Health Care Systems in Transition

Russian Federation
Keywords

DELIVERY OF HEALTH CARE
EVALUATION STUDIES
FINANCING, HEALTH
HEALTH CARE REFORM
HEALTH SYSTEMS PLANS – organization and administration
RUSSIAN FEDERATION

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World Health Organization
Regional Office for Europe
Copenhagen
1998
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Health care systems in transition — Finland
Foreword

The Health Care Systems in Transition (HiT) profiles are country-based documents that provide an analytical description of the health care system and of any reform programmes under development. HiTs form the basis of the information system on health care systems and reforms at the World Health Organization Regional Office for Europe (WHO/Europe).

The aim of the HiT initiative is to provide relevant comparative information to support the development of health care systems and reforms in countries in the European Region of WHO. This initiative has four main objectives:

- to learn about different approaches to financing, organization and delivery of health care services in the European Region of WHO;
- to describe the process and content of health care reform programmes and to monitor their implementation;
- to highlight common challenges and areas that require more in-depth analysis and which could benefit in particular from cooperation and exchange of experiences between countries;
- to provide a tool for dissemination and exchange of information on health care systems and reform strategies between different countries in the WHO European Region.

The HiT profiles are produced by country experts in collaboration with staff in WHO/Europe’s Health Systems Analysis programme. In order to maximize comparability between countries, a standard template and a questionnaire have been developed. These provide detailed guidelines and specific questions, definitions and examples to assist in the process of developing the HiT profile. Quantitative data on health services are based on the WHO/Europe health for all database, OECD health data and World Bank data.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on health care systems and the impact of health reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries. As a result, some statements and judgements may be coloured by personal interpretation. In addition, the wide diversity of systems in the WHO European Region means that there are inevitably large differences in understanding and terminology. As far as possible, these have been addressed by the development of a set of definitions, but some differences may remain. These caveats are not limited to the HiT profiles, however, but apply to most attempts to study health care systems.

The HiT profiles are a source of descriptive, up-to-date and comparative information on health care systems, which should enable policy-makers to identify key experiences relevant to their own national situation. They constitute a comprehensive source of information which can form the basis for more in-depth comparative analysis of reforms. The current series of HiT profiles covers over half of the countries in the European Region. This is an ongoing initiative with plans to extend coverage to all countries in the Region, to update the material at regular intervals and to monitor reforms over the longer term.

World Health Organization
Regional Office for Europe
Department of Health Policy and Services
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Acknowledgements

The current series of the Health Care Systems in Transition profiles has been prepared by a team led by Josep Figueras and comprising Tom Marshall, Martin McKee, Suszy Lessof, Ellie Tragakes (regional editors) and Phyllis Dahl (administrative support, data analysis and production) in the Health Systems Analysis programme, Department of Health Policy and Services, WHO Regional Office for Europe.

Data on health services were extracted from the WHO/Europe health for all database. Special thanks are extended to OECD for the data on health services in western European countries, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries.

The HiT on Russian Federation was written by Suszy Lessof and Valery Tchernjavski and edited by Suszy Lessof.
Introduction and historical background

Introductory overview and historical background

Political Transition and Health Status

The Russian Federation has a population of 147.9 million people (1995), 72.9% living in urban areas. It covers 17.08 million square kilometres and is enormously diverse with 75 distinct nationalities, numerous ethnic groups, languages and religions. All health matters on Russian territory; of health status; of health care organization; and of health system financing; have been profoundly affected by the break-up of the former Soviet Union and the creation of the Federation. A highly centralized, command economy has been replaced by an increasingly loose grouping of states and all those areas of certainty, guaranteed by the Soviet monolith are now open to negotiation. Russian health services are no exception and against a background of economic and political turmoil, planners and providers are struggling to adapt structures and regulations to a new and uncertain environment.

The central health related achievements of the Soviet Union; the provision of universal coverage and equitable access to health care; belied the fact that health status was poor in comparison with other industrialized nations. The last thirty years of Soviet power saw the population of the former socialist economy fall further behind their western counterparts in a number of key indicators. However, the uneven decline in life expectancy experienced over an extended period pales into insignificance besides the current magnitude of the increase in mortality rates.

There has been a dramatic rise in mortality, which is both unprecedented in a twentieth century industrial nation and exceptionally costly in human terms. Since 1990 Russian male life expectancy at birth has declined by seven years and in 1994 was 57.3, on a par with Pakistan. Female life expectancy has been less profoundly affected but across the population as a whole 1 000 000 extra Russian deaths have occurred since the creation of the Russian Federation, which would not have occurred had the age and sex specific death rates for 1991 been maintained. While death rates now appear to have stabilized, the gap with the West remains catastrophic and a possible block to the reform process.

The main causes of death are diseases of the cardiovascular system; neoplasms; trauma and poisoning (external causes) and diseases of the respiratory tract. Against a background of wide regional variations, national averages for mortality increased for cardiovascular disease by 7.5%; for neoplasms by 7.3%; for external causes by 191.2% and for respiratory tract diseases by 1%. When reviewed in terms of number of years of life lost the figures for external causes

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2 ibid
are particularly worrying since trauma and accidents primarily affect younger and middle aged adults.

Data on morbidity is less reliable due to a shift from recording prevalence to recording incidence only. However, there has been a fall in number of days work lost through illness over the last few years which might suggest a fall in general morbidity. This picture is confused by the large number of ‘lay-offs’ over the same period and the increasing employment insecurity which may have led people to minimize days of sick leave taken. Certainly there has been a resurgence in particular infectious diseases, at least in part due to a breakdown in the supply of drugs for immunization/vaccination programmes and treatment. Again there are wide regional variations but cases of diphtheria, tuberculosis and whooping cough have all risen.

Broader environmental health factors are also problematic with the historical tendency of industry to pollute likely to increase as central regulation and enforcement of health and safety standards break down.

As worrying is the health behaviour of Russian citizens and the decline in wider health indicators which suggest a long-term picture of raised morbidity and mortality figures. Alcohol and cigarette consumption are high and nutritional status poor which bodes ill for the future. The Russian Longitudinal Monitoring Survey tracked health indicators from September 1993 to December 1994 and revealed a 136% increase in the male consumption of alcohol in grams and a 71% increase in females although the proportion of the population abstaining from drink increased slightly over the same period. Male smoking remains high but constant at just below 60% while female smoking showed a 25% prevalence increase over the same period. However, many of the new, female smokers appear not to smoke heavily as the mean number of cigarettes consumed by women has decreased.

Dietary patterns are problematic with a continued reliance on high levels of energy intake from fat despite a slight decline over the period of the survey. Children derived 32–36% of total calories from fat, adults of 18–59, 34–38% and the elderly (60 and over), 30–36% compared with recommended levels of 30%. Protein intake has remained largely constant and the shift therefore, has been to carbohydrates or alcohol. Nutritional status, as reflected by the body mass index, demonstrated that the adult population while predominantly within normal ranges from 18–29 years, show increased levels of both overweight and obesity in the 30–59 years group and particularly high levels over sixty. 36.8% of 30-59 year olds were overweight in December 1994 and 20.7% were obese, while 37.7% of the elderly were overweight and 27% obese at the same point. The survey demonstrated that rather than the problems of underweight, which were widely held to affect the elderly, obesity posed a greater threat to health and was increasing.

Children’s nutritional status is more worrying with an increase in the prevalence of stunting; an indicator of chronic malnutrition; among children of two and under. This problem appears to have doubled between September 1992 and August 1993 and to remain high. At the outset of the survey 6.9% of infants from 0–24 months were stunted compared to 12.8% in December 1994. Children from 25 months to 6 years old showed less evidence of an increase in stunting although levels were higher at the outset with 9% falling into this category in 1992 and 10.4% in 1994. Other child health indicators are as distressing with up to 12% of the country’s

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3 Source: Data of the Ministry of Health of Russia, 1993
4 ibid
6 From 27.7 g to 65.5g
7 From 8.7g-14.9g
8 Male smoking shows a very slight decline from 59.8% in Sept 1992 to 59.4% in Dec 1994
9 From 7.5% to 9.4%
10 Problems in defining terminology mean these figures should be treated with caution.
11 Only 1.8% of the elderly (60+) were underweight at the start and finish of this survey period.
classified invalids being children. Definitions of ill health are unclear but a State Report\textsuperscript{12} estimated that the health condition of 53\% of primary school children had deteriorated and that only 20-25\% of all children completing the primary education cycle and only 3-4\% of secondary school graduates (in St. Petersburg) were ‘healthy’. Other estimates suggest that by the year 2000 some 60\% of all school children will be suffering from at least one chronic disease\textsuperscript{13}. The fact that these fears are articulated at all is telling.

Morbidity of newborns also gives cause for profound concern, estimates vary but it is believed that at birth up to 20\% have some disability and that only 35\% are ‘fully healthy’. Projections suggest that by the year 2000 no more than 15\% of newborns will meet criteria for full fitness. Infant mortality is also high with 18 deaths per 1000 deliveries in 1992 and up to 20/1000 in 1993. Figures may be falling again as the issues in the most seriously affected regions are addressed.

Women’s health, while it has been less affected in terms of mortality, is also severely compromised, particularly in relation to reproductive health. Maternal death rates are 51.6 per 100,000 live births (1993)\textsuperscript{14}, five to ten times international levels, with particularly high rural rates. A high percentage of maternal deaths are due to abortion complications (29.4\%), haemorrhagia (13.8\%) and toxaemia (12\%) of which 60\% are believed to be avoidable\textsuperscript{15}. Access to birth control is still a major issue and abortion, following clandestine traditions established during the pro-natalist policy of the Stalinist era, remains the major form of contraception. Again statistics are problematic due to shifting definitions but Russia appears to lead the world in terminations with 224.62\textsuperscript{16} induced abortions per 100 live births in 1992\textsuperscript{17}. The maternal mortality data demonstrates that these figures alone constitute a major health risk, on top of which estimates suggests that complications adversely effect 40\% of surviving women. Use of the pill and intrauterine devices is particularly low with marked regional variations (13-46.2/1000 and 66.7–278.3/1000 respectively\textsuperscript{18}). Overall only 18\% of Russian women use contraception.

**Political Transition and the Economic Impact on Health Status**

The above suggests profound problems in the long-term burden of disease in the Russian Federation. Poverty clearly plays a significant role in the situation and the growing economic uncertainties can only exacerbate the current difficulties. Lack of indexation and poor data give an inaccurate picture of change but immediately after the Russian Federation was established there was rampant inflation and a profound erosion of personal income followed by what appears to have been a relative ‘boom’ during 1994. This in turn has been succeeded by a second wave of inflation and a fall in real wages. It is commonplace for employers to be unable to meet wages bills and the practice of paying salaries two to three months in arrears is widespread. There are also considerable seasonal fluctuation in employment and income patterns, with variations of up to 15-22\% in monthly income\textsuperscript{19}. Indebtedness (of employers to employees) remains high in 1996 despite which population expenditure patterns are relatively constant\textsuperscript{20} although personal savings are likely to fall.

\textsuperscript{13} Russia; Dr V.E.Tchernjavsky in International Handbook of Public Health ed K. Harrelmann and U. Laaser, Greenwood Press, 1996
\textsuperscript{14} Vital and Health Statistics; Russian Federation and United States, Selected Years 1980-1993, National Centre for Health Statistics, Vital Health Statistics 5 (9), 1995
\textsuperscript{15} Russia; Dr V. E. Tchernjavsky op cit
\textsuperscript{16} Excludes illegal and some commercial abortions.
\textsuperscript{17} Official data of the Ministry of Health of Russia, 1993
\textsuperscript{18} Andrej A Popov, Family Planning and Induced Abortion In the Post Soviet Russia of the Early 1990’s: the Unmet Needs in Information Supply, Moscow, 1994
\textsuperscript{19} I. Kolosnitsyn, Income of Natural Persons; Russian Economy: Trends and Perspectives, February 1996
\textsuperscript{20} I. Kolosnitsyn, Incomes of Population; Russian Economy: Trends and Perspectives, March 1996
Differentiation of income, which escalated enormously in the aftermath of federation, has now slowed with the labour payment ‘gap’ having stabilized to a significant extent. The role of ‘social transfers’, i.e. state retirement or disability pensions, has become increasingly important as a share of personal income and may amount to as much as 60% of the total. The adjustment of pension indexation has done much to ensure that compensation levels have remained constant, thus protecting the more vulnerable sub-groups of the population.

Notwithstanding, the pace of economic and political change has been uneven with enormous variability in the rates and types of change in different oblasts over time. Bouts of rapid inflation have particularly affected old people and children dependent on state support. Despite expectations that the elderly living alone would suffer from greater extremes of poverty, it has been shown that it is the elderly living in households with other adults under the age of 60 and with children who are most at risk. 16.8% of the elderly living in extended households had an income of less than 50% of the official poverty line in contrast to 7.9% of the elderly living alone in December 1994. However, these figures were a substantial increase on September 1992 which suggests that poverty is a growing threat to the health status of the elderly.

There has also been a marked shift in the distribution of poverty overall from the elderly to children, the working poor and the unemployed during this period. 40% of children in 1992 and over 46% in 1993 were poor, almost double the rates of the elderly while in December 1994, 60.7% of pre-school children were ‘poor’ in contrast to 27.6% of the elderly. The suggestion is that the population over 60 are protected to some extent by their access to plots of land for the cultivation of food stuffs and to charitable donations, resources unavailable to families with children.

Real income cuts, the reduction in family income linked to the increase in part-time working and the stress associated with economic instability may all be expected to worsen health indicators in the Russian Federation. Furthermore, the economic condition of the country threatens the sustainability of the health care delivery system.

Industrial output and gross national product have declined dramatically exerting enormous pressure on health budgets while the increasing autonomy of the various republics and regions have seen the reemergence of inequalities across the country. Federal reserves are low and the government assets in the form of nationalized enterprises have been sold off in a headlong rush, in part to fund current expenditure. There has been little attempt to foster strategic investment or to develop the structure of industry long term, which raises concerns about long term economic stability. The depletion of state holdings also reduces the government’s scope to generate additional funds in the future. Privatization has now slowed but only after what may prove to have been a damaging episode to the fiscal standing of the state. Since health care funds depend on wider economic performance this situation prompts concerns about the long term future of the health system.

**Health System Reform: A Response to the Challenges of Political Transition**

The Soviet system, despite its many and profound flaws, represented a very real achievement. It provided a basis for community health activities including mandatory immunization and periodic health checks and fostered a generation committed to solidarity in health care provision. Despite the enormous challenges facing the country, the belief in a health care system centered on need rather than ability to pay remains intact. There is though, a growing awareness of the necessity of increased efficiency and a real desire to enhance user satisfaction.

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21 B.M.Popkin, N.Zohoori; Elderly Nutrition In Russia : Is There a Public Health Problem; April 1995
22 T. Mroz, B.Popkin; Poverty and the Economic Transition in the Russian Federation; EconDevelCult Change, 1994
23 S.Smirnov, Incomplete Employment Gives No Reason for Anxiety; Russian Economy: Trends and Perspectives, February 1996
24 A.Radygin, Privitization; Russian Economy: Trends and Perspectives, January 1996
These concerns coupled with a recognition of the need to address issues of sustainability have prompted a major reform of the health system centered 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 reform process of the Russian Federation.
**Historical Background**

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 center 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 Mongolian control from the 12th until the late 15th century when Muscovy, having achieved prominence, gained liberation from Mongolia and reunited the subjugated principalities in a Russian state. Under Tsar Peter I (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 (1812-13), Russia was recognized as a great power, though it remained an autocratic state with a primarily agrarian economy based on feudal serfdom. Serfdom was not abolished until 1861.

By the end of the 19th century, industrialization was underway in a number of cities and was associated with increased urbanization and a growing proletariat. Health care provision was patchy but there were some attempts at offering Bismarckian style health insurance in urban areas while the local government Zemstvo system provided a degree of coverage in rural settings. The State tended to foster initiatives focused on public health, sanitation and the control of infectious diseases rather than care delivery. Poor economic conditions contributed to strikes and riots in 1905, which led Tsar Nicholas II to initiate some constitutional reforms. In early 1917, following the catastrophic conduct of the First World War, 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. A civil war ensued (1918-1920) and the Union of Soviet Socialist Republics was formed (1922), in which Russia became the dominant force. The experience of the civil war and the subsequent famine were devastating in health terms with much of the existing infra-structure destroyed and a long term health burden created. The Second World War (1941-1945) following, as it did so soon after the establishment of the Soviet Union was catastrophic. Again the emerging health infrastructure was devastated and, quite apart from the enormous loss of life incurred, a generation with severely compromised health was created.

The post-war governments of the Soviet Union were influenced both by the experience of epidemics consequent on war and famine and by their political belief in the preeminence of the worker. They tended to focus activities both on the control of infectious diseases and the delivery of health care through the place of work. 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. A network of rehabilitation and recuperation centers were fully resourced and were 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. The epidemiological shift of the 1960s saw the government unprepared to respond both psychologically and in terms of capacity. There was a reluctance to accept the growing impact of non-communicable diseases and an institutional inability to re-gear the health system. Rather governments chose to suppress data and to create yet more beds. The Brezhnev era saw annual health checks extended to the entire population. This ‘dispensarizate’ was largely unfunded, overstretched the primary care system and prompted the creation of still more bed spaces.

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26 The USSR entered the war later than much of the rest of Europe
27 Dr Elena Varavikova - work in progress
The consequence of these preoccupations can still be felt 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 with little thought as to how any needs detected will be met, has also persisted. 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 deprioritized their pay and conditions. The fact that the bulk 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.

From the mid-1980s Soviet hegemony began to wane and a liberalization of central planning in the form of perestroika (restructuring) and glasnost (openness) allowed for experimentation in health care organization. The Kemorovo and Leningrad models (launched in 1988) did much to inform recent policy changes. They were intended to allow health system managers greater flexibility and control of resources which, it was hoped, would lead to greater responsiveness to patient needs and ultimately to a stronger focus on primary care. The Kemorovo scheme saw per capita funding for the local population placed in the hands of polyclinics who acted as purchasers of care for their patient ‘list’. Polyclinic budgets included an allowance for diagnostic tests, hospital referrals, care and emergency services. Hospitals were contracted to provide care, on a case-payment basis, often by autonomous groups of general practitioners within polyclinics, constituted as free-standing, secondary fund-holding teams. Hospitals also established autonomous teams with their own clinical budgets. 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.

In early 1992, Kemorovo piloted a compulsory health insurance programme through the ‘Kuzbass’ or sickness fund. The Kuzbass collects income related contributions from employers and subsidies from the local authorities and distributes them to local branches who compete with commercial insurers. 20% of the market is private and complex regulations guard against risk selection and ensure an equitable redistribution of funds across the region. It is interesting to note, in light of the national insurance premium agreed subsequently, that payroll contributions in Kemorovo were set at just over 10%.

The St. Petersburg model 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 gynecologist and covering a population of 8,000. 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. Performance related compensation was introduced at the group practice level with a weighted ranking system based on specific indicators i.e. days disability, delayed diagnosis, vaccination levels, complications, complaints etc. forming 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 belief that the ability to retain savings made at the primary level would encourage a reduction in the tendency to over-refer to specialists was borne out in practice. In the first four years of the Kemorovo pilot bed numbers were reduced by 1,500 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 17 to 19 days over the same period. 2,500 beds were deemed to have become redundant some of which were converted to long term nursing care. Some restructuring of secondary care was also

28 Kemorovo is an industrial/mining oblast in south west Siberia with a population of 3.5 million.
29 St Petersburg has a population of five million and is served by numerous polyclinics, 100 hospitals, 29 research centres and four medical education institutes all participating in the experimental scheme.
evident following the assumption of a greater part of the burden of care in the primary setting. Paediatric, trauma, and general surgical beds fell while there was an increase in capacity in specialized areas like oncology and orology.

Efficiency savings were made and in Kemorovo 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 from financial rather than clinical motives. Some of the benefits of the schemes also seems to have fallen away as the economic situation has worsened, raising doubts about sustainability. Nonetheless these models have been enormously powerful in defining the scope of the current reform process.

Perestroika and glasnost led to an uncontainable pressure for change. A failed coup attempt by hard-liners in October 1991, saw all Soviet republics declare independence, and on 25 December 1991 the USSR was formally abolished. A new Russian constitution was adopted with a two-chamber Parliament replacing the Supreme Soviet. The country has continued to experience rapid change and a degree of conflict (including a further failed coup attempt in Autumn 1993). Economic pressures have been enormous and the implications for health status deeply problematic. It is against this background that health sector reform is now taking place.
Organizational structure and management

Organizational structure of the health care system

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 U.S.S.R which in turn oversaw Ministries of Health within the 15 Soviet Socialist Republics. 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 had little policy formation role 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 and
- Sanatoria and Resorts.

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

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 centers (some with beds and clinics); specialist republican hospitals and polyclinics (out-patient centers); nursing schools and sanatoria. The republican administration also directly controlled oblast San-Epid stations responsible for monitoring infectious disease, environmental hazards etc. and oblast nursing schools.

The regular 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 out-patient services at a ‘state’ level and monitored rayon bodies, the next tier of administration down. Rayons oversaw smaller territories or districts and provided a central hospital and out-patient services (polyclinics). There were further rural councils providing uchastok hospitals and in remote areas either doctor led ambulatory clinics or feldsher-midwife stations.

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 were was a degree of conflict over the relative responsibilities of the two hierarchies the similarities in structure allowed for a relatively smooth incorporation of the two bodies. Sanitary and epidemiological services were upgraded and constituted as the State Committee of Sanitary Epidemiological Surveillance. This new quasi-autonomous status included responsibility for the Federal Quarantine Institution, regional Centers for Sanitary-Epidemiological Surveillance and some Epidemiological Institutions, and was the only major change in ministerial structure. It was intended to insure the independence of health services monitoring and to highlight the health status trends identified. In addition in 1991 the Academy of Medical Sciences of USSR responsible for medical research was re-established as a Russian Academy of Medical Sciences and made independent.

1993 saw the establishment of a mandatory health insurance system (detailed elsewhere) and with it the separation out of may of the funding responsibilities of the Ministry of Health. These are now located within the health insurance system under the supervision of the Federal Mandatory Health Insurance Fund (FMHIF). The Ministry of Health retains oversight of this fund’s administration and governance although the Fund has its own Executive Board reviewing performance and policy. The FMHIF regulates the operation of Territorial Mandatory Health Insurance Funds (TMHIF) that are congruent to existing oblasts. These in turn may supervise Branch Health Insurance Funds (BHIF) that are acting, in the short term as insurers of the local population. However, in the long term TMHIFs are expected to contract with private insurance companies who will be the main purchasers of care.

In August 1996, Sanitary-Epidemiological Surveillance was reintegrated into the Ministry as a department and responsibility for Medical Industry (private and state owned) 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. The organizational structure of the health system is as detailed below;

**Figure 1 Organizational chart: admin. structure of the statutory health system** [see Russian Federation -Health Care System 1993 on - (Mikko on disc) to update (1996 on) to show San-Epid reintegrated into MoH; also to delete MoSocial Protection which is now part of MoLabour and to drop Industry from the title as this has reverted to trade & ind]

**The Ministry of Health** is the highest administrative level, headed by a minister appointed by Parliament. It continues to be the central policy formulating body for the Russian Federation and retains nominal rights to oversee the work and decisions devolved to the regions. However, the level of power enjoyed by the oblasts has grown substantially, particularly in budget setting and the Ministry no longer expects to command compliance to all central directives. Medical and nursing education continue to be within its scope, as is disaster and relief management and epidemiological monitoring at a national level is once more within its remit. Its official responsibilities, carried out together with the San-Epid network of health centers include:

- state policy in health care;
- federal health programmes, including initiatives on diabetes, tuberculosis, health promotion, health education, disease prevention and forensic medicine;
- management of Federal medical establishments;
- quality assurance;
- professional undergraduate and postgraduate training in medicine and nursing;
- major capital investments in the health care system (buildings and equipment);
- epidemiological and environmental health monitoring and health statistics ;
- developing methodologies for health planning, workforce planning and policy
- the control of drugs and food additives;
- disaster relief.
The Role of Other Ministries in the Health System as in all countries the Ministry of Finance has a significant role in health care in that it determines levels of funding available. However, even in the Soviet era, direct central government allocations (as opposed to locally levied taxes) are believed to have accounted for no more than 3% of finances and the economic pressures on the Ministry of Finance make any advance on this figure unlikely. The Ministry continues to formulate national budgets and to recommend spending levels for local government. In addition surveillance, programmes for particular disease groups and certain types of capital expenditure are financed from federal sources.

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

The Role of Other Ministries and Public Enterprises as Providers of Health Care; as in many former socialist economies Ministries often run their own parallel health services. The Ministries of Defence, the Interior and of Transport all have polyclinic and hospital networks. In total over 20 Ministries provide health care directly although as structures change periodically it is difficult to give exact figures. In addition, large public enterprises continue to house health care providers and to subsidize their activities. Again it is difficult to estimate exact levels as industry is in a state of flux and firms under pressure to make profits are likely to divest themselves of health care provision. The level of funding provided through these routes is also unclear since data is not collected centrally.

Statutory Bodies; The Oblast, Autonomous or Krai Health Departments; govern regional health care. Although they no longer handle all health sector funds they are expected to finance up to 60% of costs and so retain a significant role. They report to the Russian Ministry of Health on narrow medical issues and ensure compliance with federal programmes, in particular those focused on the control of conditions and infectious diseases defined as of high social priority. Otherwise they enjoy considerable autonomy within their administrative units. Some Health Departments are clearly heavily involved in setting reform agendas, monitoring quality etc. while others have abrogated many of their responsibilities to TMHIFs and serve only as final arbiters in local disputes.

Statutory Bodies; Rayons; at a local level District Health Authorities or Rayons (DHAs) take on the executive role although again there is enormous variation in how this remit is interpreted. In many larger cities rayon authorities appear to be actively engaged in the reform process while in rural areas, the functions of health authorities have tended to become the responsibility of heads of central district hospitals.

Statutory Bodies; The Federal, Territorial and Branch Mandatory Health Insurance Funds; are responsible for the collection and allocation of the earmarked social insurance contribution. The Federal fund deducts 0.2% from the payroll contribution in order to allow for the equalization of resources across regions. It is also charged with oversight of the TMHIFs and their activities and with a policy setting role. There are 82 TMHIFs which act in lieu of DHAs in managing regional health budgets and appointing insurance companies to purchase care for local populations. It is the role of the TMHIF to monitor the activity of the companies, ensure quality of care and to encourage competition between third party payers. TMHIFs are also guarantors of care for the entire population and are obliged to make provision for those citizens failing to arrange their own insurance. In those regions which are as yet unable to support a free-standing insurance company, TMHIFs are empowered to establish Branch Funds which act as short term insurers. In this instance BHIFs enter into contracts with providers to purchase care.

Insurance Organizations; the 1993 reform of the system involved the creation of independent third party payers i.e. insurance companies who are charged with purchasing health care on behalf of local populations. Insurance companies play a role more closely aligned with the
Organization and Management of Care Consumption model\textsuperscript{30} (OMCC) than of insurers per se. They are obliged to cover all members of a local population and frequently have little choice as to care providers. Their position as regards the bearing of risk has still to be clarified but early experience suggests that it is the TMHIF rather than the companies themselves who absorb losses resulting from activity levels in excess of budget provision. Insurance companies tend to be private, joint-stock organizations and to negotiate contracts with providers on a case payment rather than a per capita basis. Their role was to include monitoring of utilization and quality and they were expected to encourage a shift of emphasis to both primary care and preventive measures. It is too early to judge their success to date but their evolution has not been entirely as expected.

**The Private Sector;** private provision, while legally permissible, has yet to develop to a significant extent. Hospitals are entitled to charge for services not included in the basic package but it appears that this generates no more than 5\% of income. It also appears that the majority of paid services are commissioned under voluntary insurance schemes managed by private insurers, rather than by individuals. The ‘closed’ clinics and hospitals of the Soviet era i.e. those state institutions that catered to the nomenklatura and were not generally accessible, absorb most of such private care provision.

Ownership of hospitals, however, remains almost exclusively in the public sector. Legal uncertainty around the security of leases purchased form the state have discouraged a wholesale shift to private ownership\textsuperscript{31}. The option of creating not-for-profit or ‘trust’ status hospitals is also problematic with considerable uncertainty around the tax position of charitable institutions and general hostility from statal bodies to the encroachment of non-governmental organizations into their traditional spheres of activity\textsuperscript{32}.

It is only in pharmaceutical supply that private provision is fully established although dentistry and ophthalmology follow closely behind in developing a commercial sector. Out-patient drugs are not covered by the basic package and must be bought from pharmacies, which were among the first wave of enterprises to be privatized. All but the most basic dental services are available on a fee-for service basis only and the provision of dentures and other prostheses are largely through the private sector.

**Professional Groups;** the Soviet Union had a wide range of scientific and professional associations but they never established a tradition of genuine independence. The creation of the Russian Federation has seen the emergence of more autonomous groupings, although the number of competing organizations in existence at independence 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. 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 are increasingly being approached by the insurance industry with a view to securing their support.

The Soviet tradition of clinicians taking on research and policy making roles persists and although policy institutes are restricted in their access to research funds\textsuperscript{33}, 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 of Health is always medically qualified. This secures the medical professions a certain degree of access to decision-makers and ensures a sympathetic hearing of professional concerns.

\textsuperscript{30} D. Chernichovsky and E. Potapchik; Needed Financial Mechanisms Under the Russian Health Insurance Legislation and Health System Reform, 1995

\textsuperscript{31} G. Malginov; Small Scale Privitization in 1995; op cit, Feb 1996

\textsuperscript{32} S. Shishkin; Non-commercial Sector of Economy Legal Area Formation; Russian Economy: Trends and Perspectives Jan 1996

\textsuperscript{33} I. Dezhina; Science Sphere: Financial Crisis at the Beginning of 1996; Russian Economy: Trends and Perspectives, Feb 1996
**The Voluntary Sector**: the voluntary or non-governmental sector is still underdeveloped and faces hostility from many traditional, statal agencies and uncertainty around its legal position. 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 ambiguity around liabilities, tax status, commercial activities and regulation persist\(^3\)_43.

Nonetheless, non-governmental organizations have been encouraged by international agencies and although they tend not to be in a position to deliver services themselves are developing a role as advocates for particular interest groups.

While much of the structure of the Soviet health system has been retained there have been profound organizational modifications most particularly in the establishment of Federal and Territorial Mandatory Health Insurance Funds. The perceived problems of rigidity and over-centralization have been addressed but there are difficulties in the operation of the new structures and in particular in the relationships between them. Lines of communication tend to be ad hoc and there are groups of issues that fall between the sphere of responsibility of the reconstituted administrative bodies. In addition to the lack of coordination between centers of authority, it is clear that in some of the more remote regions the organizational capacity assumed by the reform process is lacking and there are lacunae in the provision of health sector authority and accountability.

The direction of future adjustments to 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.

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\(^{34}\)S. Shishkin; Non-commercial Sector of Economy Legal Area Formation; *op cit*, Jan 1996
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 centralised, but all three were carried out in line with policies and standards determined at the level of the Soviet Ministry of Health. The post-1991 decentralization process however, has been so rapid and so far reaching that there are fears that there may be a breakdown of core planning and regulatory mechanisms. Further, the strains placed on the management structures that were in place in the soviet era are such that their ability to cope is threatened. Certainly the pace of the process has compromised systemic functionality in these areas.

The range and depth of the changes taking place does much to explain these difficulties. There has been a move from an integrated model with little distinction between third party payers and providers to a contract model. There are now clear separations between provider and purchaser functions, at least in those areas that have proved able to implement key reforms. Although providers continue to be, in large part, state owned, third party payments are channelled through public insurance funds and private sector insurance company purchasers rather than through local health committees. Purchaser-provider relationships are now governed by contract shifting the burden of planning and of quality control, if not regulation, to a new and relatively untested style of organisation.

Nominally, the Ministry of Health has retained responsibility for oversight of the entire system; local government owns and monitors health care institutions; and insurance funds 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 supra national ‘norms’ and the production of human resources. Planners relied on a formulaic approach which allowed historical incrementalism to dominate. The key building block was bed numbers, 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 standardised mortality data, which conferred a greater degree of equity, but there was little response to local conditions. Nor did the system reflect international trends that saw increasing attention paid to primary care and preventive measures. 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 approach to planning. The authority of central bodies to outline norms for the whole country has been rescinded and the various planning roles at a regional or local level have yet to be clearly assigned.

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 Mandatory Health Insurance Funds might be expected to take on a priority setting role yet are not 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 which determined activity in the soviet era. Health departments in the oblasts, krais, autonomous regions and rayons still have a vested interest in capital and human resource planning which affect the facilities they own and the staff they are responsible for but tend to face severe economic constraints and to be uncertain 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.

These 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 Ministry of Health sets budget targets for oblast health expenditure but regions are frequently unable to raise sufficient moneys to comply because of local financial constraints. 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. It is clear that a degree of regional variation has entered the system which defies central target setting and conflicts 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 for the formulation of health care plans and indeed, has informed the setting of priorities centrally. 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 funding of TMHIFs in different regions imperils the ability of the health service to respond to the federal agenda. There is not, therefore, an effective national health plan. Neither are there clearly stated regional plans, nor is there a single body at the oblast level with responsibility for producing such plans. The division of funding, commissioning and provider activities is not supported by any formal coordinating mechanisms between TMHIFs, insurers and local government and responsibility for planning has fallen by the way side.

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 TMHIFs and health authorities were to discourage any abuses, as opposed to initiating policy development. However, in practice case payments have edged out per-capita allowances and 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 monopsomy and this has rendered the incentives to plan and refocus policy ineffective.

Furthermore, many areas feel profoundly threatened by economic conditions and the prevailing 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 need 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 previous ability to plan bed and staff numbers has been compromised by financial constraints, which 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 yet to seriously undermine the health care delivery system but it does bode ill for future attempts to plan.

The production of doctors and nurses are still the subject of forecasting carried out by the Ministry of Health at a 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 specialities 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 local governments (the main employers of health service staff), on occasion, close facilities and make staff redundant with little warning. None of the certainties of the soviet era, whether of the ratio of doctors to beds or nurses to population, remain intact and there is no planning response that can accommodate the vagaries of current practice.

At the moment there is little perceived need to invest in new hospitals or clinics but there is considerable demand for moneys for equipment and for repairs to existing buildings. Capital allocations, are in the main, included within the per capita allocation made to insurance companies. They, in turn, are expected to include a component in case-payments to hospitals and polyclinics to cover maintenance and recurrent expenditure. It is also expected that providers apply to insurance companies for grants for the acquisition of equipment and diagnostic tools. Only major investments are to be funded from federal budgets and these are to be determined on the basis on need and equity.

In practice, where investment is taking place, it is funded by local government. Rostov oblast financed the opening of a remote nephrolithotripsy laboratory and equipped a resuscitation center and outreach teams. In Murmansk oblast ultrasound, endoscopy and laprascopic equipment have been procured for all central rayon and central city hospitals. However, there has been little attempt to integrate these acquisitions into a national policy nor do they contribute to any coherent local plan. Rather these acquisitions seem to reflect the fact that certain oblasts have surplus funds and are disposed to make one off purchases for the health sector. In contrast, many regions report a complete interruption of investment. Kursk oblast has closed 14 of 63 district hospitals and has seen the primary sector devastated. There have been no capital inputs nor is there a capital expenditure plan. In Yaroslav there was insufficient funding to meet more than 60% of in-patients’ nutritional requirements, while in Saratov hospitals could not afford bandages, let alone new equipment. Attempts to link capital allocation to utilization rates through insurance companies’ case payments have failed. Instead the role of local government as the provider of capital continues, but without the constraints or regulation that operated in the soviet era.

It is the rapid shift to regional autonomy, above all else, that has undermined planning efforts. The impact of decentralisation 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 significant choices on a purely ad hoc basis and often in response to overwhelming financial pressure. It is clear that many areas lack both the financial and the human resources to take on the burden of policy making and priority setting. Nor are there adequate mechanisms to ensure any plans made are translated into action.

35Dr V.E. Tchernjavsky; Some Regional Examples of Health Care Reforms in Russia, 1996
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 many areas have fallen back on 'historical precedents' established under the command economy and show few signs of developing a new or rational approach to planning. Implementation also appears to be very much hit and miss except in those areas privileged in financial terms or in human resources. It is unclear how the more disadvantaged oblasts will cope in the absence of federal guidance as the situation becomes increasingly stretched and as the previous models of decision-making become ever more irrelevant.

**Regulation**

Regulation has also been 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 supply and 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.

Decentralisation means that regulatory powers have been devolved to a significant degree. The Ministry of Health continues to play an important part in setting policy at a federal level but it no longer has the authority to intervene in the interpretation of standards locally. Rather increasing responsibility has been placed on the health departments or committees of local authorities as the enforcers of national guidelines with Mandatory Health Insurance Funds expected to play a lesser role in demanding that quality criteria be met. The fact that health care facilities are owned by the local government authorities themselves is not regarded as creating any significant conflict of interests in terms of regulation.

The ability of health departments to fulfil their role appears to vary significantly across regions and in accordance with the resources and skills at their disposal. In those areas that are struggling to maintain a basic service monitoring and regulation appear to have been crowded out. Although no statutory regulatory powers were vested in territorial and branch insurance funds, where they enter into contracts with providers they are expected to stipulate the quality of care required. Market forces, (in particular the ability of third party payers to take their custom elsewhere), were expected to ensure that hospitals and clinics complied with these criteria. However, the lack of competition between providers undermines the ability of insurance funds to exert influence on standards.

The San-Epid network continues to play a national role in regulation and to report to the federal Ministry of Health. It has powers to enforce legislation relating to hygiene and sanitary conditions and environmental health issues. It appears that the inspection of facilities and the monitoring of matters within the network’s jurisdiction continues despite the changes that have taken place. However, the ability to impose compliance with standards has been compromised.

Pharmaceuticals are subject to regulation at various points in the chain of supply. The manufacture of pharmaceuticals is under the auspices of the federal Ministry of Health which licenses production and the San-Epid network who are responsible for ensuring that production

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36 Territorial and branch insurance funds are regulated by the Federal Mandatory Health Insurance Fund which has national responsibility for purchasing authorities.
processes are not environmentally damaging. Neither body seems able to maintain an active regulatory presence. Imports of drugs are under the oversight of the Ministry but again, little active monitoring or regulation goes on although the supply of controlled drugs is policed. Pharmaceuticals are dispensed either through hospitals, where they remain free of charge, or via pharmacists which may be in either the public or the private sector. Chief doctors are responsible for prescribing to inpatients while local authorities check standards in pharmacists regardless of ownership. There is no attempt to limit the number of outlets opening privately although dispensing staff must be qualified and local taxes paid but there are caps on the prices that may be charged, as a percentage of costs. Again, enforcement of regulations by local government is extremely patchy.

Controls over the acquisition of high technology have also fallen into disuse and although production and import of equipment is nominally still subject to Ministry oversight the centre no longer has the power to dictate policy to the regions. 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 powers to challenge hospital or clinic purchasing decisions. However, in practice, health authorities are highly influential since they fund most purchases (as insurance funds have yet to play a major part in acquisitions) and have an overall responsibility for health care facilities. There does not appear to be an agreed approach to evaluating requests for equipment or for judging their clinical merits. Nor is there evidence of any systematic review of existing equipment, its condition or the quality of maintenance. Health committees appear to be susceptible to requests for sophisticated equipment and when funds become available often support such investments rather than blocking them or imposing stated commitments to weight funding towards primary care.

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 relevant skills training 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 no license is required for staff to carry out particular procedures, although such a scheme has been mooted. Qualification confers the right to practice. The Soviet system of requiring doctors to attend post-graduate/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, however, they do so because it is seen as a route to advancement and can lead to salary bonuses and not because the requirement is enforced. Doctors who do not chose to seek recognition of their increasing experience through the upgrading procedures in place 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.

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 are using clear quality criteria. While they do have the right to review physical conditions, staff qualifications and medical practice and ultimately to close facilities, the reality is that most local authorities are heavily involved in seeking to keep services going rather than in regulating providers.

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

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37 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.
Despite this trend towards the decentralisation of regulation, there are areas of government surveillance that are carried out on a national level. The insurance funds are scrutinised by the Federal Mandatory Health Insurance Fund which monitors the performance and financial probity of territorial funds and seeks to make funding adjustments that will restore equity across regions. The FMHIF 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 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 private medical schools. It liaises with the Ministry of Education to oversee standards, monitors 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 no longer able to scrutinise closely the quality of local regulatory procedures. Nor is it able 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 and a three year programme for family doctors/general practitioners developed. However, as with undergraduate education once the core content has been agreed and the quality criteria are put in place it is the oblast health departments who are on site and able to scrutinise activity locally.

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 collapse 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 respond to demands in an ad hoc manner and without taking a long term view. It is unclear what the future holds but there are no plans to introduce further regulatory bodies, rather it is hoped that the general situation will stabilise allowing existing bodies and insurance funds to carry out their roles more effectively.

**Management**

One of the aims of the reform process and indeed of Soviet experiments with the New Economic Mechanism was to ‘liberalize’ management. Previously the planning and regulation 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 were working within such clearly prescribed constraints that there was little scope for effective management intervention.

The Kemorovo experiment was among the first to attempt to empower individual hospital managers allowing them the discretion to adjust staffing levels, hire and fire, negotiate pay and bonus packages and make demands of staff in terms of performance. They were also given a degree of financial autonomy and allowed to income generate and retain profits within the hospital or polyclinic. This approach while it is allowed for within the new insurance scheme is not the basic model advocated, rather insurance funds are to make purchasing decisions independently of providers. However, the shift in managerial role has been widely generalized and has been transferred from the soviet context into the new Russian setting.
The focus on empowering individual managers and allowing them greater control of their own institutions typifies the approach to management reform. It has sought to effect managerial change from the bottom up but has not fully grasped the need for strategic management of overarching health care issues. Primary care, secondary and tertiary providers are all managed increasingly independently and at the level of the institution. 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 as a whole at a district or regional level. There are no well-defined mechanisms that allow management to feedback into the planning process or visa versa. Only the national standards set by the Ministry of Health and the population’s basic entitlement to care place shared obligations and constraints on health systems managers.

Hospital and polyclinic directors now have extended rights, although the legal basis of some i.e. the ability to sack staff, are questionable. The chief doctor is in effect the general manager and is responsible for budgets, financial administration and income generation. This includes negotiating and signing contracts with insurance companies, or directly with employers or making the arrangements necessary 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 associated with invoices and contract management has prompted complaints. Similarly, there are concerns about the heightened stress that comes with the growing responsibilities for issues that are effectively beyond the control of individual managers.

Lines of accountability have been clouded by the reform of the financing system and the disruption to the regulatory mechanisms that has followed on decentralisation. Local health authorities, as the owners of institutions and the formal guarantor 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 body to scrutinise activity nor are they required to do so. Indeed, there is no provision for meaningful citizen’s 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 associated with ensuring efficiency, effectiveness and humanity of care. They have also, by default, to take on some of the strategic decision making at the level of the oblast or region under the auspices of the TMHIF.

The heads of Territorial Mandatory Health Insurance Funds 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 experience or expertise to allow them to take a truly proactive role or to be able to guarantee quality local inputs. Planning is largely based on past practice and custom. This is part because the entitlement of the population to the basic package of care constrains the choices of purchasers. 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 harness scientific evidence to meet the information needs of commissioning agencies. The epidemiological data required to carry out a needs assessment is collected and ‘owned’ by the San-Epid network, who are not tied into the structures of the health insurance fund system. Nor is the information that is routinely gathered, geared to advising local purchasing strategies. 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 then is in line with centrally set minimum requirements and past practice and not a more 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. Hospitals and polyclinics cannot be expected to take an overview of regional issues and the Ministry of Health no longer involves itself actively in oblast decisions. The local government bodies or Health Committees who, in the past, might have taken on this role are compromised in that much of funding no longer passes through their hands thus weakening 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 are then ad hoc responses to local issues that no longer benefit from an overall regional management perspective, although this does vary widely across the country with some areas coping significantly better than others.

**Decentralization of the health care system**

Until the late 1980s the management of the health services in the former Soviet Union was completely centralized. The Ministry of Health of the USSR regulated management and resource allocation throughout the whole system via the Republican Ministries of Health and there was little scope for customized responses to local needs. Even within the Soviet system however, this came to be seen as unsatisfactory and a number of initiatives were mounted to test out the scope for decentralization. These pilots were still underway at the break up of the USSR but the value of decentralization in terms of creating incentives for efficiency and encouraging cost containment had been clearly demonstrated. These successes, together with the emerging demand for regions to be allowed greater autonomy and an increasing sense that centralization was politically unacceptable set the scene for the dispersal of power.

The new government of the Russian Federation has taken a number of steps to decentralise the health care system. The law of March 1992\(^3\) specifically grants rights to the citizens of the Russian Federation to determine the scope of health sector financing and to take on responsibility for the management of health care and medical establishments with a view to securing the maintenance of health for all citizens. This act implicitly shifted the burden of responsibility for health care provision and financing to the local level and made health care establishments increasingly dependent on the economic and management resources of the surrounding territory. It has resulted in the expression of decentralization in a variety of forms.

The first, the deconcentration of powers, is typified by the extent to which the Ministry of Health has allowed the oblast and rayon health committees to assume responsibility for the regulation of standards. The Ministry continues to determine those standards centrally and retains the ultimate authority to enforce them but it is sub-national bodies who have taken on the administrative task of monitoring compliance. Devolution, represents the passing of a greater degree of responsibility to regional or local government and implies some independence of decision making. The setting of budgets at the oblast, krai and rayon level are representative of powers that have been devolved. There is no longer an obligation to stay within national guidelines or to seek central approval for budgets set. This has allowed local government bodies to vary the degree of support they make available to the health sector locally and to redefine the terms of the funding provided for hospitals and clinics within their boundaries.

Perhaps the most significant form of decentralisation in the Russian federation is delegation and the most significant delegation of powers has been the creation of mandatory health insurance funds as third party payers. The whole structure of the insurance scheme is quasi-public with the FMHIF, TMHIF and BMHIFs falling outside the sphere of government despite remaining under overall government control. Federal and Territorial funds now exercise responsibility for the purchasing role carried out by branch funds and insurance companies and so effectively control the flow of public funds to providers. In theory at least the major roles in the prioritising of health care needs and the planning of provision are filled by a series of non-governmental bodies. This represents a major step away from the conventional soviet model.

\(^3\) Law of the Russian Federation No2449-1
Although safe guards are in place to ensure access to a basic package of care and despite an ongoing commitment to equity in health matters this allows for a degree of variation between regions that would have been an anathema to soviet planners.

Privatization is the final form of decentralisation and it has been a feature of the Russian health reforms in a number of ways. The new purchaser provider split allows for the introduction of private insurance companies that will compete with each other in offering cover for populations at a local level. These companies represent the privatization of the state’s role as the guarantor of health care. The effective ban on the private provision of services has also been lifted and doctors, dentists and pharmacists may all operate in the private sector. Lastly there has been some privatization of health care facilities. The actual transfer of ownership of physical units of the health delivery system has been confined to pharmacies and some dental polyclinics but the principle whereby health can be offered for-profit is a major departure from the pre-1991 position.

While all the above have the potential to enhance choice within the system and to allow a greater responsiveness to the needs of local populations, the whole decentralisation process has been anything but unproblematic. The speed of the unravelling of central control has been immense and the responsibilities of local government, insurance funds and providers has burgeoned beyond the speed at which local bodies are able to keep pace.

There has been, in consequence, a breakdown of the main centres of authority with real gaps appearing. The regulatory system no longer functions effectively, since local government bodies are often too poorly resourced to measure conditions or quality of practice let alone to enforce standards. Furthermore, insurance funds lack the leverage they would require to impact on practice because they so often operate in conditions of monopoly or monopsomy. There is a distinct lack of coordination between centres of authority and therefore shortcomings in the carrying out of those functions which are shared or not clearly assigned to any one agency.

There are also very real issues about the capacity of the bodies to whom powers have been devolved or delegated to take on their new responsibilities. The formulaic, soviet approach to planning, regulation and management did not foster the organisational structures or skills needed to process local information, formulate appropriate priorities and act accordingly. Nor did it allow for horizontal connections to develop which might allow local networking or the sharing of best practice. Rather, the soviet system positively discouraged the exercising of individual initiative in official settings and fostered a cohort of risk-averse managers. These same people are now expected to rise to new challenges and to take on levels of responsibility that would have been unthinkable prior to 1991. The fact that they are often unsuited to the tasks at hand is to be expected. The number of regions and individuals who have risen to the new challenges effectively is perhaps more remarkable.

The strains on the health system imposed by the shift in power and the breakdown in authority is exacerbated by the fact that the legal framework governing private and privatized organisations has yet been properly established. 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. Even where not-for-profit organisations have sought to get involved in provision of services the legal situation has hampered their ability to take on what were government functions.

39 Branch Mandatory Health Insurance Funds are only meant to operate where no private company emerges.
40 A.Radygin op cit There are still legal doubts about the status of privatized enterprises. This uncertainty was reflected in the sharp drop in privatization in 1995 and prior to the election, which indicated the concerns of investors. Notwithstanding, pro-government banks have supported sales that produced short term income flows for government. This despite concerns that investors are cherry picking without regard to the long term structure of services, industry and their capital assets.
41 The federal law “On Charity Activities and Charity Organizations” (June 1995) and “On Non-Profit Organizations” (Dec 1995) failed to clarify the status of such organizations and have allowed the state to sustain its hostility to their activities.
The open ended liabilities of NGOs and their questionable tax status both restrict the extent to which charitable organisations have been able to function in the health sphere\textsuperscript{42}.

The impact of the decentralization of power continues then to be chaotic. While there has been a positive response to the enhanced scope for local inputs in some areas, in others the abolition of old certainties has left a vacuum. The tendency to abolish traditional mechanisms before new ones have been established has created real difficulties in areas of disadvantage and there is increasing evidence of inequalities entering the system. There are no plans to extent decentralisation at the moment but there is a real need to consolidate the reforms that have taken place and to address the needs that they have thrown up.

\textsuperscript{42} S. Shishkin, Non-Commercial Sectors of the Economy, Legal Area Formation, Jan 1996
Health care finance and expenditure

Main system of finance and coverage

The soviet system would have claimed to have paid for health care almost exclusively through compulsory, statutory systems of finance. Officially, the population were guaranteed comprehensive coverage, free at the point of use and were only asked to pay out-of-pocket for out-patient prescriptions. Health sector finances were tax based, in that they were collected by government, although local funds were derived from rental income rather than earnings related levies. Rayons covered the costs of the health care facilities within their boundaries except where these offered services to the oblast as a whole, when the oblast government was responsible for funding. The republican facilities were paid for from republican budgets while the All-Soviet Ministries of Health and Finance made some attempt to equalise income disparities between republics and to support USSR wide initiatives. There were no sin taxes as such and no earmarked insurance style 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 systems. There was no voluntary system prior to 1991 and only minimal amounts of private practice were officially tolerated. However, in practice patients frequently had to pay directly and out-of-pocket for services albeit under-the-table.

The new Russian federal, government was acutely aware both of the shortcomings of the previous system and of the difficulties of sustaining the ‘traditional’ approach to financing. The reliance on general taxation was regarded as unsustainable given the escalating costs of health care provision and the profound economic crisis that followed on the break up of the Soviet Union. Policy-makers wanted to find a way of increasing funds for the health system, protecting health budgets and introducing pressures towards efficiency while retaining free health care coverage for the entire population. They put forward a social insurance scheme to supplement the support for health from general taxation. This allowed the government to preserve the solidarity between high and low earners and those without income by relying on an obligatory public scheme to which the whole population had to subscribe. But it also allowed for far reaching changes including the creation of a role for private insurance companies in statutory provision and the introduction of market forces in purchase-provider relationships.

The Russian Federation therefore, introduced a compulsory social (or public) health insurance scheme in 1993 which was to be based on statutory, income related contributions by employers of 3.6% of the monthly salary paid (employees were to make no separate contribution). Central government fixed the rate and also stipulated that coverage was to be universal, based on citizenship and tied to residence of a region or district with local government paying matching contributions on behalf of all those not in employment to ensure ‘entitlement’. Insurance payments were to be collected by the mandatory health insurance system with the federal and territorial levels of the system taking on the role of guarantors of health care to local populations. At a branch or local level insurance funds or companies were to be the key third party payers or purchasers of health services. The population were to be

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44 The figure 3.6% is progressive and the total contribution has no ceiling – it includes 0.2% for a federal fund which adjusts income levels between regions.
45 This was to be in addition to the contribution from local taxation to the costs of health care providers.
entitled to choose between competing providers within their local area but were not to be allowed to opt-out of the system. Those on high incomes were given the right to purchase additional voluntary insurance but could not be denied their basic entitlement.

The federal fund (FMHIF) was to have oversight of the system as a whole, to be answerable to Parliament and in particular to monitor the activities of the 82 territorial bodies or TMHIF. The FMHIF was also to have a policy setting role and to subtract a 0.2% levy from funds to allow for the equalisation of resources flowing to different regions. The FMHIF is now in place and is exercising its role as envisaged.

The Territorial Mandatory Health Insurance Funds were to act as district or regional health authorities in respect of priority setting and the management of regional health budgets. They were to appoint insurance companies to purchase care for local populations and were held responsible for encouraging competition between third party payers. They were also charged with monitoring the activities and ensuring the quality of local purchasers. Where no private companies were able to take on the purchasing function, it was to be the job of the TMHIF to establish a Branch Fund (BMHIF) to act as the short term insurer of the local population. They were also legally obliged to make provision for those citizens failing to arrange their own insurance. TMHIFs are functioning, and have in practice been responsible for more local activity than was anticipated. They have had to appoint BMHIF in some regions and to take on the role of BMHIF in others and are, in effect, the guarantors of care for the entire population.

While the funds were set up as quasi-public bodies that were accountable upwards, ultimately to the federal level, the insurance system overall was envisaged as relying on private bodies as the actual purchasers of care. Independent insurance companies were expected to emerge and to compete with each other to act on behalf of local populations. They were to be obliged to cover all local residents to avoid cream skimming and were expected to contract with providers, exerting leverage to drive costs down and enhance efficiency and quality of care. Fewer of these companies than anticipated have come into existence and more BMHIFs and TMHIFs are covering their roles. Where private companies are operating it is not entirely as might have been envisaged. It was unclear at the time of the legislation how far these companies were expected to be risk bearing but as time has progressed it is evident that it is the TMHIF and not the companies who are absorbing losses where these are incurred. Insurance companies are normally structured as private, joint-stock organizations and do not have the wherewithal to withstand any substantial shortfalls of income relative to expenditure. They do negotiate contracts with providers as expected but on a case payment rather than a per capita basis and are increasingly playing a role along the lines of the Organization and Management of Care Consumption model (OMCC) rather than of conventional insurers. It is unclear how far they will be able to influence quality of care or patterns of utilization in practice or to what extent they will shift resources to primary care and preventive measures in the long term. In the short term however, they seem to be bound by custom and practice.

Overall, the social insurance scheme is operational although it cannot be said to be fully functional. The key structures are in place but the economic difficulties in many regions mean that payroll contributions are not forthcoming. In some areas political resistance to the changes coupled with the lack of funding has left the previous model of health care financing fundamentally intact. Even where there is support for the reformed model the lack of competition between providers (and indeed between insurance companies) prevents contracts from really delivering cost containment or quality improvements. Similarly, the failure to address the issues of risk sharing or risk-adjustment and the effective underwriting of private insurers by TMHIFs has meant that insurance companies have not taken on the full responsibilities anticipated by the reforms (see also payment of hospitals).

However, it must be stressed that the introduction of this new financing channel was not seen as superseding the role of general taxation. The aim of the insurance system was to earmark

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46 D. Chernichovsky and E. Potapchik; 1995 *op cit*
additional funds to supplement those already provided by the system. It was always intended that the contribution from general taxation was to continue\textsuperscript{47}.

Indeed, the calculations and guidance issued suggested that 30\% of income would be contribution led and 60\% would continue to be government provided. (This means in effect local government provided, since the federal mechanism only ever accounted some 5\% of revenues locally\textsuperscript{48}). The remaining 10\% was to come from other sources presumably the sale of services not covered by the basic package, contracts with employers for preferential treatment of staff and so on. There was never any official acceptance of the proposition that the salary linked contribution by employers and the matching contribution by local government for non-employed people should displace existing funds.

However, there is widespread evidence that displacement has taken place. Furthermore, there is evident confusion about what constitutes the governmental input of 60\% of finances. In some regions this is interpreted as including the contributions made for non-working population members while in others it is understood as being in addition to these contributions. It seems that the original intention of the legislation was that the per capita contributions be apart from the 60\% of ‘core’ funding but it has not proved possible to enforce this policy uniformly. Some areas do receive this ‘double’ stream of finances but in others government support to the health sector, above the payment of individual contributions, has all but ceased leaving an undue burden on the insurance component. In others still it is clear that government is failing to meet its obligation to make payments for individuals but continues to provide support to facilities in line with bed numbers and staffing levels, very much as in the soviet era.

There are elements of the system that continue to be funded outside this model for example the parallel health system of 20 plus other ministries. These provide polyclinics and health care for their employees and sometimes their dependants at the expense of their own ministerial budgets. The contribution these make and their relationship with the mandatory insurance model are poorly defined. Relevant financial information is not passed to the Ministry of Health but only to the Ministry of Finance, which does not disclose figures. More significantly it is unclear whether payroll related insurance contributions are made on behalf of employees who are covered under the parallel system.

Enterprise based health care provision may be included in this definition of the parallel system or viewed as another branch of health services. There was a strong soviet tradition of enterprise based medicine and there were, and continue to be, hospitals based at enterprises and also polyclinics. Traditionally these received some state subsidy and then supplemented the funds available in order to offer better services thus bringing additional resources into the health system. There have never been reliable figures for the amount of funding entering the health system through this route. The viability of this form of health care provision was called into question on the breakdown of the centralised soviet economy and with the increasing pressure on enterprises to make a profit. However, now employers are being asked to pay an insurance contribution of 3.6\% of the monthly salary bill it seems all the more unlikely that they will continue to subsidise health services. It is probable that they will divest themselves of their health care facilities thus ending the hidden subsidy that was made in terms of staff and equipment. It is unclear what impact this will have or what extra burden will be placed on local health services.

The current system may fairly be said to be in a state of flux. The move from tax-based funding to a statutory insurance scheme was never intended to achieve a complete switch from one financing mechanism to another but the current balance between the two has yet to reach a comfortable equilibrium. The introduction of a second stream of finances was prompted by a desire to secure additional funds for health care and to earmark these new moneys so that they were not diverted to meet other needs. This has been only been successful in certain areas and the parts of the country where extra funds have not become available are precisely those that

were most in need at the outset of the reform process. It was also hoped that the emergence of insurance companies and the shift to the commissioning of care would introduce pressures on providers to tailor provision to health needs and would contain costs. However, these benefits have yet to materialise largely because of the lack of competition between providers and insurers and the failure of the system to deal with risk effectively. The transition process is clearly hampered by a lack of skills at the local level and by real resource constraints which encourage short term responses and an over reliance on custom and practice.

At the moment the insurance system continues to undergo change in response to shifting conditions that it cannot control. However, planners and policy makers remain committed to the principle of a mixed financing base. They accept that legislation and practice are out of synch but prefer to wait for a clearer modus operandi to emerge before taking further action.

**Health care benefits and rationing**

The statutory health care system guarantees access to a comprehensive range of services for the entire population. Those in work are covered by insurance contributions made by employers while children, students, the disabled, pensioners and the unemployed are covered by contributions made on their behalf by local authorities. TMHIFs underwrite care for those who have not arranged insurance cover for themselves and in areas where the insurance scheme is not fully functional local authorities continue to fund health care facilities to treat patients on demand.

The federal government has sought to define the entitlement to care of the population on a number of occasions including in its ‘Basic Programme of Health Services’ in 1992\(^\text{49}\). The definition of the care to be provided is the same for the whole population and includes,

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

The above includes what is referred to as ‘the minimal volume’ of medical care in 29 medical specialities that include cardiology, rheumatology, gastroenterology, orthopaedics, obstetrics and gynaecology. The full list covers the standard range of secondary medical services and ‘the minimal volume’ of medical care is taken to mean the provision of all such care as can be medically justified.

In patient drugs are included in the basic package but the cost of pharmaceuticals prescribed to out-patients 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 i.e. veterans, children, diabetics etc.

Other legislation elaborating on this level of entitlement includes the Ministerial Order 146 of 21 June 1993 which specifies the rights of the working population to the basic package of care and the laws on the implementation of health insurance provision of 1992 and 1993 which specified the generalized right to diagnostic, curative and preventive services\(^\text{50}\). Despite the statement of the rights of the population there is also provision for a wide degree of regional

\(^{49}\) Government Order n 41, 23 January 1992

variation as long as the care available does not fall below the minimum standards specified. There are clearly increasing disparities across regions and services that area readily available in some areas may no longer be on offer in others.

There are also medical services which are explicitly excluded from the basic package of entitlement. These include:

- cosmetic surgery
- homeopathic or alternative therapies offered by practitioners with no medical qualification and other forms of ‘non-professional’ medicine
- 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 health centres other than those approved by the Ministry of Health
- training in emergency procedures and nursing and
- pharmaceuticals for out-patients.

There is also recognition of the right of medical staff to determine the most appropriate treatment and, therefore, to refuse to treat a patient who has referred themselves in line with the instructions of that patient. This has removed one of the more onerous entitlements of the population as guaranteed under the soviet constitution.

The rationale for these exclusions is mixed. In the cases of homeopathic therapy and rehabilitation outside the mainstream health care system they reflect concerns about the scientific evidence supporting the treatments offered. In the cases 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 the revisions to the definitions have 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 these and 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 on these grounds. Far more worrying is the fact that the system is so over-stretched in some areas that it cannot meet demand yet has no formal mechanisms for prioritising between competing needs.

Neither TMHIFs or insurance companies have yet come to terms with the fact that demand for dialysis, organ transplantation and other major surgery exceeds the capacity of the system to cope. In the absence of formal rationing guidelines, providers tend to take decisions using a variety of informal mechanisms. Unofficial waiting lists, under-the-table payments and the practice of requiring patient’s 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 tend to pose the threat that the worst off will get excluded. However, anecdotal evidence suggests that doctors try to compensate, asking patients with money to purchase more materials than they need and using the surplus supplies to treat poorer patients and so on. Although this ad hoc extension of the tax system to the sphere of the hospital itself may protect the poorest in the population, it does not resolve the issue of how rationing decisions are taken in the long term.

Policy-makers are unclear as to what response to make. There is a growing acknowledgement of the need to contain costs but a political reluctance to address the possibility of limiting the basic entitlement to care. It is likely then, that at least in the immediate future, no formal steps will be taken to reduce benefit coverage but that rationing will take place on an ad hoc basis.

51D. Chernichovsky, E.Potapchik, Jan 1995: Needed Financial Mechanisms Under the Russian Health Insurance Legislation and Health System Reform
Complementary sources of finance

The bulk of health sector finances come through the social insurance scheme and taxation. However, complementary sources of health service funding have always played some role and continue to be important. They include the parallel system of health care provided by ministries and employers as outlined above, some direct, out-of-pocket payments and some external support. It is extremely difficult to quantify the relative contributions of the different sources, not least because records are not available and some data is simply not collected. The table below sets out a rough estimated of the relative importance of different funds.

Table 1. Main sources of finance (%)

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Sources: various
* the cost of outpatient prescriptions is not included because, traditionally, they were not regarded as a health service expense
** includes the cost of outpatient prescriptions

The presumption is that in the 1980s and until 1990 all health service funds were derived from general taxation. This includes the contribution made by other ministries through their parallel systems and that of employers. This is because no clear figures are available for their relative contributions and because all those funds were from the public purse anyway (including those of the enterprises which were wholly, publicly owned). The experience of other countries in Eastern and Central Europe suggests that up to 10% of official expenditure on health services may have come from sources other than those governed by the Ministry of Health. The percentage of expenditure derived from taxation is shown as declining over time because of the introduction of statutory insurance. However, the figures for income from taxes in 1994–1996 continues to include the input of other ministries and employers although it seems likely that their share will have declined as enterprises shift their contributions into the insurance system.

The main difficulty in estimating the percentage contribution of the various sources of finance is the fact that no accurate figures are available for under-the-table payments. In the soviet era health care personnel routinely supplement their incomes through the widespread practice of accepting gratuities. The full extent of this was unknown not least because it was illegal. Attempts to collect figures were hampered by an official reluctance to accept what was happening and by the fact that payment 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 in particular in terms of the payment of doctors and nurses.

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52 Health Care Systems in Transition: Poland (1996 draft)
53 Anecdotal evidence suggests the bulk of these payments subsidised the income of staff, with very little going to purchase supplies or other medical goods.
It would appear that under-the-table payments continue to be a major source of funding today. This is despite hopes that the introduction of the insurance scheme would bring home to patients the fact that they have an entitlement to the basic package of care free of charge. Again it is impossible to estimate with any confidence the size of the contribution made by these payments but they do seem to represent an important subsidy to the salaries of staff. There is no attempt to include these unofficial contributions in the table above. Rather the figures shown as deriving from out-of-pocket payments reflect the cost of outpatient drugs and the growth of a market for private health care. Since the liberalisation of laws governing private practice and hospital management it has been possible to sell health care on a fee for service basis and this source of income has begun to expand, although very slowly. Figures are not accurate but it seems that up to 5% of revenues are secured in this manner (including pharmaceutical costs). The slow rate of growth in private practice may reflect the commitment of patients to public health services and/or the fact that the economy is depressed and not many people are able to afford private services. However, it seems likely that many of the treatments offered on a fee-for-service basis do not appear in the figures above because payment is made under the table to avoid tax liabilities.

External sources have never made a major contribution to health care financing and what aid there was, in response to 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 therefore not significant in terms of actual provision of health care to patients in the short term. What impact support for initiatives on primary care, mother and child health and capacity building have in the long term remains to be seen.

**Out-of-pocket payments**

The insurance scheme as it operates in the Russian Federation does not include provision for cost-sharing. Both official and unofficial out-of-pocket payments are entirely the responsibility of the patient.

There are no official charges for mainstream hospital or ambulatory services except for

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

Charging for dental care, for prescriptions for patients treated in the ambulatory setting and for prostheses were all standard soviet practice. There has been no significant growth in the number of services for which patients might be expected to pay within the mainstream setting. There has however, been appreciable inflation in the cost of pharmaceuticals as the private sector has taken on an increasing role in their import and distribution. This accounts for some growth in out-of-pocket payments between 1991 and 1996.

There has also been some growth in care offered on a fee-for-service basis. This follows on from a greater legal tolerance for ‘private’ practice and includes some supplementary services purchased in a hospital setting and some private consultations. The growth in this area cannot be measured accurately because figures are not reported to a central source and because the cost of pharmaceuticals tends to be included in estimates. However, out-of-pocket payments for drugs and privately purchased services seem to account for no more than 5% of health service funds.

The figure of 5% seems low, even for officially recognised out-of-pocket payments. This is because many of the most vulnerable groups in society are exempted from paying for
health care systems in transition — finland

pharmaceuticals so their drug requirements are not included in the amounts paid out-of-pocket. It is also because the development of private medicine and the growth of fee-for-service treatments are not fully reported as physicians attempt to reduce any tax liabilities by accepting legitimate fees under-the-table.

Under-the-table payments appear to make up a very significant proportion of out-of-pocket expenditure but it is impossible to quantify the phenomenon accurately or to be certain about the trend in payment levels. It was hoped that the reforms by specifying citizens’ rights and making it clearer that the population were already paying for health care through payroll contributions, would diminish the practice. However the failure of medical salaries to rise and the limited scope of incentive and profit sharing schemes to date suggest that little has changed.

It is hoped that in the future, as the reforms are consolidated and the economy stabilises all payments will go through official channels. This implies some growth in figures for out-of-pocket payments as a proportion of expenditure but does not necessarily suggest that there will be an increase in such payments in real terms. It remains to be seen where the balance between the care provided as part of the basic package and that which is paid for out-of-pocket will lie.

**Voluntary health insurance**

Voluntary health insurance was first authorized in 1991 and further legislation on its governance was passed the following year. It may be offered to individuals or to groups or collectives e.g. 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, although there is no bar to non-profit organisations entering the field.

Voluntary insurance plays only a very small part in the provision of health care in the Russian Federation with less than 1% of the population holding policies. This figure rises to between 2-4% in St. Petersburg and approximately 3-5% in Moscow but elsewhere subscriptions remain low and the share of expenditure derived from voluntary insurance overall is no more than 2%. 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. The 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 and 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. The benefits 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. However, the intention seems to be to extend coverage and to encourage take up rather than to address the issues of fast-track access to scarce resources and the emergence of a two-tier system.

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54 War veterans, T.B. sufferers, diabetics and another 28 categories of patients are exempted from charges on an agreed list of 96 essential drugs under Ministerial Order N 157, July 1994.
56 State Law on "Insurance Practice", November 1992
External sources of funding

External sources of finance do not include the contributions to health provision made by various ministries through their parallel health care systems or by enterprises. Rather they 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 and the aid provided on the collapse of the Soviet Union, went mostly to newly independent states.

The international assistance currently channelled into the country is in the form of technical expertise and support and is focussed chiefly on capacity building and on developing key policies. The extent to which World Bank, W.H.O and European Union backing is able to effect the achievement of long term objectives or impact on the delivery of health care will only become clear over time.
Health care expenditure

All figures for health care expenditure in the Russian Federation are problematic due to issues in the reporting of finances. The indicators widely used in OECD-countries are absent and make all international comparisons complex. Core areas of concern are the budget provided by the parallel health system which go unrecorded and the precise amount being spent in the various oblasts now exercising independent control and deviating from expected norms. In addition little is done to record the amounts of money raised by the sale of services within the hospital and polyclinic system and there is no way of recording the extent of under-the-table payments. Even those amounts spent out-of-pocket under official auspices (in particular expenditure on pharmaceuticals) are difficult to quantify.

Further complexity is added to estimates by the experience of rapid inflation and changes in governmental approaches to recording. Attempts at indexation have proved problematic but have taken as a benchmark expenditure levels in 1990-1991, at the break up of the Soviet Union. It appears against this fixed point that real spending has fallen and that there is inadequate provision within the system to meet basic needs.

Table 2. Trends in health care expenditure in the Russian Federation, 1970–1993

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<tbody>
<tr>
<td>Value in current prices (10 million roubles)</td>
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<td>Value in constant prices (10 million roubles)</td>
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<tr>
<td>Value in current prices, per capita (US $PPP)</td>
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<tr>
<td>Share of GDP (%)</td>
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<tr>
<td>Public as share of total expenditure on health care (%)</td>
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</table>

Source: OECD health data, 1996.

Russian figures show health care expenditure as a share of GDP as being low by international standards and as having fallen over the last ten years. They estimate that only 3.3% of GDP was devoted to the health sector in both 1991 and 1992, with 1994 and 1995 figures stabilising at between 3% and 4% (this in contrast with a quoted OECD average of 7.6% for 1990). This was in comparison with an estimated share of 9.1% in 1987 and of 12.3% in 1970\(^58\). These figures also place Russian Federation spending behind other central and eastern European countries\(^59\) and suggest a fall in spending per capita to a fourth of expected levels between 1991 and 1995\(^60\). Other sources have described health spending at a higher percentage share of GDP. WHO’s Health For All database, for example shows expenditure at 4.8% of GDP in 1994 (see Fig. 4).

These discrepancies notwithstanding, there is broad consensus on the situation in the Russian Federation. All parties agree that the collapse of the soviet economic system and the rampant inflation that followed on the establishment of the new state make it impossible to arrive at a set of precise figures. They also agree that the value of the rouble fell dramatically and that GDP collapsed thus making attempts to measure spending trends in terms of GDP all but

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\(^58\) Estimates based on Ministry of Health data.

\(^59\) Estimates given are the Czech Republic from 4-6% for the period 1981-1992, Hungary 4-5.3% for 1981-88, and Poland a 5.5% average for 1985-91.

\(^60\) V. N. Denisov Na puti k reforme zdravoohranenija. - Probl. soc.gigienny i ist.med. N 6, 1995. 36-37
meaningless. It is generally accepted that there was a sharp, real terms fall in public expenditure on health and that the system is experiencing considerable strain as a result.

The fact that health sector personnel are paid relatively low salaries (a legacy of the era when medical staff were defined as ‘unproductive’ and received less than factory workers), goes some way to protecting the purchasing power of the health budget. However, the privatization of pharmaceutical, energy and food supplies has created rapid inflation in the cost of these inputs. Prices for particular goods are comparable with those in countries with far higher GDP per capita and this places further strain on health budgets.

Fig. 1. Total and public health care expenditure as a share of GDP (%) in Western Europe, 1993

<table>
<thead>
<tr>
<th>Country</th>
<th>TOTAL</th>
<th>PUBLIC</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland</td>
<td>6.8</td>
<td>6.8</td>
<td>69</td>
</tr>
<tr>
<td>France</td>
<td>6.3</td>
<td>6.3</td>
<td>74</td>
</tr>
<tr>
<td>Austria</td>
<td>6.3</td>
<td>6.3</td>
<td>74</td>
</tr>
<tr>
<td>Finland</td>
<td>6.9</td>
<td>6.9</td>
<td>65</td>
</tr>
<tr>
<td>Netherlands</td>
<td>6.9</td>
<td>6.9</td>
<td>78.2</td>
</tr>
<tr>
<td>Germany</td>
<td>6.9</td>
<td>6.9</td>
<td>70</td>
</tr>
<tr>
<td>Italy</td>
<td>6.2</td>
<td>6.2</td>
<td>73.1</td>
</tr>
<tr>
<td>Iceland</td>
<td>7.4</td>
<td>7.4</td>
<td>83.9</td>
</tr>
<tr>
<td>Belgium</td>
<td>7.4</td>
<td>7.4</td>
<td>88.9</td>
</tr>
<tr>
<td>Norway</td>
<td>7.4</td>
<td>7.4</td>
<td>93.3</td>
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<tr>
<td>WE avg.</td>
<td>7.4</td>
<td>7.4</td>
<td>93.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>6.2</td>
<td>6.2</td>
<td>77.3</td>
</tr>
<tr>
<td>Spain</td>
<td>5.9</td>
<td>5.9</td>
<td>81.9</td>
</tr>
<tr>
<td>Portugal</td>
<td>4.1</td>
<td>4.1</td>
<td>76.6</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>5.1</td>
<td>5.1</td>
<td>84.8</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>5.3</td>
<td>5.3</td>
<td>91</td>
</tr>
<tr>
<td>Ireland</td>
<td>4.3</td>
<td>4.3</td>
<td>76.7</td>
</tr>
<tr>
<td>Denmark</td>
<td>3.9</td>
<td>3.9</td>
<td>92.6</td>
</tr>
<tr>
<td>Greece</td>
<td>1.4</td>
<td>1.4</td>
<td>75.8</td>
</tr>
<tr>
<td>Turkey</td>
<td>1.4</td>
<td>1.4</td>
<td>52.3</td>
</tr>
</tbody>
</table>


Fig. 2. Trends in health care expenditure as a share of GDP (%) in the Russian Federation and selected Western European countries, 1970–1993
It seems that unofficial and ‘private’ inputs have played an important part in bridging the deficit. The extent of these has not been effectively measured but the users of health services make significant contributions. Inpatients buy pharmaceuticals and disposable medical goods themselves, despite their constitutional rights to free hospital care, and subsidise staffing costs through under-the-table payments. Staff also underwrite the costs of health service provision, working for low salaries and continuing to turn up for work even when salary payments are three and four months in arrears (a not uncommon situation particularly from 1992–1994).

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 passed under-the-table or is not formally recorded. Nor is it possible to make comparisons over time when the currency has faced massive devaluation and huge swathes of economic activity now take place in the informal economy beyond the reach of tax collectors or those who estimate GDP. However, it is clear that the health sector faces real difficulties in securing sufficient resources to continue to function. What is most striking however, is the extent to which these difficulties vary between regions. Moscow, St. Petersburg and other urban centres appear to be managing well despite the formal economic indicators. It is the provinces and rural areas that seem to be experiencing the real stresses of the new order. Although, there was always some inequity in the soviet system standardised mortality data was used as a proxy for need and prompted some redistribution of funds. Under the new system inequalities appear to be widening and the real impact of the worst case scenario figures are being experienced.
Fig. 4. Total expenditure on health as a percentage of GDP in WHO’s European Region, 1994

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of GDP</th>
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<tbody>
<tr>
<td>Austria</td>
<td>9.7</td>
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<tr>
<td>France</td>
<td>9.7</td>
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<tr>
<td>Switzerland</td>
<td>9.6</td>
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<td>Germany</td>
<td>9.5</td>
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<td>Netherlands</td>
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<td>Italy</td>
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<td>Finland</td>
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<td>Israel</td>
<td>8.2</td>
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<td>Belgium</td>
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<tr>
<td>Iceland</td>
<td>8.1</td>
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<tr>
<td>Ireland</td>
<td>7.9</td>
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<tr>
<td>WE average</td>
<td>7.7</td>
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<tr>
<td>Austria</td>
<td>9.7</td>
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<td>France</td>
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<td>Switzerland</td>
<td>9.6</td>
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<td>Germany</td>
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<td>WE average</td>
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<td>Switzerland</td>
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<td>Germany</td>
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<td>Ireland</td>
<td>7.9</td>
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<tr>
<td>WE average</td>
<td>7.7</td>
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Source: OECD health data file, 1996; World Bank; WHO Regional Office for Europe, health for all database.
**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 over provision 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 indeed fill) unnecessary beds. By 1991 the bias towards hospital based care was deeply entrenched and hospitals were absorbing the lion’s share of resources.

The intention of the original reform programme was very much 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 money as efficiently as possible. To the planners of the reforms this implied shifting resources into primary care and preventive medicine. They saw this as containing costs and thus allowing insurance firms to take a reasonable profit. However, insurance companies do not often have the skills to be able to measure the most cost-efficient approaches. Nor do they tend to take the long-term view that would make investment in health promotion worthwhile. Instead they have tended to fall back on traditional patterns of provision and to perpetuate the imbalance between the secondary and primary sectors. The shift to billing on a fee per case basis, with the insurance company taking a percentage of the charges processed as a handling fee has only exacerbated this tendency to allow hospital expenses to continue unchecked.

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 that became outpatient specialists in polyclinics were only one rung higher in the pecking order. The best doctors were believed to go into hospital medicine and in consequence patients continue to push for referral to hospitals rather than accepting care in an ambulatory setting.

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 on year. This picture 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 money spent on capital investment has declined dramatically from a high point in the 1970s when building and expansion was taking place. Building programmes have ceased altogether and there has also been a marked decline in the money spent on equipment. 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. However, the percentage spent on inpatient care is largely static (see Table 3), despite statements by planners and policy makers that they would encourage a shift to primary care and preventive measures.

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61 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.
Table 3. Estimated health care expenditure by categories, as % of total expenditure on
health care 1970–1992

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<tbody>
<tr>
<td>Public (%)*</td>
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<tr>
<td>In Patient care (%)</td>
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<td>Pharmaceuticals (%)</td>
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<tr>
<td>Public investment (%)</td>
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* allows for under-the table payments

Source: OECD health data, 1996.
Health care delivery system

The Russian Federation inherited a health care system which was dominated by the Semashko model and by 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 which raged through the Soviet Union after the Civil and Great Patriotic Wars. The emphasis on creating enough capacity in the system to cope with infection by isolating sufferers 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. The attempt during the Brezhnev era to provide annual health checks only exacerbated this tendency. On the positive side the fear of epidemics was responsible to a large extent for the development of the San-Epid network, which was highly effective in monitoring disease outbreaks, but also played a positive role in wider public health issues. It did though encourage the neglect of non-communicable diseases and left the system unprepared for the demographic and epidemiological shift in disease patterns of 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 primary care on site. However, there was a tendency to commit resources to the industrial workforce perhaps out of proportion to real health needs. Curative and rehabilitative ‘rest homes’ were, and continue to be, included in mainstream health services provision. So are a range of therapies like massage and spa treatments. While this is not bad in itself, these areas are excluded from many Western systems because of cost and because they are not seen as a genuine part of health care provision. The Russian Federation however, would 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 what is often an expensive and cumbersome system to keep going. What is more, it must struggle to meet the very high expectations of its population.

Structure of the soviet health care system

The soviet health service infrastructure delivered care through a hierarchy of facilities. The basic unit was the ‘uchastok’ and in rural areas this covered a population of approximately 4000. 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, which would normally employ a general physician and a generalist 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. More complex cases still would be referred to rayon polyclinics or hospitals. These were district level facilities offering specialist secondary services in either an outpatient setting (polyclinics) or on an 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.\(^\text{62}\)

\(^{62}\) Cases that clearly required complex specialist attention could be referred directly to the oblast or tertiary level without passing through all the intermediary stages.
The urban population was in principle covered in the same way except that the network of primary carers was made up of doctors working out of polyclinics. They were meant to deal with the basic needs of the population, just as the rural health posts might, 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 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 role of the general practitioner, blurring the boundaries between primary and secondary care.

The links between secondary care in polyclinics and hospitals was also problematic. 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 into the care of 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 package of care. 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. 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 that there was 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 has changed relatively little since soviet times and polyclinics continue to be offer primary care and specialist outpatient services side by side. The reform of the financing mechanism has yet to prompt the rationalisation of the system or the redefinition of the boundaries between primary and secondary care.

Primary health care and public health services

The first point of contact with the health system for citizens of the Russian Federation is meant to be through the uchastok or basic unit of primary health care. As in the soviet era this means that in rural areas patients are covered by health posts that are staffed by feldshers and/or midwives and in urban areas they present to the primary care physician based 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.

The models of provision and the services offered are as follows:

**Health Posts/Feldsher-Midwife Stations** cover a population of about 4000 persons 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. a feldsher/midwife) are normally trained for two years beyond the basic nurse training and are employed by the local government body and supervised via the nearest health centre or polyclinic. There is no patient choice.

**Health Centres** cover a number of uchastoks or "micro-districts" or larger rural conurbations of 7000 persons or above. They are staffed by a general physician, a paediatrician and sometimes an obstetrician or gynaecologist as well as nursing staff. They offer a range of primary care services, including immunization, screening, treatment of minor ailments and supervision of chronic conditions, 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. Again 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** house a number of generalist (uchastok) physicians 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 will normally have approximately 1700 patients on their list. In small towns paediatric generalists may also share the same polyclinic facilities, although they will cover only 800 patients on average. Each patient is assigned a doctor on the basis of their postal address (the streets and apartment buildings being divided between the local doctors) and, as in the soviet era, patients have a technical right to change their general practitioner. However, this requires the approval of the head of the polyclinic and is not widely exercised. The fact that doctors continue to be allotted 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.

Most doctors in practice now tend to have qualified in the soviet era and so to be associated with the negative image of primary medicine. However, the introduction of a three year post-graduate training programme for GPs in 1992 means that future entrants to general practice will be specialists in their own right and significantly better trained than their equivalents in the previous generation. This is expected to raise standards and enhance public confidence in the primary care giver. The role of nurses was also underdeveloped and they continue to act as little more than doctors’ aides. Plans to enlarge their clinical and patient management input are being developed. There have also been discussions on how to allow patients greater choice.

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

**Special Focus Polyclinics** in large towns and cities 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 age15. 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 provide the staff of the enterprise/s which support them with the same basic package of primary provision available through residence based general practitioners, 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 concern for the industrial worker. Previously, both local government health committees and the enterprises themselves contributed to the costs involved. However, the position of all workplace care has been compromised by the shift to the insurance model. Employers now make payroll contributions on the monthly salary of all employees and are unlikely therefore, to continue to fund special provision of health services. It seems probable that these facilities will either close down or integrate fully into the neighbourhood health system.

The above represent the main focal points for primary health care provision. There are also independent dispensaries in urban areas offering an equivalent to the care available through rural health posts/centres and 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 the 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.

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 or for budget holding to the individual GP. General practitioners could not realistically set up a single-handed practice within the public sector and the conversion of polyclinics into group practices took place only as a part of experimental pilot projects. Rather the reforms elected to vest the responsibility for purchasing care in insurance companies rather than in GPs.

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 all will receive significant core funding from local government. In areas where the insurance mechanisms are not operational all funding of 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 factor which determines the survival of a facility.

Almost all facilities remain within the public sector and only small amounts of primary care are offered privately, either on a fee-for-consultation basis (in independent polyclinics) or through voluntary insurance schemes.

Notwithstanding the similarities with past practice there has been a shift in the perception of primary care by policy makers. They have formally recognised the importance of the sector in providing cost-effective and appropriate treatment. The term "primary health care" was officially recognised in legislative terms for the first time in 1992 when the Ministry of Health issued a decree on the phased transition to a system of family medicine. The Ministry has also supported the introduction of special training for GPs and has facilitated the input of
international experts in addressing training needs. They are also committed to reviewing nurse training for the primary sector.

It is hoped that enhanced public confidence in primary care will encourage patients to present in the primary setting rather than going directly to a provider of secondary care. It is also hoped that better trained GPs will minimise patient dissatisfaction and will be less inclined to refer patients on without good cause. Finally, the insurance programme is seen as a concrete means of strengthening the GP gatekeeping role through the creation of financial incentives for polyclinics to treat patients on-site.

Fig. 4. Physician contacts per person in WHO’s European Region, 1994

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

*For report of patient satisfaction surveys see under secondary 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 outposts (sanitary-epidemiological stations) reporting upwards from the rayon to the oblast and the oblast to the republican level (and ultimately to the All Soviet Ministry of Health). Accountability was clearly to the centre rather than to local government bodies, as was appropriate for the key surveillance structure. Its core duties included delivering immunization programmes, the control of outbreaks of infectious diseases, the collection of epidemiological data, disaster relief and the monitoring and regulation of conditions of sanitation, hygiene and environmental health.

The role and structure of the San-Epid network has remained largely intact within the Russian Federation. It continues to be the body charged with environmental and communicable disease control functions and health and safety issues. It also, through its local branches, manages the coordination and delivery of immunization programmes and collects and analyses epidemiological data passing it upwards to the federal level. Furthermore, the majority of duties for health promotion, health education and prevention also belong to the sanitary-epidemiological stations.

There have been some attempts to reform the system but these were conceived of very much as refinements to the approaches in place. In 1991 legislation was passed on the ‘sanitary and epidemiological well-being of the population’ which established legal standards for the rights and obligations of individuals, firms, and organizations (whether private or public) with regard to health. A new State Committee for Sanitary and Epidemiological Surveillance was established as an agency independent of the Ministry of Health, (although this was subsequently reabsorbed into the ministry framework). There has also been increasing interest in the integration of preventive and therapeutic services with prophylactic packages of care being targeted at TB sufferers and attempts to train new GPs in health promoting measures.

Despite these attempts to enhance its operation, the San-Epid network is acknowledged as being broadly effective in fulfilling key public health obligations. It was however, established with a view to the surveillance and control of infectious diseases, and not to address non-communicable disease issues so it has never been fully geared up to deliver health promotion. There were campaigns against smoking and heavy drinking that ran throughout the 1980s under San-Epid control but these have lapsed and there is little in the way of major coordinated health education efforts coming out of the network at the moment. This reflects the other strains being faced by the organisation and the priority placed on maintaining core activities. It is also in part because there is some uncertainty as to how to precede with initiatives that are targeted at changing behaviours when there is a generalised suspicion of centralisation and a reluctance to be seen to be overly directive. There is something of a lacuna in health education therefore, which is only being partly filled by the external assistance programmes that are collaborating on efforts to address substance misuse and sexually transmitted diseases, HIV and AIDS.

The reform of the financing of health care is seen as an opportunity to shift more responsibility for promotion and prevention activities into the primary care sector and onto the GP. Immunization and screening are already delivered through local doctors, (although there are also some school based delivery routes) and most family planning and ante-natal services are currently included in general practice provision. It is now hoped that insurance companies will create financial incentives for GPs to extend their routine screening and to carry out other preventive measures, including counselling patients on health behaviours.

Finally international collaborators are working with the planners and policy makers to identify how best to address the issue of family planning. They are reviewing the siting of services and

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65 Routine immunization by polyclinic paediatricians and schools programmes are coordinated and monitored by the San-Epid network, which may account for the high level of coverage recorded in figure 6 of 88.2% for 1994.
the way in which they are presented to women in an effort to reduce the enormously high ratio of abortions to live births.

**Fig. 5. Levels of immunization against measles in WHO’s European Region, 1994**

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*Source: WHO Regional Office for Europe, health for all database*
Secondary and tertiary care

The network of secondary and tertiary facilities combines hospitals, hospital out-patient 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 organised on a territorial basis. The basic units that provide secondary care are as follows:

Uchastok hospitals/health centres: these are small 30-50 bed units in rural areas offering fairly basic inpatient cover often with a staff team of a single surgeon, physician 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 will be served by a district or rayon hospital with between 100 and 700 plus beds (depending on the population covered). They are intended to meet the secondary and inpatient care needs of 40 000–150 000 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 will also provide an outpatient care centre with a full range of specialities to treat those that do not require hospitalization. Rayon hospitals themselves 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: an oblast is a region normally comprising between 10 and 50 rayons with a population of approximately 1-6 million. 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 will also serve 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: there are hospitals (and polyclinics) devoted to paediatrics with a full range of specialities and sub-specialities offered and hospitals (and polyclinics) exclusively for women, although these tend to specialise in obstetric and gynaecological care only. Again these will take referrals of more complex cases from lower down the system both for inpatients and outpatients.

Enterprise and other Ministry hospitals and polyclinics: very few enterprises offer inpatient facilities but there are some beds, often on former collective farms, that admit patients albeit for fairly rudimentary care. Enterprise polyclinics offer some specialist outpatient services. The provision through the parallel health systems varies from ministry to ministry but again it is common to offer secondary outpatient care through polyclinics and more unusual to provide inpatient beds. The Ministry of Defence, which provides medical facilities for the army, is the major exception, offering as it does a full range of services (other than obstetrics, gynaecology and paediatrics). There are some other examples of inpatient secondary, and indeed tertiary, care offered by ministries in what was the closed system but it is difficult to access information on the services offered.
Federal hospitals and polyclinics  the most complex care is offered at large and highly specialized hospitals or polyclinics which are mostly located in the federal capital. These are often associated with research institutes in their respective fields and offer highly sophisticated secondary and tertiary services.

All the above remain in public ownership, with title vested in the appropriate tier of local 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 subsidy from general taxation (passed through local government structures) and to enter into contracts with insurance funds for treatment provided to the population covered. 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, although no accurate figures are available.

There is an emerging private sector but it is very small and only a handful of facilities are private as such. These 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 ‘closed’ clinics and hospitals of the Soviet era i.e. those state institutions that catered to the nomenklatura and were not generally accessible, 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. Russia has one hospital bed for every 79 persons and had an average length of stay of 18 days in 1994, both or which are much higher than OECD averages. The annual hospital admission rate of 21.6 per 100 population is also relatively high, as is the outpatient consultation rate at 8.9 visits per person per year (1994). This does shows a slight decrease from 1980 when the annual rate was 10.1 visits per person but is still nearly double the average ratio for the OECD (see Table 5). The high bed to population ratio (see Fig. 7) and high utilization rates are due in part to the lack of social care provision and the use of acute hospital beds to provide long stay places for the elderly and the chronically ill. They also reflect the long-term impact of tying hospital income to bed numbers, which creates incentives to expand bed capacity and then to fill the beds available.

By contrast, the condition of hospital 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. 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.

Recent 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 1,400 respondents from 17 regions of Russia and showed that only 14% were satisfied with medical services. The most frequent complaints were about drug prices (which were seen as too high), the skills and qualifications of doctors (seen as too low), the attitude of staff (they were perceived as inconsiderate) and the waiting time to see a physician (too long). Another opinion poll of 1,000 persons in Moscow revealed extensive support for privatization in the health sector, (50% of respondents were in favour of transferring health care facilities to private ownership, 35% were against, and 15% were undecided). As it is questionable whether privatization and its consequences are fully understood by the Russian population following 70 years of communism, support for private ownership should perhaps be interpreted as a measure of dissatisfaction and a call for change, rather than a clear mandate for health sector “privatization” per se. Interestingly the practice of under-the-table payments were not cited as a cause of dissatisfaction. Anecdotal evidence suggests that this is in part because it so
widespread as to be seen as normal and no longer worthy 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.

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 hyper-inflation. There have also been problems with payment and it was not uncommon for staff to be paid two and three months in arrears at the height of the economic crisis. Poor working conditions are also cited as causing dissatisfaction including poorly maintained facilities, out-dated equipment, and the severe shortages of medical supplies and pharmaceuticals.
Fig. 6. Hospital beds per 1000 population in WHO’s European Region, 1980 and 1994

Source: OECD Health data 1996 (for western Europe); WHO Regional Office for Europe, health for all database (for CEE and CIS countries and for Israel, Norway and Switzerland).
Policy-makers and planners at the centre are acutely aware of the burden of over provision on the health sector. They are also conscious of the tendency to use the capacity available and so for surplus beds to lead to longer average stays and higher recurrent costs. The Ministry of Health does not, however, have the authority to close facilities that are the responsibility of local government. Rather, it is hoped that the introduction of the health insurance mechanism will impact on the balance between modalities of care. A shift to contracting using case payments would certainly be one mechanism by which to reduce length of stay. Similarly, contracts are expected to create incentives for day case surgery and for broader cost containment policies. It is too early however, to expect significant change, particularly as the intended insurance mechanisms have had to be modified so limiting the extent to which companies are able to exert leverage. There are also parts of the country where no insurance companies have been established and where local government is the main source of finances. In these areas there are no mechanisms in place to encourage bed closures. Old funding formulas apply with their perverse incentives, which encourage high bed and staffing levels. This is not to say that there have been no bed closures carried out by local health authorities. However, where these have taken place they have tended to be an ad hoc response to a funding crisis rather than part of a systematic review of local provision.

There have been discussions between the Ministry of Health and local government authorities as to a possible shift of beds to the social care sector. Estimates suggest that up to 20% of existing beds could usefully be redesignated as for long stay or social care. However, it is unclear how this agenda might be advanced within the reformed funding framework.
Table 5.  In patient utilization and performance in WHO’s European Region, 1994

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\(^a\)1993, \(^b\)1992, \(^c\)1991, \(^d\)1990.

Source: OECD, health data, 1996; WHO Regional Office for Europe, health for all database, Slovakian data from MOH.

Although there is an increasing awareness of the extent to which inappropriate secondary care is provided, utilization remains high with above average indicators in a number of areas (see Table 5). The payment mechanisms, as outlined above, are a major contributory factor, but there are also social and cultural issues which combine to exacerbate conditions. The population 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 as they are felt to reflect a decline in standards. There are also widespread beliefs,
some of which are based in fact, that it is particularly difficult for patients sent home early to cope in Russia (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 \(^{66}\). The absence of nursing homes or sheltered accommodation offers few alternatives means of meeting social need.

The process of introducing change will be complex, therefore. It is hoped that insurance companies will seek a more rational use of resources and will 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, if complemented by enhanced quality and efficiency on the part of primary care providers, will make the substitution of outpatient care for inpatient care both feasible and acceptable.

\(^{66}\) It is unclear whether the soviet practice of giving inpatients a rent rebate continues, but there are savings for the elderly hospital patient in terms of hotel costs (food, heat etc.) which create perverse incentives for them to remain in hospital.
**Social care**

Community care services are all but non-existent and 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 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 take on the range of responsibilities, (in particular for the elderly) of other 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.

There are a very small number of ‘homes’ for the elderly provided through the welfare budget but these are woefully inadequate both in the accommodation provided and in terms of availability. As of 1993 there has been an attempt to establish nursing homes for the elderly and chronically ill, but although the model is successful demand for spaces far outstrips supply. Long-term provision therefore, tends to be offered through mainstream hospitals and their geriatric beds. The financing mechanisms of the Soviet era allowed for 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 handicap 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 medicalised routes. There is no formal mechanism to prioritise 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 government 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. Quite how the responsibilities for financing this cover will be assigned is yet to be determined.
Human resources and training

The Russian Federation continues to have high levels of health care personnel by international standards. 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. The fact that doctors and nurses were regarded as non-productive elements of society made them cheap to employ and gave hospital and clinic directors few incentives to control staffing levels. The basic framework of pre-1991 health services remains in place and there continue to be high numbers of personnel employed despite some adjustments in recent years.

The figures cited by the Ministry of Health for the Russian Federation are not always directly comparable with those recorded in international databases due to the different approaches to categorising staff. However, they do give an indication of the scale of the issues under discussion. There were 429 doctors per 100 000 people shown in one Russian estimate for 1994 and one doctor to every 292 persons in another. This compares to OECD averages running at approximately half the levels cited (see also Figures 10 and 11). The figures include doctors of public health or sanitary-epidemiological specialists of which there were 35 000 in 1994 and 3,600 physiotherapy specialists. If these groups were to be excluded the doctor patient ratio for 1993 would fall to 268 per 100 000 (or one doctor 373 people). WHO figures suggest there were 3.8 physicians per 1000 population in 1994, well above CIS and CEE averages.

The numbers of nurses to patients is also relatively high when compared with CEE averages and the levels in Western European nations, excluding Scandinavia and the Benelux countries. Again figures are confused by the classification of nursing assistants, nurses, feldshers and midwives but WHO data suggests that were 6 nurses per 1000 population in 1994 (see Figures 10 and 11). More striking than the number of nursing staff however, is the paucity of the nursing role in almost all instances. Nurses in polyclinics and hospitals are little more than doctors’ aides and have almost no role in clinical work. The only instances of nurses taking a part in patient management and treatment decisions is in the feldsher-midwife model where, following additional training of between one and two years, nurse-practitioners are able to take on the first call primary care role.

There are also relatively high number of pharmacists and dentists, but as they are increasingly operating outside the public sector full records are not available.


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Source: OECD health data, 1995; WHO Regional Office for Europe, health for all database
It is striking that the figures for 1994 show the Russia Federation as having an over supply of medical personnel despite the falls recorded in the numbers of both doctors and nurses in the years 1991 and 1992. This is an indication of the extent of over provision in the Soviet era. In terms of the numbers shown leaving the various medical professions immediately after 1991, it would appear that this reflected a number of separate artefacts. Some of the apparent fall is due to the adjustments of previous data to exclude non-Russian parts of the former Soviet Union that are now independent and that had slightly higher ratios of doctors to population than Russia itself. Some is due to an exodus of those nearing retirement age who, it seems, felt more inclined to retire than to adjust to changes in the system. Others still entered the private sector. There were also some cuts in staff when small rural facilities closed in the face of overwhelming financial pressure and various enterprise-based clinics shut down as industry ground to a halt. A number of these have reopened with the stabilisation in the economy and in the manufacturing sector and staff appear to have been reinstated.

Finally, part of the drop in numbers of doctors was the result of Soviet attempts to address overstaffing issues in the mid and late 1980s when they took steps to reduce the numbers of entrants to medical schools. Because of the long lead in time with such measures, this gave rise to a fall in individuals entering the medical profession in the years immediately after 1990. Taken together with natural wastage this created a drop in total staff numbers that was independent of the changing circumstances of the Russian state.

Interestingly, although the year on year totals of medical school graduates have yet to rise above the numbers of those graduating at the end of the Soviet era there are increasing numbers of students entering medical school. This suggests that the numbers qualifying and entering the workforce over the next five years will exceed those at the height of the production of doctors in the 1980s. The numbers of staff defined as ‘medium level health care personnel’ i.e. nurses, feldshers and midwives appears to still be below the level in 1991. However, both the number of students graduating nursing school and the number entering have been on the increase since 1990.
Given the poor rates of pay of medical staff, the poor working conditions and the high levels of dissatisfaction reported by existing members of the 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 which they perceive as worthwhile. It is also clear that although official levels of pay are low students studying medicine expect to command reasonable salaries. It is less clear whether their expectations are linked to a belief that levels of pay will rise in coming years or to an acceptance of the system of under-the-table payments. Interestingly, the majority of students continue to express a desire to specialise, and in particular, to enter high tech medicine, despite the hopes of planners and policy makers that primary care will become increasingly important.

Fig. 10. Nurses per 1000 population in the Russian Federation and selected European countries, 1970–1993

The number of specialities recognised within the Russian Federation is higher than in much of the rest of Europe. There are over ninety branches of medicine which are listed as constituting a specialist area of practice. The number of doctors that are recognised as specialists is also high, in part in consequence of this proliferation of specialities and in part because the soviet system with its specialist ambulatory services encouraged reference to secondary and specialised care. It certainly undervalued the generalist and the primary care physicians. The need to shift the emphasis of provision to the primary sector has now been recognised and with it has come recognition of the importance of training for general practitioners. A three year training programme has been introduced which will make general practice a speciality in its own right. In addition to enhancing the skills of family doctors, it should raise their status.

Other training needs, which are being addressed coherently for the first time, are management skills. There is no special career path for hospital or polyclinic managers. Rather, as in soviet times, the chief doctor of a hospital or clinic acts, as the de facto chief executive officer. They take responsibility for staffing decisions, budgets, the maintenance of facilities and negotiations with third party payers (both local government and insurance companies or funds). Until recently there was very little appropriate training available. The assumption was that a senior doctor would automatically have the financial and people management skills to carry out the range of duties involved effectively. Now, with support from international partners, training
programmes are being developed which will provide more concrete skills for managers in health services. There is not yet full coverage nor are these issues addressed in the undergraduate syllabus but the process of developing management capacity is underway.

Fig. 11. Number of physicians and nurses per 1000 population in WHO’s European Region, 1994

It is too early to assess how effective initiatives to adapt human resources and training to the new challenges facing the Russian health system will be. The syllabus for undergraduate studies has only undergone relatively minor readjustment (removing political components and increasing the coverage of non-communicable diseases) and the expectations of medical students do not seem to have taken on board 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 specialisations. Furthermore the progress that had been made in cutting back admissions to medical school has been reversed as decentralisation has allowed regional schools to admit increased numbers.

Great hopes are placed on the reform process and the shift to insurance and contract based purchasing of care. However, as has been seen the system is not yet operational in much of the country and is somewhat compromised where it does operate. While market forces ought to provide a mechanism for the establishment of appropriate levels of staff and a suitable balance between primary providers and specialists there is little evidence of medical unemployment emerging. This suggests that the impact of the changes have yet to be felt, as redundancies would be a logical consequence of rationalisation.

Time will tell whether the hoped for improvements in the quality and humanity of care come about as a consequence of contract based provision and a greater awareness on the part of medical staff of the need to satisfy patients who are also the holders of insurance cover. Without some improvement in the pay and conditions of medical staff, however, it seems
unlikely that these objectives will be achieved or that the practice of under-the-table payments will die out.
Pharmaceuticals and health care technology assessment

The level of consumption of pharmaceuticals is difficult to measure because of the various routes through which patients are provided with the drugs they need and because the system is no longer as heavily regulated as in the Soviet era. However, cultural expectations of medical transactions appear to include the belief that each consultation should lead to the prescription of some drug or other. Certainly, consumption of pharmaceuticals before 1991 was relatively high in terms of prescriptions per consultation if not in terms of cost. As the private sector has become involved in the supply of pharmaceuticals and as foreign firms have begun to market directly to consumers the pressures on doctors to prescribe have increased. So too have the costs of drugs, particularly when they are imported.

The Ministry of Health, in consultation with external counterparts has taken steps to improve the cost-effective consumption of pharmaceuticals. In July 1994, Ministerial Order number 157 adopted a list of essential drugs, which included 96 drugs in 31 different categories. Hospitals and polyclinics are encouraged to restrict themselves to the administration of drugs listed as essential but compliance is incomplete.

There are also attempts to encourage prescribing of generics but this is problematic because the supply of unbranded products is unreliable and because patients are now subject to advertising from drug companies and want to use named products. There is not a negative list as such.

The use of controlled drugs continues to be closely monitored and physicians, hospital and polyclinic managers and pharmacists are all accountable for the prescription and distribution of opiates and other ‘hazardous’ substances.

Pharmaceuticals are provided for inpatients by the hospital while outpatients must purchase their prescriptions from pharmacies. There are some problems of supply but many of these appear to be related to affordability and cost rather than availability per se. While inpatient prescription costs are meant to be met from the hospital’s budget or through the case payment made by the insurer, it is not unusual for inpatients to have to purchase their own drugs. This reflects, in the most part, the financial constraints facing hospitals. Hospital directors acquire the bulk of the pharmaceuticals used through commercial channels and must therefore pay market rates for goods supplied. This can lead to shortages within hospitals even when drugs are available in the private sector.

The supply of pharmaceuticals to outpatients is fairly efficient with 84-85% of respondents in a December 1994 survey reporting that they had been able to get any prescriptions filled. Figures were the same for urban and rural respondents although a higher percentage of country dwellers cited their physician as a source of drugs (20%). Of those reporting difficulties in securing their pharmaceutical of choice over 70% did say that this was due to the fact that the drugs were simply not available at the pharmacy while only 20-25% said they could not afford the drugs.

The structure of the pharmaceutical industry and the distribution network have changed quite radically since 1992. The break up of the former Soviet Union disrupted the production of pharmaceuticals but more importantly saw whole areas of production ceded to newly independent states. The industry that remained was largely old fashioned and poorly maintained. This led to an increased reliance on imports and, as decentralisation has made regulation less acceptable, to somewhat laissez faire imports. There are still basic quality controls by the San-Epid network but until 1994 there were few attempts to ensure the efficacy of imports. It is hoped that the clear statement of a list of essential drugs will address the proliferation of imported pharmaceuticals although there are few mechanisms left which will

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allow the Ministry of Health to enforce policy. It is also hoped that the pharmaceutical industry can be regenerated with the help of external assistance.

In addition to the breakdown of local production and the deregulation of imports the distribution networks have changed significantly. Many pharmacies were sold to the private sector immediately after the establishment of the Russian Federation. 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, pharmacists are obliged to supply drugs free of charge to vulnerable groups and then to apply to local government for the reimbursement of costs. It seems that 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 in obtaining stock.

Hospitals can expect central government to provide core drugs to meet basic public health requirements i.e. insulin, vaccines and TB prophylactics. However, other pharmaceuticals must be purchased directly from suppliers out of the hospital budgets. This creates difficulties since hospital finances are already overstretched and the allowances made by local government (or in case payments) for pharmaceutical costs do not keep pace with inflation in the sector. This accounts for the shortfalls in the provision of drugs for inpatients and the demands on patients to secure their own requirements. The expense of pharmaceuticals however, does create incentives for hospital managers to monitor the type and quantity of pharmaceuticals provided. Chief doctors now review the prescribing patterns of medical staff in an attempt to achieve a balance between clinical need and cost.

Regulation of the pharmaceutical sector has suffered with decentralization and is no longer as coherent as in the 1980s. Responsibilities are divided between the Ministry of Health, which takes an overview of regulatory issues and monitors controlled drugs and imports, the San-Epid network that inspects industry and the quality of goods and local authorities which oversee pharmacists. The regulation of new technology is largely in abeyance. However, this is less of an issue as at the moment very little capital expenditure is being undertaken in the Russian Federation.

In theory though, case payments are expected to include a component to cover the cost of routine acquisitions and the maintenance of equipment. Where providers want to invest in high technology or expensive equipment they are meant to apply to the insurance company/companies with whom they have contracts to secure a grant to cover the costs of the acquisition. It is assumed that insurers will exercise control and only support purchases which tally with health care needs in the area, prioritising primary and preventive medicine. In practice, insurance companies have not proved able to support capital programmes and in those areas where purchases have been made these have been funded by local government out of tax revenues.

Problems have arisen in those few areas which have had access to funding, as there is no mechanism to encourage local government to take rational decisions and 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 specialised niches and invest inappropriately and without regard to long-term strategy or the stated health needs of the population.

Although it is hoped that the primary care sector will increasingly be recognised as a key priority and that the tendency to invest in high technology at the expense of preventive measures will wane, there is no evidence that this is taking place. However, there are no plans to reimpose legislation or central controls to restrict the rights of institutions to purchase equipment.
Financial resource allocation

It is important to realise that 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. It is also the case that the relative importance of the two allocation routes varies from region to region, so that the process that results in the funding of health care in Moscow may be quite different from the process governing funding in Orsk or Pevek.

A portion of the third party payments that support health care provision comes from general taxation collected nationally and by local governments in the form of rent. The health committee at the rayon and oblast level then agree funding requirements with the health care facilities based on their territories. The level of financing will depend on the target spending levels set out by the Ministry of Health, the historical budget of the institutions concerned (based on staffing and bed numbers and fixed costs) and the extent to which the insurance system is working locally. The second tranche of finances is meant to come from the local, private insurance companies (or in their absence the branch or territorial mandatory health insurance funds). Insurers have contracts with hospitals and polyclinics which are based on case payments. These are intended to reflect the priorities of the third party payers and the volume of activity of providers.

The combination of these two approaches to resource allocation is the result of a conscious decision by planners, politicians and policy makers to introduce a partial reform of the financing mechanisms in the first instance. This guaranteed a breathing space in which adjustments to the new system could be made while a safety net was still in place. It also ensured that statutory authorities, in the shape of local government bodies, would continue to have some input in the management of health care facilities and would provide local accountability in a way that could not be achieved by the insurance companies or funds.

The fact that the balance between insurance contributions and local government payments varies so widely from region to region reflects the political and economic divergence on the ground. Decentralization has meant that rayon and oblast governments can now take policy decisions locally and their political commitment to insurance has a major influence on the success or failure of schemes on the ground. Perhaps more importantly decentralisation has also allowed the emergence of real economic differences between regions as state efforts to redistribute resources and employment across the country have fallen off. This has resulted in growing inequalities in local employment and income levels which, in turn has affected the ability of employers to make payroll related contributions. This means that local authorities in areas experiencing major deprivation face different pressures to those in economically successful regions. The efforts of the Federal Mandatory Health Insurance Fund to offset the variations in economic conditions locally by reallocating 0.2% of all contributions is not enough to prevent growing inequities between regional health budgets. In the face of varying constraints local governments have adopted different strategies for the allocation of resources.
Third-party budget setting and resource allocation

The main source of finance for health care traditionally came through the state budget. The Ministry of Finance, after negotiations with the Ministry of Health, determined the proportion of the annual budget to be allocated to health care in any given financial year, and the level set was then adopted by Parliament. Oblast and rayon governments were then expected to draw up local budgets that reflected the decision making at national level. The key determinant of these resource allocation exercises was always the budget of the previous year and the facilities and staff in place. There was scope, however, for adjustments to reflect changes in GDP or a shift in national priorities.

The decision to split resource allocation between government bodies and private insurance companies has changed the nature of the decision making process. The Ministry of Health now seeks to calculate the expenditure needs of the health sector and then to set the level of insurance contributions that will be required to cover the estimated spending. However, the changes since 1991 have reduced the ability of government to determine what the total health care budget will be. Laws on decentralisation passed funding responsibilities to the regions and reduced the ability of planners to force regions to comply with the overall targets for health care expenditure, while increased economic uncertainty has undermined all planning efforts. Nonetheless, the Ministry of Health and Ministry of Finance still 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). They also calculate the anticipated budgetary needs of the system as a whole as a percentage of GDP and review the total population and earning base in order to set an insurance contribution rate.

The rate set provides the basis not only for employers’ contributions but for the contribution that should be made by local authorities on behalf of the population not in work (including the elderly, children, the disabled and the unemployed). The total pool of contributions then combines with local government’s direct support to make up the full allocation for a region or district. The FMHIF is expected to compensate for variations in resources arising from differences in the wages base of different regions. However, inequities arise because employers are not always able to meet their obligations to contribute and because the level of funds that local government provides varies in accordance with the shortfall faced by the health sector and the ability of the local authorities themselves to raise funds.

Decentralisation has also undermined the attempts of the Ministry of Health, and indeed of parliament, to prioritise particular programmes. There have been consistent calls from the centre for primary care and preventive measures to be given additional resources. However, there is no mechanism by which the federal authorities can impose decisions on the periphery. Local resource allocation seems to be determined chiefly by custom and practice and the fact that there are large numbers of hospitals and clinics in place. Budgets continue to be heavily tilted towards secondary and tertiary care and to the maintenance of existing levels and modes of provision.

Capital investments are no longer centrally planned and regulated (although individual areas can apply for central support in making essential acquisitions) rather they depend on the funds available locally. This allows for regional inequity to creep in and also for local purchases to be made which are at odds with stated health priorities.

68 The insurance system assumes that employers will contribute 3.6% of their total monthly payroll to the Mandatory Insurance Fund in respect of their employees. The FMHIF then deducts 0.2% to allow it to adjust for variations between regions. This leaves 3.4% at the territorial level.
Third party budget setting may best be described as an area of uncertainty. Clearly stated objectives are interpreted at the local level and requirements, which might be seen as absolute, have to be negotiated in line with circumstances in the region or district. The funds available on the ground seem to determine what proportion of resources are provided and by whom.

In some areas the two main finance flows are supplemented by direct contracts between enterprises and providers, in others voluntary insurance schemes fund private treatments in mainstream facilities boosting the income of the health sector. It is impossible to secure data on the value of the contribution made by the parallel health systems of other ministries, but it seems likely that their alternative provision (at least in some areas) will subsidise conventional services. It is also clear that out-of-pocket payments, particularly those made under-the-table, contribute significant amounts to the total health sector budget. None of these sources of finance are detailed in the third party budget setting process or are really open to scrutiny. It seems likely that in some areas (most probably at the level of the district) the contribution they make will be crucial, but it is not possible to illustrate this with agreed data or to comment on the impact these funds have on equity between regions or districts.

**Fig. 7 Financing flow chart showing financing flows and service flows between consumer, third party and providers (WHO)**

<table>
<thead>
<tr>
<th>MoH</th>
<th>Federal Hospitals</th>
<th>Federal Polyclinics</th>
<th>FMHIF</th>
<th>Other Ministries</th>
</tr>
</thead>
<tbody>
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<td>Oblast</td>
<td>Oblast Hospitals</td>
<td>Oblast Polyclinics</td>
<td>TMHIF</td>
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</tr>
<tr>
<td>Rayon</td>
<td>Rayon Hospitals</td>
<td>Rayon Polyclinics</td>
<td>BMHIF</td>
<td>Insurance Companies</td>
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<td></td>
<td>Health Posts</td>
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<td>Pharmacies</td>
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<td>Private Providers</td>
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**POPULATION/EMPLOYERS**

A graphic representation of funding flows is set out at Chart 2. It illustrates the flow of locally collected taxes/rents to health care institutions in the rayon or oblast and the corresponding flow of resources from insurance companies to health care providers. It also records the attempts by the FMHIF to adjust funding between regions. It is not able to capture the variations between regions or to set out the role of all the complementary sources of finance as described above. It is hoped that over time these variations will disappear as the system matures and the economy is consolidated. Plans to shift the balance further towards the insurance approach may then be progressed.
Payment of hospitals

Historically hospitals were paid global budgets based on the number of beds, staffing levels and an allowance for costs such as heating and light. Polyclinics received funds in line with 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. This historical incrementalism of the Soviet era failed to create any incentives for hospitals or polyclinics to deliver a quality service or to address issues of cost. If anything there were 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. Hospitals and polyclinics were expected to contract with insurance companies to provide care to an insured population on a case payment basis. The prospective payment method was to fix the price for any particular in-patient case against a schedule of diagnostic classifications. It was intended to create incentives for hospitals to reduce the length of stay and to use tests and investigations more rationally. Payments to polyclinics were to be by visit with limits set as to the number of visits appropriate in any given case. This was expected to encourage them 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 40% of their finances from the oblast or rayon based on their actual costs. In practice the operation of the new funding approach 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 Mandatory Health Insurance Funds contract with Medical Insurance Companies for the provision of care for insured populations. (Insurance companies tend to be ‘privately owned’, frequently constituted as joint-stock companies and are for-profit.) At the outset a per capita allowance was made by the TMHIF to the insurance company for each individual covered. Insurance companies then contracted with local providers (hospitals, polyclinics and/or dispensaries) for the provision of the basic package of care as set out by the Ministry of Health in association with the Federal Mandatory Insurance Fund. Prices were at the discretion of the provider unit but had to be agreed in negotiations with the insurance company.

This basic model is still in place except crucially, TMHIFs do not any longer pass a per capita allowance to the insurance company. Rather they hold funds centrally and reimburse insurers for expenditure.

This fundamental change in the system was in response to fears of abuse following a review of expenditure and reserves held. Although allegations of corruption have not been fully substantiated, it became apparent that large sums of money had gone missing from the system (estimates suggest $100,000,000 was unaccounted for). At the very least there had been some significant mismanagement. It was felt that the roots of the difficulties lay in the transfer of lump sums (in respect of per capita allowances for the population covered) to insurance companies who were inclined to invest these reserves speculatively. Given the lack of security within the banking system and the uncertainty of the Russian economy much speculation failed. This practice was therefore discontinued.

Insurance companies continue to negotiate a system of case payments, most frequently linked to a form of diagnostic related group which specifies the appropriate length of stay, package of interventions and tests and appropriate clinical standards expected in each case for any given condition. They are not however, risk bearing. They pay providers on a case by case, or visit

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69 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.
Health care systems in transition — Finland

by visit basis and bill the TMHIF 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.

This is because they have no formal mechanism for limiting hospital provision, but rather ‘underwrite’ care for a whole local population. Contracts are based on the basic package, but do not otherwise specify volumes of activity to be purchased. Companies do not select patients covered on the basis of a preliminary medical examination and have no discretion to exclude ‘high risk’ patients. While this evitates ‘cream skimming’, at least in the mandatory system, it does appear to expose the insurance system (or at least the territorial level of the insurance system) to considerable risk. However, the financial reforms of the system are still incomplete and there remains considerable scope for informal mechanisms of regulation. Monthly or weekly meetings between insurance companies and provider units, chiefly hospitals, allows for an ongoing review of activity levels and expenditure relative to the global budget available. It would appear that informal alliances between staff of the two types of institution substitute for formal mechanisms as a regulatory measure in adjusting workflow to fit budgets.

There also remains a degree of leeway within the system since the practice of costing and pricing have shallow roots and the widespread belief that additional activity generates few if any additional costs persists. It is true that many hospital costs are indeed fixed and are unaffected by activity levels. However, this view overlooks the reality that recurrent costs are associated with any activity and that in principle, staffing levels and therefore fixed costs might be reduced if activity levels were to drop. The failure to fully register this gives rise to a general willingness to continue to act even in the face of budgetary constraint to the point where exhausted budgets need not be an obstacle to the provision of services. This ‘indulgence’ is fortified by the fact that funding still comes from a variety of sources and while there may not be, in reality, any other source of income the belief that federal or municipal funds may meet the shortfall inspires a relaxation in budgetary controls.

Medical Insurance companies then are very much tied in to a process of billing and bill processing. They now derive their profits on the basis of a percentage charge on each intervention invoiced, rather from making savings in their expenditure on health per capita 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 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 Fund 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 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 added disbenefit of further advantaging 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. Certainly the suggestion is that the private sector will increasingly exit the market preferring instead to offer voluntary insurance only.

Despite steps taken to prevent the St Petersburg and Moscow experience spreading, it is unclear how the risk is to be borne if care of the insured population exceeds the combined per capita budget available to the Territorial Mandatory Insurance Fund. Although in theory hospitals are open to being penalised if they exceed the norms set out in the medical and social standards and may not be reimbursed for excess expenditure above contractually agreed levels per case there are still no effective limits on the number of cases they treat. The possibility of activity levels exceeding those expected remains real as does the issue of who absorbs the excess costs of
treatments that exceed budget limits. The use of historical activity levels in determining projected expenditure and the emphasis on bed reduction and the shortening of length of stay significantly reduce this risk. However, it must be assumed that local authorities will be expected to cover any deficit, thus undermining the ‘insurance’ component of the new financing mechanism still further.

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 in-patients 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.

It is also important to recognise the role of debt in financing the health system. It has been standard practice for hospitals to fail to pay salaries and wages for weeks, if not, months at a time. Staff appear to accept this as the norm and the leeway debt allows appears to do much to buy up the finances of the health system.

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 the incentives it creates for greater efficiency and for cost containment. It is widely held that, in the longer-term hospitals will take on the role of invoicing insurance funds and accounting for treatment offered in line with the hospital ‘kuzbass’ experience of Kemorovo. While this may secure against the abuse of the system it will tend to inflate the role of hospitals at the expense of primary care. It is still unclear how the need to ensure financial probity and the desire to enhance primary care and preventive medicine will be reconciled.30

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 through a variety of financing mechanism. However, the value of their receipts falls short of the cost of actual outgoings. While some of the funding gap is met by unofficial out-of-pocket payments it is unclear how long this situation can be sustained.

30 S.J. Tillighast and V.E. Tchernjavsky; 1996; Health Insurance Companies: Building Health Promotion into Health Care Reform in Russia - Health Promotion in Finance Reform
Payment of physicians

All health care personnel work on a salaried basis and most continue to be employed by the institution in which they work, and so indirectly by local government. Contracts of employment determine the rate of pay and specify the hours or shifts to be worked. Adjustments are made to reflect the attainment of post-graduate qualification, years of experience and the responsibilities of their post but do not reflect the volume of work carried out or its quality.

Salaries in the health sector are relatively low. This is a reflection of the Soviet tradition which valued manufacturing posts and, in effect penalised medical personnel for being ‘unproductive’. In 1991, average earnings in the health services were only 75.4% of the national, average. However, even the unfavourable position prior to 1991 has now deteriorated. This is because of the hyperinflation of the early 1990s. The period from March 1991 and March 1992 saw the cost of living increase some thirteen fold while the salaries of health care workers increased by a factor of 3.5 only. By May 1992 the average salary in the sector had fallen to 49% of the average industrial wage and there has never been a serious attempt to address this imbalance. A doctor is currently paid at a similar level to a primary school teacher and earns little more than a nurse or feldsher.

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 a hospital setting to further their qualifications and take on extra responsibilities so they do tend to have marginally higher salaries.

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 little pressure has been exerted to date 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 gives rise to a range of negative consequences for health service performance.

Not least amongst these is the frequently cited phenomena of doctors who make little or no effort, see very few patients and refer on as a matter of routine yet receive the same monthly income as colleagues who are committed to their patients. This undermines the motivation of productive staff. In response there has been an attempt to extend the rudimentary bonus scheme which came into existence during perestroika. Hospital and polyclinic managers were granted the autonomy to pay bonuses to staff who performed well out of reserves in the 1980s. Now that the rights of health care facilities to generate income and retain profits have been extended chief doctors are expected to have greater resources to commit to ‘performance related’ payments. It was hoped that these funds would be used to create incentives for staff to prompt more efficient and effective work. It appears that the use of bonus payment to supplement pay is commonplace and that as much as 20% of any individual’s monthly pay cheque may be derived from the top-up component. However, this has failed (or has been seen to have failed) to deal with the issue of free-loading. This appears to be due to the fact that, in the absence of any formal mechanism for assessing performance, these bonuses have normally been awarded across the board and do not normally reflect differences in 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 constitute a difficult group to discipline. It is still hoped that the introduction of a more mixed formulae for paying medical staff may be achieved linking outputs (rather than outcomes) with reward.
It must be recognised though, that any attempt to create incentives for staff through increments based on existing salaries is destined to face real difficulties while salaries are so depressed relative to other sectors of the economy and to the cost of living. It seems that even a 20% upgrade on current rates of pay is not sufficiently attractive to achieve changes in behaviour. The ability to influence staff through pay is further undermined by the extent of the practice of under-the-table payments. Although it is impossible to quantify the value of the ‘gratuities’ paid by patients it is undeniably standard practice and almost certainly contributes significantly to the incomes of medical personnel. While both nurses and doctors accept under-the-table payments doctors have greater power over resources, access to drugs, tests and hospital admissions and so are able to supplement their official income more readily. It is thus one of the unofficial means by which doctors establish earnings differentials relative to nursing staff and fieldshers and by which hospital doctors and specialists secure higher incomes that generalists and those in the primary sector.

Reformers had hoped that the insurance approach would create a greater sense of entitlement to the basic package of care amongst the population and lead to a refusal to pay for services under-the-table. The fact that this shift in expectations has not materialised is in part because the insurance approach has not been fully established. It also reflects the scarcity within the system and the lack of formal rationing procedures which make patients weak relative to doctors when it comes to insisting on their statutory rights.

The private sector, although it is 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% with the remainder contributing to running costs.

The government has clearly recognised the need to address the issue of pay within the health sector. It is hoped, that despite the difficulties experienced to date in adapting payment mechanisms, further steps will be taken to link performance to pay. In the first instance it is hoped to extend the use of bonus payments to give staff incentives to meet work targets while in the longer term a more mixed formulae may be developed. It is acknowledged that to fully resolve the issues of motivation and performance requires a general upgrading of salary levels.
Health care reforms

Determinants and objectives

The roots of the current health sector reforms predate the foundation of the Russian Federation. By the mid-1980s the shortcomings of the Soviet system were becoming increasingly apparent and health service planners had come to recognise the need to address the oversupply of facilities, the inefficiency of the system and the poor morale of health sector staff. They introduced some tentative reforms, in particular the pilot projects in Kemorovo and Leningrad, in an attempt to find ways in which the imbalance between secondary and primary care could be addressed. These experiments looked at the introduction of market mechanisms and at ways of vesting health budgets in the primary sector but were superseded by events.

The break-up of the Soviet Union not only brought to the fore the criticisms of the old approach to health services management, it exacerbated the conditions in the health care system and in the wider economy, creating a still 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, a huge boom in excess mortality amongst men from their late teens to early forties, the resurgence of infectious diseases that had not been seen in decades, and growing morbidity and mortality associated with chronic conditions. This trend may have started prior to the political upheavals as a consequence of ongoing neglect of non-communicable diseases. However, it was clearly 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 were unable to respond effectively and needed to be overhauled if they were to meet the growing health needs.

The cost of health provision was also thrown into sharp relief by the collapse in GDP and in the tax base of the country that followed on the events of 1991. While the staffing costs which make up a major part of health expenditure in any country were relatively low in the USSR the health sector still commanded a large share of the gross domestic product. This was clearly linked to the capital expansion of the 1970s and the oversupply of beds, hospitals and clinics. The expense of maintaining the levels of provision of the Soviet era were untenable in the face of the implosion of the tax base. It also threw into sharp relief the inefficiency of the system as it was configured and the poor quality of the services offered. The amount of waste and duplication was a clear impetus to reform the system.

Finally the political disquiet which did so much to bring about the end of Soviet power was a factor in shaping the demand for health sector reforms. Just as under perestroika and glasnost there had been a raising of expectations and heightened demand for change, so with the founding of a new government policy makers and planners, as well as the wider population, expected reform. A key area that was perceived as requiring radical change was the high degree of centralization of the state. Decentralization was seen as a critical strand of any reform policy not just in order to allow greater responsiveness of 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 centred around issues of funding, efficiency and centralization it is 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 years immediately after the Russian Federation was founded, the steep decline in GDP meant the health service was looking for additional resources at a time when quite clearly none would be forthcoming from the new government. Payroll based insurance contributions were seen as a means of introducing additional funds into the health sector with the advantage that they would be earmarked specifically for health care. Furthermore the insurance system was to be a means of introducing a range of more efficient management mechanisms into the health sector. Insurance funds were to act as guarantors of the population’s health under the auspices of government but private sector insurance companies were to contract with providers to buy cost-effective care. Market forces were to be harnessed to facilitate a shift of resources from the secondary to the primary sector and from inpatient to ambulatory modes of care. The rationalisation of patterns of health care delivery together with the impact of the new resources would, it was hoped, begin to address the fundamental health needs of the population and so reduce the decline in health status.

In addition the Ministry of Health supported reforms in the training of general practitioners, in the autonomy of hospital and polyclinic managers, in the payment of staff and in planning and regulation. The intention was to combine a range of measures to overturn the effect of years of rigid, bureaucratic control. The reforms then would decentralize management and financial responsibilities, improve the economic rationale of medical decision-making at all levels of the system, and encourage greater efficiency through better service delivery. In addition, they were intended to improve the responsiveness of health care system to individual, patient and citizen needs.
Content of reforms and legislation

The health sector reforms have been proliferated in a variety of acts, laws and ministerial orders. The basic sequence of legislation is as follows:

1991

- Law on Medical Insurance of the Citizens of the Russian Federation (State law 1492-1) - setting out the basic framework for an insurance system;
- Law on the sanitary-epidemiological well-being of the population – stating the rights and the responsibilities of the population, health care providers and both public and private organizations;
- Creation of The Russian Academy of Medical Sciences as a separate legal entity;
- Separation of the State Committee for Sanitary and Epidemiological Surveillance from the Ministry of Health and establishment as a free-standing body (subsequently reintegrated into the mainstream structure in 1994).

1992

- The Basic Program of Health Services under Mandatory Health Insurance for the citizens of the Russian Federation (Government Order 41) – outlining the package of entitlement under health insurance.
- Decree by the Ministry of Health of the Russian Federation on the phased transition to primary health care based on the principle of the general practitioner or family physician – legally recognising the term "primary health care" for the first time and set 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
- Law on Oblast and Krai Administration (No 2449) – together with the Health Insurance Law this paved the way towards decentralization, setting out the shift of government financing responsibilities from the Ministry of Health to the regional and local level 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.
- Law on Insurance Practice and directive of the Council of Ministers on Measures of Implementation of the Law of the RSFSR on Health Insurance of the Citizens of RSFSR – both specifying generalised rights to diagnostic, curative and preventive services and setting out further details of the operation of the insurance scheme.

1993

- A parliamentary decree, determined the compulsory health insurance premium rate – each employer was to pay 3.6% of the monthly wage bill for each employee. Other amendments to the health insurance law were also adopted by Parliament.
- Act of the Supreme Soviet of the Russian Federation on the Federal Fund for Mandatory Health Insurance (N 4543-1) under which compulsory health insurance became a social security measure - federal and regional health insurance funds were established to ensure
state health policy, to accumulate compulsory health insurance premiums, to adjust the income levels between districts and regions in the interests of equity and to guarantee coverage of all citizens by mandatory health insurance.

- Ministerial order on the rights of the working population to the basic package of care (N 146) – there was also provision for the unemployed, children, the elderly and others not in work to be covered by their local authorities

- Law on Psychiatric Care

- Law on Organ Transplantation.


- Presidential decree "On measures to control diphtheria in the Russian Federation".

- Presidential decree setting up interdepartmental commissions on health care and environmental safety, within the State Security Council.

1994

- Ministerial Order adopting a list of essential drugs, covering 96 drugs in 31 categories (N 157).

1997

- Recommendations on the population’s health as a factor in Russia’s national security – outlining critical health status factors and calling for increased support for the health sector.

- Decree ‘about measures of stabilization and development of health care and medical sciences in the Russian Federation’ (N 1387) – to strengthen the position of primary and preventive services relative to secondary provision, encourage evidence based medicine and reinforce the health insurance mechanisms.

Efforts are also being directed toward the development and modernization of the pharmaceutical industry and the redefinition of the roles and functions of specialists (other than general practitioners) in out-patient facilities. It is also intended to address the issues of the pay and conditions of health care personnel and there are plans to raise salaries, both in relation to other groups, and in real terms, and to differentiate salaries in line with job content, qualifications, the quality of performance and outcome measures.

**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 are informing the health sector reform process within the Russian Federation💁💅.

\[71\] Y. M. Komarov, Moscow 1995 Prioritetnie problemy zdorovia i zdravooohranenija i vklad NPO v ih nauchnoje obosnovanie. Aktovaja rech

Reform Implementation

The reforms to the health system of the Russian Federation are so far-reaching and the country is so vast and so diverse that it is not a simple matter to assess their implementation.

There has been a very real and very 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 the spheres of planning, regulation and management (Law on Oblast and Krai Administration No 2449). There is now the scope for local authorities to feed into policy making and to customize provision to local needs. Where insurance companies operate there has also been a rolling out of power to non-governmental 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 capacity in terms of management and financial skills which has led to a decision making vacuum in some areas.

The picture with regard to health insurance is even more mixed. The legislation governing the federal, mandatory and branch funds was all enacted as was paving legislation for the operation of private insurance companies. However, 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 Funds has been legally constituted. The failure of employers to meet their obligations to make payroll based contributions though has meant that the income accruing to different funds varies widely. These differences are amplified by variations in the response of local authorities to their obligations to make payments for the population that are not employed. In some areas this is made in lieu of the standard tax based payments made to hospitals and polyclinics in others it is in addition to the annual budget cycle. In others still, no per capita payments are made at all, rather all the funds raised through local taxation and destined for the health sector are allocated to providers directly.

The role of insurance companies also differs from that envisaged in the earliest legislation. The system of paying the per capita allowances for the population covered directly to the insurance company had to be discontinued after a series of speculative investments on the part of companies led to the loss of substantial capital reserves. In light of the insecurity of capital markets in the Russian Federation it was felt apposite to retain the funds at the level of the TMHIF and to shift the basis on which insurance companies were to be paid. They now negotiate contracts with providers on a case payment basis, although they do not set limits to the volume of care to be purchased, and then pay the hospital on case by case basis invoicing territorial fund for each item covered. Their profit is derived from a percentage charge on each invoice processed, in effect a handling fee. This has tended to undermine the insurance element of the scheme. Although it was never the intention of the reforms to use this approach to set limits to the care available under the basic package the new interpretation of the model removes any incentives for the insurance company to encourage providers to contain costs. Further challenges to the system have emerged in Moscow and St. Petersburg where it became evident that insurance companies were exploiting their ‘risk free’ position by approving high volumes of treatment in order to earn their own percentage or ‘handling charge’. It is still unclear how this situation will be resolved, but the disinterest shown by private insurers in continuing to have a presence in the public insurance field, if it is to be fully regulated, suggests that a public or quasi-public alternative commissioner of care will need to be found.

Other elements of the reform package appear to have met with greater success. General practitioners are being trained in line with a revised vision of the function of primary care and plans to enhance the role of nurses are being supported by external consultants. There have been initiatives to address substance misuse and the threat of HIV and AIDS, which could not previously have taken place. There is also a deepening commitment not just to the role of health promotion in disease prevention but as a tool to actively involve the population in responsibility for their own health behaviours.
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. Health care providers, or rather doctors, have not taken a key role as a profession but this is entirely consistent with their relative powerlessness 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.

Non-governmental organizations and population or user groups have also played little part in the formulation of the reforms and, indeed, are only beginning to establish themselves. There is considerable ambivalence on the part of the authors of the health reforms and traditional providers as to the potential for involvement of such groups, in part because there have been instances of abuse of popular campaigns in the recent past. However, international organizations involved in advising on the reform process are anxious to see the non-governmental and not-for-profit sectors actively involved so some accommodation is likely.

Multi-lateral 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 models of health sector financing in existence have proved highly influential in offering possible approaches to change and in fuelling debate.

While there are differences in approach between key actors there was considerable consensus at the time the reform package was first put forward. The fact that the various interest groups were prepared to sublimate their differences is an indicator of how seriously the crisis in the health sector was taken. The major revisions to the proposals put forward reflects more on the extreme difficulties faced by the system as a whole than on the efforts of any party to undermine the approach. 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 is simply not enough economic or financial stability nor enough resources to have really allowed the first wave of reforms to have succeeded as originally envisaged. Perhaps more important still, is 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 between the various funding mechanisms lies remains to be seen.
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 have been 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. Nor has the insurance mechanism created an explicit priority setting process. Rather de facto rationing takes place without scrutiny. There are now very serious threats to equity as the various regions and districts struggle to survive economically. On an individual basis the ability to pay under-the-table remains crucial with all the implications that has for equal access to health care.

Health status in 1991 was hugely compromised. 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 take on board the huge importance of non-communicable diseases. However, even more significant was the massive downturn in health indicators associated with the economic chaos that followed 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, perhaps as a result of the stresses associated with great uncertainty. The reforms, by rationalising the health care delivery system, were meant to free resources to really address health needs. However, health indicators continue to be dismal and although the reform was 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 materialised.

Efficiency may have been enhanced in those units that are able to use incentives effectively but it is impossible to make any over all comments since so much of what takes place is crisis management. Consumer choice has not been expanded except where consumers are able to pay and the quality of care again has only improved in the private sector.

It is unfair to attribute all the shortcomings that are still evident to failures in the reform process but it does seem clear that in parts it was over ambitious. 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 events external to the health sector to stabilise. It would be helpful for planners and policy makers if there could be an age of stability and certainty on the horizon however, there seem to be no such guarantees. Rather the Russian health system faces the challenge of how to manage in huge uncertainty and within the constraints applying while trying to secure health gain.
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