn in health indicators associated with the economic chaos following the break-up of the Soviet state. This evidently interrupted effective health care delivery but most critically appears to have directly impacted on individual health, most likely as a result of the stresses associated with great

Russian Federation

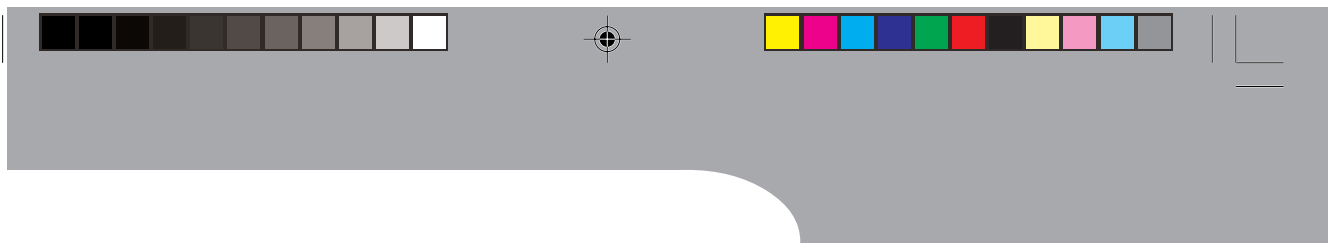
uncertainty and economic collapse and increases in alcohol consumption in times of stress. The reforms, by rationalizing the health care delivery system, were meant to free resources to address health needs more effectively. However, health indicators continue to be dismal, and although the reforms were intended to create incentives to shift the emphasis of care and to take appropriate action in the primary and preventive arena in time to secure real health gains, this has not happened.

Efficiency may have been enhanced in those units able to use incentives effectively, but it is very difficult to make any overall comments, since so much of what takes place is the result of crisis management. However it can be concluded that efficiency gains have not been made to the extent hoped, and this is in large measure due to the incomplete implementation of the health insurance legislation, and the only partial functioning of insurance companies as envisaged by the legislation.

Consumer choice has not been expanded, also contrary to what was stipulated in the legislation, except where consumers are able to pay, in which case they freely choose providers. It appears, too, that the quality of care has only improved in the private sector.

It is unfair to attribute all the evident shortcomings to failures in the reform process, but it does seem clear that the reforms were over-ambitious in some respects. The economic background has made all reform and planning-related tasks extraordinarily difficult, but the urgent need to address health issues overrode the possibility of waiting for the situation to stabilize before embarking on a reform process.

It is possible that the concept of reforms introduced through the new health care financing mechanism was biased excessively in favour of the perception that the fundamental problem in the health care system was a lack of sufficient resources. As a result, the issues of health, quality of care, effectiveness and efficiency in the use of resources, received too little attention as issues in their own right demanding separate consideration. It is not that these issues were ignored. It was believed, rather, they would be effectively addressed indirectly and automatically as a consequence of the workings of the internal market that was being created through the establishment of the health insurance system. The market was perceived as a panacea for resource shortages and the other ills of the system. It has not proved to be so, and the Russian health care system now faces the challenge of trying to secure health gains despite huge uncertainties and formidable constraints.



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