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Foreword

This review of the Russian health system was undertaken at the request of the Council of the OECD within the context of the request by the Russian authorities to accede to the Organisation. Thus, this study forms part of a broader effort to assess the coherence of policies of the Russian Federation with those of OECD member countries. The development of health outcomes in the Russian Federation has contrasted sharply with developments in the OECD area over the last quarter of a century. This report follows on the *OECD Reviews of the Health Systems* of Korea (2003), Mexico (2005), Finland (2005), Switzerland (2006 and 2011) and Turkey (2008).

The review assesses the institutional arrangements and the performance of the Russian health system. As with earlier reviews of health care systems, performance is assessed on a range of criteria: access to health care services of high quality; the degree of insurance coverage for health care costs; the fiscal/financial sustainability of the health care system; and the overall efficiency with which health care services are produced and provided. In addressing these issues, the report aims at furthering the debate on health reforms in the Russian Federation through a review of the strengths and weaknesses of the current system and an evaluation of alternative paths of reform drawing, where relevant, on the experience of other countries.

The study benefited from a mission to the Russian Federation, in the course of which discussions were held with federal and regional government health policy makers as well and a range of experts from public, semi-public and private groups and other international organisations such as the World Bank. The OECD would like to thank, collectively, the many people who provided background information for this study. Particular thanks go to the Ministry of Health and Social Development for their support in financing the study and in providing the detailed comments on some of the more recent reforms. In a context where most of the documentary evidence is not in English, the health-system reports by the European Observatory were a particularly helpful source of information.

The main authors of this report were, in alphabetical order, Evguenia Bessonova, Howard Oxley and Valerie Paris. Useful comments were received from John Martin, Peter Scherer, Mark Pearson, Bill Tompson, Michael Borowitz and Elisabeth Docteur. Marion Devaux, Christine LeThi and Valerie Moran provided statistical support. Tatiana Gordine helped with translation, while Judy Zinneman provided secretarial support. Thanks also go to Lucy Hulett and Marlène Mohier for their editing work. Thanks also go to Judith Shapiro for comments on earlier versions of the report.

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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CEFIR	Centre for Economic and Financial Research
CT	Computed Tomography
DALE	Disability-adjusted Life Expectancy
DRG	Diagnosis-related Group
EBM	Evidence-based Medicine
FFMHI	Russian Federal Fund for Mandatory Health Insurance
FOM	Public Opinion Foundation
GDP	Gross Domestic Product
GGP	Government Guarantee Package
GMP	Good Manufacturing Practices
GP	General Practice
HIV	Human Immunodeficiency Virus
HLE	Healthy Life Expectancy
ICT	Information and Communications Technology
IMR	Infant Mortality Rate
MHI	Mandatory Health Insurance
MHSD	Russian Ministry of Health and Social Development
MRI	Magnetic Resonance Imaging
NCD	Non-communicable Disease
NPPH	Russian National Priority Project “Health”
PPP	Purchasing Power Parity
RMLS	Russian Longitudinal Monitoring Survey
Rosstat	Russian Federal State Statistics Service
RUB	Russian rouble
San-Epid	State Sanitary Epidemiology Service, network responsible for core public health services during the Soviet era
SMR	Standardised Mortality Rate
TB	Tuberculosis

TIRSP	Retail selling price, all taxes included
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UST	Unified Social Tax
UTS	Unified Tariff Scale
WHO	World Health Organization

Introduction

The Russian Federation has faced a difficult period of economic and social transition since the move to a market economy. Severe recessions in the 1990s were accompanied by reduced financing of the health system and consequent reductions in the availability of health care services. Partly as a consequence, indicators of health outcomes weakened sharply and the overall size of the population declined. Recent improvements in the overall economic climate, increased financing for the public health system and a strengthening of broader health care policies in a number of areas appear to be having a positive impact on broad indicators of population health. The decline in the population has progressively slowed; and there was actually an increase in 2010. Mortality has also fallen somewhat and life expectancy at birth has increased starting from around 2004 onwards. Despite these improvements, the Russian Federation still lags behind OECD countries by a considerable margin. For example, Russian average life expectancy at birth – at 69 years in 2010 – is around ten years lower than the average of the OECD countries. The Russian authorities are placing great emphasis on achieving further improvements in the future.

There have been significant reforms to the health care system since the transition to a market economy. In the early 1990s, there was a shift from an integrated, hierarchical model of health care finance and provision to a more decentralised and insurance-based system. While the central authorities continued to play their role of co-ordination and system-wide oversight, responsibility for the provision of care services was largely decentralised to the governments of the constituent parts of the federation and the municipalities. This was complemented in 1998 by a programme of State Guarantees for Free Medical Assistance to Russian Citizens which provided for a basic package of free health care services.

However, due to the second financial crisis that started around mid-1998 – and a reduction in public health care spending of nearly a third over the period 1998-2000 – this plan was never fully introduced and the move to the new arrangements has remained unfinished. A progressive increase in public financing of the health system has taken place since then and latest information from the authorities suggest that the public sector financing is now broadly adequate to cover the Government Guarantee Package (the basic package of free health care) as long as these new resources are used efficiently and effectively. Reducing inefficiency in the provision of health care services could help bridge remaining gaps in resource needs.

In the light of these developments, this report looks at possible reasons for poor population health. In doing so it examines some of the problems of the current health system against the background of the reforms put in place in the 1990s and more recent policy efforts to correct some of the most important problems. The analysis in this report suggests three main problem areas underlying the weak health outcomes:

- First, unhealthy behaviour by the Russian population has been translated into very high levels of chronic disease – notably (but not only) for cardiovascular conditions – and prevention appears to be of particular importance in policy measures to address these issues.

- Second, a significant share of those falling ill may not have had adequate access to proper medical care: per capita public health budgets have varied enormously across regions and availability of health care services outside cities can be limited. During the years of severe budgetary restraint, many health care providers relied on informal payments and chargeable services to finance at least part of the provision of care. Where out-of-pocket payments were high and household incomes low, access to care may have been constrained. While the magnitude of these effects are difficult to assess, recent increases in remuneration of health professionals have reduced the *raison d'être* of these practices. The significant increase in patient contacts with the health care system over the last few years indicates that the prevalence and importance problems may now have declined.
- Third, for those that sought care, the health care system was often not able to meet patient needs for high quality and timely care, reflecting the lack of medical materials/supplies, hospital pharmaceuticals (high-tech) equipment and poorly maintained hospitals and clinics. This situation is improving as public financing increases.

The remainder of the paper develops these issues in greater detail.

The report is organised as follows: the Assessment and Recommendations provides a summary assessment of the health system and health policies more generally. Some tentative policy conclusions are highlighted. Chapter 1 presents a short description of the Russian health system. Chapter 2 takes a critical look at some recent policies. Chapter 3 reviews the performance of the system. It begins by examining health outcomes and their longer-term implications. This is followed by an assessment of system performance structured around four key objectives of health systems: *i)* access to care; *ii)* the quality of care; *iii)* the financial sustainability of the system; and *iv)* efficiency and effectiveness in the provision of health care services.

Before beginning, a general remark regarding the available statistical and other information is necessary. On some occasions, the absence of data – and above all – internationally comparable statistical data has complicated the preparation of the report. While information was available from the Russian Ministry of Health and Social Development, the Ministry of Economic Development, Rosstat (the Russian Statistical Agency) and the WHO, additional and more up-to-date information is needed in order to undertake a full evidence-based evaluation of system performance. Furthermore, the absence of readily available and up-to-date information on the health system, how it currently works and recent reforms has also proved to be an additional stumbling block. As a result, this report has had to draw heavily on secondary sources often produced by other international organisations and specialist groups. While the Russian Federation is not the only country to face such problems, it is to be hoped that increased availability of information will enhance the capacity of the authorities to monitor the performance of the health system.

Assessment and recommendations

Health outcomes in the Russian Federation have been poor by international standards...

It is a fact that Russian health outcomes fall well below those of OECD countries. Russian life expectancy at birth averaged 69 years in 2010 (63 years for men and 75 for women) and lags behind the OECD average by slightly more than ten years. The Russian Federation's life expectancy is also low when compared with OECD countries with similar levels of income per capita – e.g. average life expectancy is about seven years less in the Russian Federation than in Chile and Poland. A similar picture emerges using other concepts of longevity such as disability-adjusted life expectancy (DALE) and healthy life expectancy (HLE) (see Chapter 3).

The gap in life expectancy between the Russian Federation and other countries appears to have been partly the result of developments during the transition to a market economy. Over this period, mortality in the Russian Federation rose markedly, particularly during the two severe economic recessions in 1992 and in 1998, falling back slightly in each case as economic conditions improved. These mortality trends appear to have been associated with the extreme social and economic stress experienced during the period of systemic change. Such developments – and their implications for health outcomes – appear to have been more marked in the Russian Federation than in most other eastern European countries (see Chapter 3).

...but are now improving

However, there is now some cause for cautious optimism based on the most recent trends. The fall in life expectancy halted in 2004 and life expectancy increased by 4.1 years for men and 2.6 years for women between 2004 and 2010. This improvement has occurred even though the economy was in recession for part of the time and part of it seems to reflect recent reforms and increased public spending on health (see Chapter 3).

Differences in mortality rates, when compared with the average of OECD countries, are largely explained by non-communicable diseases (e.g. cardiovascular diseases and cancer), as well as external causes (such as injuries, road accidents and suicides). These differences have been largest for men of working age. Among chronic disease categories, cardiovascular disease is a major factor accounting for the large gap. Mortality from communicable disease remains very low – as in OECD countries.

Three sets of interlocking factors appear to have contributed to high levels of mortality

While there is no consensus concerning the reasons for the high levels of mortality in the Russian Federation, this report highlights the potential role of three sets of interlocking factors. A first key feature is poor health-related lifestyles of the population. Alcohol consumption is estimated to kill, either directly or indirectly, half a million persons per year and smoking between 300 000 and 500 000 persons. Suicide rates are high, as are injuries and deaths from traffic accidents.

Second, access to health care has been compromised and some share of those falling ill may not receive the care that they need. Spending across regions has been very unequal and this suggests that the supply of health care services may have been inadequate in the poorer parts of the federation. Although people are, in principle, entitled to a basic benefit package of free health care services, they have often continued to make informal payments to medical professionals, thereby helping to compensate for the low salaries. At the same time, growing use has been made of chargeable services (outside the basic package) by institutional providers (e.g. hospitals and polyclinics) in order to increase their incomes. Although the overall importance of the associated cost sharing is difficult to judge, surveys do show that a significant share of the population makes private payments for both doctors' visits and for hospital services (see Chapter 3).

Third, until recently, the Russian Federation has underinvested in health care such that for those who can and do seek care, the current health care system has not always been able to provide cost-effective care of high quality that is in line with patient needs. This, in turn, led to deterioration in physical and human capital in the health sector and a weakening in the capacity to provide care. Buildings and equipment have been allowed to deteriorate and many are in poor repair while, at certain times, there has been a general lack of affordable drugs and medical materials, even in hospitals where they should be free.

In examining these three sets of issues, more attention needs to be paid to getting value for money

The Russian Federation is now addressing all these issues, and has committed significant amounts of public money to many of them. However, experience across OECD countries indicates that big increases in health spending can sometimes lead to disappointing outcomes, if not accompanied by reforms to ensure enhanced efficiency of provision. For example, the current configuration of health care provision, with its emphasis on high-cost hospital and specialist care, limits the capacity of the system to adapt to emerging patient needs and can reduce both the efficiency and effectiveness of the health care system.

The challenge for the Russian Federation is, therefore: how to pursue its efforts in the area of prevention; to ensure access to care; and, to improve the quality of care; all the while focusing on increasing value for money. This challenging agenda is familiar to many OECD countries.

The remainder of this section sketches out some of the implications of the broad results summarised above and highlights some of the options and policy constraints facing the Russian authorities as developed in this report. It makes some recommendations as to where the Russian authorities may need to focus particular attention in order to achieve their stated objectives and achieve greater value for money in the health sector.

Increased emphasis needs to be given to prevention

Prevention efforts need to focus on changing unhealthy lifestyles

Until recently, prevention efforts have mainly focused on communicable disease.¹ While a number of important policy risks remain in this area, prevention policies need to address the overwhelming importance of chronic conditions in determining morbidity and mortality. Such interest has been highlighted by the WHO Moscow Declaration on Non-communicable Disease in 2011. The authorities have been aware of the importance of non-communicable disease for some time and are now moving to address other lifestyle factors such as tobacco and alcohol abuse, the latter being a major reason for the high numbers of deaths from external causes such as suicides, traffic accidents and violence (see Chapters 2 and 3).

New initiatives for prevention have been taken

More effective policies in this area need to begin with the establishment of a legal framework for building broadly-based prevention policies. In this context, the Ministry of Health and Social Development (MHSD) laid out a broad framework in 2008 for building policies in this area, both at the federal and regional levels, drawing on a range of actors and a number of key policies have been put in place or are under consideration (see MHSD, 2008 and Chapter 2).

In terms of more specific measures, the Russian Federation ratified the WHO Framework Conventions on Tobacco Control in 2008 and some recent measures – mainly in the area of packaging and health warnings – have been put in place. Measures to reduce alcohol consumption are also being set up at both the federal and regional levels. Excise taxes will be increased progressively over the next few years but remain low. Action plans (concepts) in both these areas have been established out to 2010 and 2020 (depending on the programme) and such efforts have been echoed at the level of the regions (see Chapter 2).

A number of prevention activities to encourage more healthy living have also been introduced: advertising campaigns have begun; a health-related internet portal has been set up; centralised telephone hotlines have been introduced and, according to the MHSD, these appear to be reaching a significant share of the population (see Chapters 2 and 3).

Health concerns need to be taken into account in policy making across government through “Health in All Policies”

Looking into the future, it will be important to bring together a wide range of participants in both the public and private sectors because many measures needed to lessen health risks are the responsibility of authorities other than federal and regional health ministries (e.g. road transport). *Health in All Policies* needs to be more than a slogan in Russian policy making. Indeed, the MHSD should take on a coordinating and advocacy role in ensuring a widely based policy is put in place and adhered to. The authorities will also need to strive to minimise the influence of interest groups who benefit from the current situation (such as the tobacco and alcohol industries). Finally, long-term financing will also need to be assured as the benefits of prevention are likely to appear only after long and uncertain time lags.

Looking at more specific policy areas, the authorities will need to focus particular attention on the most cost-effective interventions, *i.e.* those that maximise outcomes for the money spent. Increased taxes/prices of alcoholic beverages and tobacco products are a

welcome development as these are among the most cost-effective policies available to change risky behaviours. But such policies need to be pushed further. For example, it is worth noting that tobacco taxes in the Russian Federation still remain among the lowest in the European area (Chapter 3).

Issues of access should be addressed

At an aggregate level, private health spending accounts for 37% of total health care spending, which is higher than the average of 28% in OECD countries. Because private spending is relatively high for particular items of health care – in particular, pharmaceuticals but also for some forms of care where informal payments are still often received from patients, the dissuasive effects of private health spending may be higher than would otherwise be expected.

Two issues are of particular importance in ensuring access to care: the uneven geographical distribution of health care services across the country, and the importance of private out-of-pocket spending for some health goods and services which may have a disproportionately large and inappropriate impact on whether people receive the care they need.

Greater equalisation of resources across regions is needed

Wide differences in per capita public health care spending exist across regions. They reflect differences in wealth, in budgetary choices, but also differences in the amounts accruing to Mandatory Health Insurance (MHI) regional funds. Until now, MHI regional funds came from MHI contributions paid for workers of the region, from risk-equalisation transfers operated by the federal MHI fund, and from contributions paid from regional budgets for the coverage of non-workers. Thus, available MHI funds were highly dependent on the employment rate in the region, as well as the willingness of regions to pay the contributions for non-workers. In addition, money directly allocated to health from regional and municipal budgets also depend on local governments' ability and willingness to invest in health care. All in all, these factors led to very large differences in per capita public spending for health across regions, ranging from a low of RUB 3 430 to a high of RUB 23 559 in 2009. The ratio of the highest to the lowest (6.8) appears to be much higher than in other federal countries. For example, the same ratio is 3.2 in Canada, 2.1 in the United States and 1.3 in Australia.²

While regional health outcomes are not systematically linked to regional public health spending, regions with low levels of spending tend to have worse health outcomes. This suggests that the poorer regions with smaller health care budgets would benefit from larger transfers from both MHI funds and regional government budgets. In this context, the 2010 Law on Mandatory Health Insurance changed the methods of fixing budget allocations across regions with the main aim being the reduction of the differences between regions for the funding of the Government Guarantee Package (GGP). The federal MHSD intends to largely eliminate the variations in per capita public spending across regions by 2013.

An increased funding of the Government Guarantee Package could reduce the need for chargeable services and the prevalence of informal payments

From the 1990s, it became common practice for patients to pay for “chargeable services” – *i.e.* services not included in the Government Guarantee Package (*e.g.* earlier access to high-tech imaging or better equipped rooms) or because the medical institutions had inadequate resources to provide the services included in the GGP (*e.g.* pharmaceutical drugs). In addition, doctors or other medical personnel often received informal payments from patients for care that is normally free of charge. These payments have permitted the health system to continue to function during periods of particular fiscal stress, and allowed health care professionals to obtain higher incomes than otherwise.

While it is difficult to gage the importance of these out-of-pocket payments, chargeable services appear to be widespread (see Chapter 1 for a list). In 2007, half of the patients admitted to a hospital paid something. Moreover, and in spite of the fact that medical care is free for a wide range of services, almost half of the population indicate that they would like to purchase chargeable services but do not do so for financial reasons.

The relative pay of health care professionals needs to be raised and informal payments curbed

Until recently, the Russian Federation has paid its medical workers using the Unified System of Payment for Labour which covered the entire public sector. It is widely accepted that the salaries of health professionals are low. Doctors’ salaries are about 1.5 times the average wage while for OECD countries for which data are available this ratio is of 2.5 for salaried general practitioners and 3 for specialists. Recently, salaries of certain categories of medical personnel (*e.g.* primary-care doctors) have been increased under the National Priority Project “Health” (NPPH). In addition, increased funding from the social security tax in 2011 and 2012 is expected by the authorities to permit additional increases in wages and salaries of doctors and nurses by more than 35% by the end of 2012.

Changes in the method of paying wages and salaries in the public sector more generally are currently under implementation permitting greater flexibility in setting remuneration. Current pay arrangements are often made up of a fixed salary accompanied by bonus payments – the latter drawing on revenues from chargeable services to finance them. However, the introduction of the bonuses has not always been linked to performance. Such links could be strengthened within the context of achieving a variety of potential performance goals as a counterpart to higher wages. Increases in wages of health professionals are also likely to be important for getting broad agreement among doctors and nurses to support needed reforms as their opposition can often sound the death-knell of any reform programme.

The importance of informal payments remains an issue. As noted above, a significant share of health professionals benefit from informal payments from patients and this may affect access, particularly for low income households. It is difficult to gage their current importance or their impact on access. But the rapid increase in patient contacts (mainly the elderly) with the health system over the past few years suggests to the authorities that any impact on access is currently limited.

The authorities are attempting to reduce these payments. But they will be difficult to wind back fully because of the long-standing tradition in the Russian Federation of patients giving gratuities to doctors. Current efforts in this direction by the authorities should be strengthened

to ensure that any negative effects are minimised. Any substantial salary increase should, therefore, be accompanied by a well-publicised public information campaign demonstrating why informal payments are no longer justified.

The capacity of the health care system to provide high-quality care needs improvement

Public financing of health care is increasing with the new social security contributions

Total health spending in the Russian Federation was 5.6% of GDP in 2009, which is far below the OECD average (9.6%) but roughly in line with countries with similar levels of income (Mexico, Turkey). However, public spending was only 3.6% of GDP, which was lower than all OECD countries except Mexico. There was widespread agreement that the existing public funding for health care was insufficient to finance the Government Guarantee Package.

From 2011, the Unified Social Tax has been replaced by social insurance contributions paid directly to MHI funds. Under this reform, MHI contribution rates have increased from the current rate of 3.1 to 5.1% of wages. But this will provide for increased public spending only to the degree that it is not offset by reduced transfers from the regional and federal budgets to the MHI funds³ (or reduced MHI revenues because firms opt to increase their use of “grey” labour to avoid paying the tax). As noted above, there is also considerable scope for extra revenues from a significant increase in so-called “sin” taxes on alcohol and tobacco consumption, all the more so as such taxes are likely to be less distorting than a wage tax.

Nonetheless, recent reforms have significantly increased public resources allocated to the health system. Russian authorities project public spending on health care will rise to 4.2% of GDP in 2011 and may rise further to 4.9% in 2013. Both the federal authorities and some regional health ministries have initiated spending programmes, most notably under the National Priority Programme “Health” (NPPH). These have served (see Chapter 2) to make inroads into the backlog of the needed refurbishment of buildings, the replacement of outdated equipment, more widespread availability of high-tech medicine and a revalorisation of primary care. These investments have without doubt served to increase the capacity to provide high-quality care. But if further funding is to be made available to bring the overall health system up to standard, it will be particularly important to ensure that any additional funds are being spent in an appropriate and efficient manner. Any increase in financial resources needs to be carefully used to “buy” change in the system so as to ensure better access to quality health care and, above all, to improve the cost-efficiency and cost-effectiveness of the system.

More attention to system governance is needed

The role of both regional and federal authorities should shift towards health system governance and away from day-to-day management of the system. As regards governance, regional authorities will need to put in place strategic plans that include both prevention and cure over a longer time horizon and set targets to be achieved in terms of population health and other performance indicators, something that is often done already in many regions. Data collection and analysis to measure the success of the regional authorities in ensuring quality of care and cost-effectiveness of provision is now underway (Chapter 2). The usefulness of

this information would be greatly enhanced if the authorities used international definitions as this would permit international as well as national benchmarking of performance.

The Government Guarantee Package may, nonetheless, need greater focus on cost-effective care

The federal health authorities may need to identify more clearly the contours of the basic Guarantee Package. Discussions in this area will need to bring in the regions because of the extra coverage provided by some. Such a review should not be aimed simply at limiting the costs of the system. It is also important to make clear – to both patients and providers – what is provided under the Guarantee Package in terms of types of care and their volumes. For example, a set of minimum priority services and drugs should be established – in place of the current broad categorisation of diseases – on the basis of their cost-effectiveness. The construction of federal clinical practice guidelines would be helpful in the review of the coverage of the basic package as there are certainly benefits from eliminating care from the basic package that is known to have little effect on health outcomes.⁴ In addition, there needs to be greater clarity for the population regarding what is free and what is included in the list of chargeable services. In this context, the prices of the chargeable services may need review as there can be wide differences across providers of these services even within a single region (Vishnevskiy *et al.*, 2007). The Russian authorities should seek to improve access to essential cost-effective drugs to the whole population as soon as possible. Drug consumption patterns suggest, for instance, that secondary prevention of cardiovascular diseases (by *e.g.* antihypertensive/anti-cholesterol treatments) may be under-consumed in the Russian health system despite strong evidence of its effectiveness in preventing premature deaths from cardiovascular diseases. Recent increases in spending on pharmaceutical drugs (see Chapter 2) may have eased such problems.

Particular attention needs to be given to the quality of primary care

The view persists amongst the general public that existing primary care is of poor quality, leading many patients to ask to see a hospital specialist unnecessarily. The widespread introduction of general practitioners (GPs) or family doctors in place of the existing district doctors is seen by many as a means of countering this prejudice as long as the GPs do provide better quality care. Evidence suggests that there seem to be clear benefits from switching from district doctors to bring them closer to a GP model. This can take pressure off specialists working in polyclinics and also reduce the need for referrals to hospital specialists (Marquez and Lebedeva, 2010). Anecdotal evidence suggests this may bring improved patient satisfaction as well. The role of GPs in encouraging the shift from hospital to ambulatory care would be enhanced if they took on a stronger role as gatekeepers in the system with the GP following individual patients over time to ensure better care co-ordination. Unfortunately, the pace at which doctors are being retrained currently to become GPs remains slow and subsidies are required to encourage GPs to move into rural areas.

There is considerable scope for efficiency gains

There are wide differences across regions in health outcomes and these do not necessarily correlate strongly with either average incomes or the level of public health care spending. Indeed, a number of less well-resourced regions have been able to achieve notable improvements in health outcomes through more coherent approaches to health care provision

and improved prevention than some richer, less well-organised regions. This suggests considerable variation across regions in the efficiency and effectiveness of resource use. Thus, how the funds are used is possibly as important as the level of financing. It also suggests that there may be, potentially, a stronger role for federal institutions in helping some of the poorer performers to get better health results.

At the same time, recent studies based on international comparisons and comparisons across regions within the Russian Federation suggest that efficiency gains of up to a third may be possible if performance of individual republics were brought up to the standard of the best performers (Hauner, 2007; World Bank, 2008). In this context, a number of policies could be considered.

The introduction of a “single payer” for financing providers for their services is a positive step

Until now, the dual financing of the GGP did not provide clear incentives to providers. As it stands, 60% of public financing of the health care system originates from budgetary sources and the budgeting of providers largely takes place on an input rather than an output basis. The remainder largely comes from the MHI system even though the original legislation intended that the Government Guarantee Package be mainly financed through the MHI system contributions. Multiple payer arrangements can lead to conflicting incentives for providers. For example, to encourage a reduction in hospital supply, insurers may pay providers on an activity basis. However such incentives may be diluted if, at the same time, the provider also receives funds from the budget on the basis of the number of beds, whereas if all funding came via one institution, it would be easier to influence behaviour.

Methods of paying providers should be reviewed

In practice, a wide range of payment methods have been used across the Russian Federation and many of these do not encourage greater provider efficiency. While the situation is improving, a large number of regions still reimburse providers on the basis of a fee-per-outpatient (polyclinic) visit or pay by bed day in the hospital sector. Both of these methods of payment encourage over-use of the system and reduce the incentive to enhance prevention. Most European countries have moved away from such payment systems towards prospective payment arrangements that reimburse providers on the basis of a single episode of care within the institution (*i.e.* output-based DRG-type systems). However, while there are incentives in such arrangements to reduce the length of hospital stays, there is also an incentive to increase patient throughput, something of particular concern in the Russian Federation where the supply of beds is large and the potential for overuse is high. One widely discussed alternative would be to channel both budget and MHI contributions to the regional MHI institutions who would distribute these to individual insurers who would then use these funds to purchase services for their insurees within the basic package, an approach that is already used in a number of regions.

To address these issues, the new Law on MHI will channel all financing of the basic package through the MHI funds from 2012. In the future, private insurers will act as purchasers of health care services for their insurees and competition among providers will be largely based on quality. Money will follow the patient and payment of providers will be fixed nationally, leaving the regional funds the possibility of providing supplements. Providers will be accredited by the authorities.

Private insurers and contracting among providers need to be carefully monitored

In the new system, competition in insurance and provider markets is being strengthened, although full information on the reforms is not yet available. The preceding arrangements were based on a model of managed competition in which private insurers receive funds from the regional MHI funds for their insurees, and use these resources to pay providers for care services. This competitive model has not been working as intended when the system was designed in the 1990s. In practice, employers chose the insurance company on behalf of their employees and regional departments of health essentially choose for the non-employed population. In the provider market, insurers are obliged to contract with all providers and prices are set, for the most part, by regional committees that bring together the main actors. Selective contracting among providers is not allowed. Individual patients are normally constrained in their choice of provider as they are obliged to go to their local polyclinic or hospital even where there are alternative providers nearby. Under these conditions, there appears to be little scope for the play of competitive forces to improve efficiency. The insurers simply act as a conduit to channel funds from the regional MHI funds to the providers, adding costs to the system with little benefit except to take on an increasing role in ensuring that providers are not over-charging and that the quality of care is up to contractual standards.

Competition in insurance and provider markets is being strengthened

The recent legislative changes appear aimed at increasing significantly the role of market forces. Under the new arrangements, consumers will have free choice of insurer, doctor or care institution (e.g. polyclinic or hospital).⁵

The new law contains express provisions that an insurance company must be chosen by the person and the insurance company will therefore want to offer the insuree the best package of services to an insured party. Second, the rights of medical insurance organisations to monitor the provision of medical care are defined more clearly. Protecting the rights of insured parties must be the main concern of insurance companies in relation to consumers and this should include such parameters as: the choice of medical organisations for the provision of care, following up the client at all stages of care provision and monitoring how the care was provided. As regards ownership, providers can be either public or private.

But increased competition in insurance and provider markets and increased patient choice may not be easy to sustain over the longer haul unless insurers are obliged to accept – as insurees – all individuals and that effective systems of risk adjustment in insurance markets are able to limit the incentive for “cream skimming” of poor risks. Failing this, those with poor health may find it more difficult to obtain insurance coverage. More generally, Tompson (2007) and Smith (2008) detail a daunting range of regulatory and legislative requirements that appear necessary to make the competitive model work in health care systems. Such models have been tried in relatively few OECD countries (in practice only in the Netherlands) and the jury is still out as to whether the goals of the health care system are better achieved in such models, even in countries with well-developed and stable health insurance and health care arrangements. Thus, while some Russian regions may wish to opt for increased competition, it would seem wise to leave open the option of less complicated arrangements as well (e.g. single-purchaser arrangements as in the Leningrad region).

A further shift from hospital to primary care needs to be engineered

Seen from a budgetary perspective, the low cost of labour inputs in the Russian system is compensated (to an unknown degree) by high numbers of medical professionals and beds, thereby increasing the overall costs. This creates a significant potential for gains by using these inputs more efficiently. In this context, the key policy area for increasing cost-effectiveness is through a shift from hospital to primary care provision, something that is getting underway under the current reforms. At present there are large numbers of beds, high rates of utilisation and long lengths of stay. Every year, one quarter to one fifth of the population spends time in a hospital and 30% of hospital stays are thought to be unnecessary (Sheiman and Shishkin, 2010). Shifting care from the higher-cost hospital sector to lower-cost primary care should help improve provider efficiency. But there are considerable vested interests in maintaining the status quo at both the ambulatory and hospital levels. Any downsizing of the hospital sector would, however, also need to take into account the needs for long-term care beds, particularly for the elderly – of which there are very few outside the hospital sector.

In order to raise both accessibility and quality of outpatient medical care a three-tier system of primary health care provision has been developed by the federal authorities.⁶ The third (or first level of contact with patients) is made up of well equipped municipal outpatient clinics.⁷ The second tier will be made up of inter-regional outpatient centres offering specialised outpatient medical care for areas of care where demand/need is the greatest. At this level, a wide range of diagnostic procedures and special X-ray examinations, including CT and MRI will be offered. The first tier will provide very specialised consultation and diagnostic services for patients from outpatient institutions with more difficult medical conditions. These institutions will also perform a continuing education role aimed at keeping medical professionals up to date with most recent developments in their field. A key aim of this reform is to increase the proximity of care to providers by creating third level clinics closer to patients.

Under the proposed model, one of the main functions of outpatient departments is to develop preventive care. To this end, outpatient clinics are implementing measures to: increase the population coverage of periodic preventive examinations, particularly for the employed; and, visits to health centres promoting healthy living.

Taken together, these measures – if implemented carefully – should facilitate a reduction in the need for twenty-four hour beds and a redistribution of medical care in favour of primary health care institutions. But there is always the risk that such systems will simply lead to a doubling up in supply with excessive levels of both hospital and ambulatory care.

More attention needs to be given to institutions controlling for quality

International evidence on the quality of medical care in the Russian Federation compared with other countries is lacking and there are wide differences across available Russian surveys in the evaluation of various dimensions of quality. Surveys by the MHS suggest that around two thirds of patients are satisfied with their hospital care and the clinical quality of care received. A more detailed survey organised by one of the largest insurance companies⁸ showed that 60% of patients (in the MHI system) are satisfied with the quality of medical care provided, but 70-80% are not satisfied with the organisation of health care provision (time spent in the queues, work of the reception desk, etc.).

But if the health care system is to improve in terms of quality, a regulatory framework for evaluating quality and safety of care is essential. In this context, there has been growing awareness on the part of the authorities of the need for change and they have taken several steps to introduce a unified system of accreditation of medical institutions, the certification of doctors and quality control during the past ten years. But there has been a lack of coherence in introducing these systems and this has resulted in overlapping of responsibilities of different regulatory bodies and there is no assurance that health workers and providers are complying with the regulations. In addition, regions have very different attitudes and approaches to these matters, partly linked to financing and the lack of individuals with skills in this area. As a result, the regional systems of control are *ad hoc*, the role of federal surveillance agencies has been weak and neither regional authorities nor federal regulatory bodies have had administrative power to implement a coherent policy of improving the quality of health care provision.

Currently, two different state bodies have responsibility for quality control at the federal level. The first is the Federal Service for Supervision of Consumer Protection and Human Welfare (*Rospotrebnadzor*). This replaced the san-epid system for epidemiological surveillance but took on wide additional responsibilities (e.g. it controls the implementation of the Law on Consumer Rights Protection and has the charge of prevention policies such as anti-alcohol and tobacco campaigns and HIV/AIDS). The second, set up in 2004, is the Federal Service on Surveillance in Health Care and Social Development (*Roszdrazhnadzor*) which oversees the operations of municipal- and state-owned hospitals and clinics together with regional departments of health and the private insurance companies on the basis of the regulations on standards of the MHS. The scope of the activities of these institutions is wide – and they will need to be adequately staffed if they are to be effective.

Building a wide consensus for further reform

A careful review of legislative and regulatory coherence could enhance the functioning of the system

The reforms initiated in the early 1990s have not been fully completed despite a significant burst of legislation and regulations/instructions, both at the federal and regional levels. At the same time, there has been wide variation across regions in how the reforms were introduced as well as a more general lack of coherence. New laws have come on top of a range of existing legislation and the implications of the interactions between the old and the new have not always been fully understood. Many laws have been introduced, but the necessary secondary enabling legislation has sometimes not followed, leaving great uncertainty as to how the initial legislation should be interpreted. Regions have passed their own legislation and issued orders which may not be fully consistent with similar legislation at the federal level (Tragakes and Lessof, 2003).

The creation of an over-arching legislation to clarify the architecture of the health system and to strengthen co-ordination and governance of the overall health system would appear to be an important medium-term priority. The Plan for the Development of the Health Care System to 2020 represents a start, but it also demonstrates that it has not been easy to establish a consensus as to how progress is to be made. In this context, there is a need to establish institutions that bring together the key policy actors at the federal and regional levels, the medical profession as well as the wider public (e.g. users' associations).⁹

The new Law on Compulsory Medical Insurance just referred to – which was passed in the Duma at the end of 2010 – potentially introduces a number of significant improvements in the organisation of the system both for services provision and for the financial stability of the

system. However, overall judgement on the new system will need to await the necessary enabling legislation/ instructions and regulations which are not yet fully available. Hopefully the supporting documents and instructions will be worked out soon.

A strong information base is essential for improved system governance

A further systemic issue concerns the role of the federal authorities in system oversight and governance. The 1993 law gives responsibility to the federal authorities for the “establishment of a common federal statistics and accounting system in health protection” (Tragakes and Lessof, 2003). The MHSD has collected considerable amounts of information but these have not always been made available to researchers and have not always been produced using internationally-agreed definitions. This makes international benchmarking difficult.

A new policy dynamic may be appearing?

The reforms to the health system in the 1990s and more recently have had to develop under difficult conditions and policy makers and providers have undertaken reforms that in many respects took the system into uncharted waters. The weaknesses in the system, as voiced in this assessment, must be seen against the vast size of the country, a backdrop of extremely difficult economic and social conditions and limited financial resources.

More recently, there have been some encouraging results with regard to health outcomes. As noted, life expectancy has begun to rise again even though economic conditions have been difficult and the associated reductions in mortality have been broadly based. Financial resources allocated to health care have increased and appear set to continue. This should improve access and increase the capacity of the system to fulfil the care needs of Russian society.

In this context, a new policy dynamic may be emerging in which the authorities have begun to address health system issues in a more systematic manner. The authorities are putting in place new prevention policies to address the main causes of mortality: cardiovascular diseases, cancers, road accidents and suicides. Efforts are being made to reduce risky behaviour: anti-tobacco and anti alcohol abuse legislation – although possibly in need of strengthening – has been introduced while chronic diseases are also receiving more attention. Changes to the institutional framework for financing and providing health care are under consideration. Nonetheless, the Russian Federation will continue to face enormous challenges in bringing their health outcomes in line with those in OECD countries. The authorities will need to find additional resources to ensure the maximum impact of the measures taken. In this context, any resource difficulties could be eased if the efficiency of health care provision were enhanced. The policy recommendations set out in Box 0.1 are aimed at helping the authorities achieve these objectives, drawing on the experiences of OECD countries with adaptation to the specific circumstances of the Russian Federation.

Box 0.1. Policy recommendations for the Russian Federation

Reforms to the health system in the Russian Federation need to take account of the need for changing lifestyles and the reduction in risky behaviours. But with mortality having a strong social gradient, this will need to be combined with wider efforts aimed at improving the situation of low-income and socially-marginalised households. Reforms need to focus on improving access to care and increased quality of care received and more efficient use of resources.

System-wide oversight and coherence

- Increase the information base using international definitions to allow better benchmarking of performance across regions and internationally.
- Review the existing health care system legislation at both the regional and federal level to: reconcile regional legislation with federal laws, increase system-wide coherence in the legal framework governing the system.
- Identify more clearly the scope of the Government Guarantee Package and strengthen patient rights legislation to provide recourse where guarantees are not met.
- Switch to single-source financing of health care and revise the role of private insurance companies in quality control.
- For the scope and contents of the Government Guarantee Package (basic package), shift away from broad categorisation of diseases towards cost-effective procedures on the basis of international best-practice medicine and technology assessment.
- Include outpatient pharmaceuticals in the basic benefit package.

Financial sustainability

- Increase public health care spending up to levels of OECD countries with similar GDP per capita (around 5-6% of GDP). Link increased financing of the health care system to improved efficiency of provision: for example, tie increases in federal transfers to regions to performance goals including provision, access, efficiency and quality.
- Increase remuneration of health care professionals in exchange for: an end to informal payments; regular training to maintain skills; and, an increased emphasis on quality.
- Better estimate the needs for different types of health care (especially for high-tech care).

Prevention

- Pursue building of coherent population-wide prevention policies to reduce risky behaviour and encourage healthy lifestyles, particularly among the poor.
- Establish targeted programmes for marginalised households where health risks are highest.
- Continue to develop special TB and AIDS programmes for at-risk groups (former prisoners, drug addicts) accompanied by better social insertion.
- Increase taxes on tobacco and alcohol consumption and curtail unofficial production of the latter.

Access to care

- Better equalise resources across regions linked to meeting performance targets.
- Reduce out-of-pocket payments through increased public funding of the Government Guarantee Package.

- Ensure better access to high-tech care, especially for low-income groups.
- Make transparent the system of price setting for chargeable services.

Quality control

- Introduce access to and use of international best-practice medicine.
- Specify the roles and responsibilities of state regulatory bodies and regional and federal authorities in the organisation of quality control.
- Introduce the system of licensing doctors and accreditation of institutional providers and strengthen the role of medical associations in the licensing of practitioners.
- Review the role of insurance companies in the MHI system in quality control.

Efficiency

- Reduce hospital beds and shorten hospital stays, taking into account long-term care needs.
- Rapidly shift provision towards high-quality primary/ambulatory care though either improving the qualifications of district doctors or by the introduction of more primary care GPs aimed at reducing the rate of referrals to hospitals and specialists.

Move to incentive-based systems for paying providers, such as cost and volume contracts and budget-holder or fund-holder based systems.

Notes

1. Policies to improve prevention of non-communicable diseases were under discussion in the late 1980s and early 1990s. But the impact of these earlier efforts was probably limited, given the economic, budgetary and social changes that followed.
2. Ratios for the Russian Federation and Canada refer to public spending only, while ratios in the United States and Australia refer to total spending.
3. As occurred to some degree in the economic crisis in 1998 (Tompson, 2007).
4. This was the procedure used to define the scope of the Seguro Popular insurance system in Mexico (OECD, 2005).
5. Information on how this is expected to work in practice was not available at the time of completion of the report (Federal Law No. 326-FZ of 29 Nov. 2010 “On Compulsory Medical Insurance in the Russian Federation”).
6. Procedure for the Provision of Primary Health Care (draft order of the Ministry of Health and Social Development of Russia).
7. Services that this level is expected to provide include: local therapeutic services, including specialist doctors, preventive care departments, photofluorography, X-ray studies, electrography, health schools, medical and social care departments, laboratory diagnostics and health centres, day hospitals and acute care.
8. www.medquality.ru/index.php?action=conference/index
9. The National Health Council in Mexico, which brings together the federal and regional health ministers to forge common policies, is one possible example of how to achieve such system coherence (OECD, 2005).

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Chapter 1

The organisation of the Russian health system

This chapter provides background material aimed at helping to understand better the context of current health policy in the Russian Federation and its recent development. It then goes on to describe the economic size of the health sector and key features of the Russian health care system, in particular the arrangements for the financing and supply of health care and public health services.

Geography and economic diversity

The Russian Federation is the largest country in the world in terms of surface area. Distances are enormous and providing adequate health care to the entire population is a challenge of epic proportions. This influences the costs of the health system as ensuring a basic level of care in rural areas where population density is low is expensive. While this is one reason often put forward to explain why the Russian Federation has such high levels of hospital beds and numbers of doctors when compared internationally, other countries with similar geographical features such as Canada and most of the Nordic countries appear to be able to achieve much better outcomes with lower levels of inputs. There are also wide differences in economic conditions ranging from oil-producing regions where the level of GDP is 18 times the average per capita GDP to rural regions in the south of the country (Ingushetia Republic) where it is 3.5 times below the nation-wide average (Table 1.1).

The switch to a market economy during the 1990s and the associated economic decline was marked by a widening in the distribution of income and an increase in the share of households living in poverty, as measured by those living below the officially calculated subsistence level.¹ In 1992, an estimated 33.5% of the population belonged to this group. Rapid economic growth over the course of the current decade has helped reduce the overall share of the population with incomes below the subsistence level to 13.1% by 2008^{2,3} (Rosstat, 2009a). Given the large share of out-of-pocket spending for health care, this decline in the poverty rate seems likely to have increased access to care over this period (see below and Chapter 3).

There remains, nonetheless, considerable inter regional differences in the degree of poverty (as measured by the share of the population lying below the subsistence threshold), ranging from 8.4% of the population in the Republic of Tatarstan to 38.4% in the Republic of Kalmykia in 2008 (Rosstat, 2009a, Table 1.1). Somewhat surprisingly, there is little relationship between income per capita and the share of the population below the subsistence threshold.

The transition to a market economy, economic crises and population health

The social, political and economic upheaval that occurred in the Russian Federation during the transition period provoked dramatic changes in the lives of ordinary people. There was a drastic loss of real savings and salaries as a result of rapid inflation during the first years of reforms, leading to the impoverishment of a significant part of the population. The economic and social dislocation meant that a good portion of the population had to change their profession, jobs or modes of living. These changes had serious implications for broader social and economic life, leading to social disorganisation and loss of social capital.

At the same time, new governance arrangements have had to be developed and the political system rebuilt in an environment where there was only limited experience in law-making, good governance and effective stewardship. This occurred against a background of rapid decentralisation with 83 “constituent parts of the Federation” gaining varying degrees of autonomy, including responsibility for the funding and provision of health care.⁴

The two serious economic crises in 1992 and 1998 were followed by a rise in mortality and a shortening in life expectancy. From 1992 to 1994, life expectancy of Russian males at birth dropped from 63.8 to 57.7 years. Female life expectancy dropped from 74.4 years to 71.2 years (Figure 1.1) (see Chapter 3 for greater detail).

Table 1.1. Inter-regional differences in selected dimensions: highest and lowest regions ranked by GDP level, circa 2008

Russian Federation as of 1 January, 2009

Regions	Population density (persons per sq. km)	Population (in thousands persons)	Share of rural population in total population (%)	Share of population higher educated per 1000 persons (15+) in 2002	GDP per capita (roubles)	Regional structure of value added (% of extracting industries)	Share of the population under subsistence level (%)
Russian Federation	8.3	141 915	26.9	160	241 767	9.9	13.1
1 Central Federal District	57.1	37 118	19.2	197	348 107	0.9	
Ivanovo region	50.1	1 067	19.2	137	79 979	0.4	20.1
City of Moscow	9 632.4	10 563	-	299	804 718	0.0	11.8
2 North West Federal District	8.0	13 437	17.6	179	252 220	6.9	
Pskov region	12.6	689	32.2	128	104 801	0.2	16.2
City of Saint-Petersburg	3 275.1	4 600	-	265	310 567	0.0	11.0
3 South Federal District	38.7	22 968	43.2	144	120 028	1.8	
Republic of Ingushetia	140.0	517	56.9	111	38 110	2.1	27.8
Volgograd region	23.0	2 590	24.5	149	165 812	4.6	13.5
4 Privolzhsky (Volga) Federal District	29.1	3 011	29.7	138	177 124	12.5	
Republic of Marij El	30.0	698	36.6	142	96 057	0.1	25.2
Republic of Tatarstan	55.5	3 779	25.1	144	245 162	22.0	8.4
5 Urals Federal District	6.7	12 280	20.3	137	396 763	35.1	
Kurgan region	13.3	948	43.2	105	111 277	0.6	17.9
Tyumen region	2.3	3 430	20.4	151	928 374	52.9	10.4
6 Siberian Federal District	3.8	19 561	29.2	140	178 596	9.2	
Republic of Tuva	1.9	317	48.8	109	78 039	5.4	32.9
Krasnoyarsk territory	1.2	2 894	23.4	144	256 130	4.2	16.3
7 Far East Federal District	1.0	6 440	25.7	154	239 109	20.6	
Jewish autonomous region	5.1	185	33.8	97	143 930	0.5	23.6
Sakhalin region	5.9	511	21.8	134	650 259	49.5	11.5

Source: Rosstat (2009), *The Demographic Yearbook of Russia 2009* and Rosstat (2009), *Regiony Rossii 2009*.

Figure 1.1a. Life expectancy of women at birth, Russian Federation and selected countries, 1980 to 2010

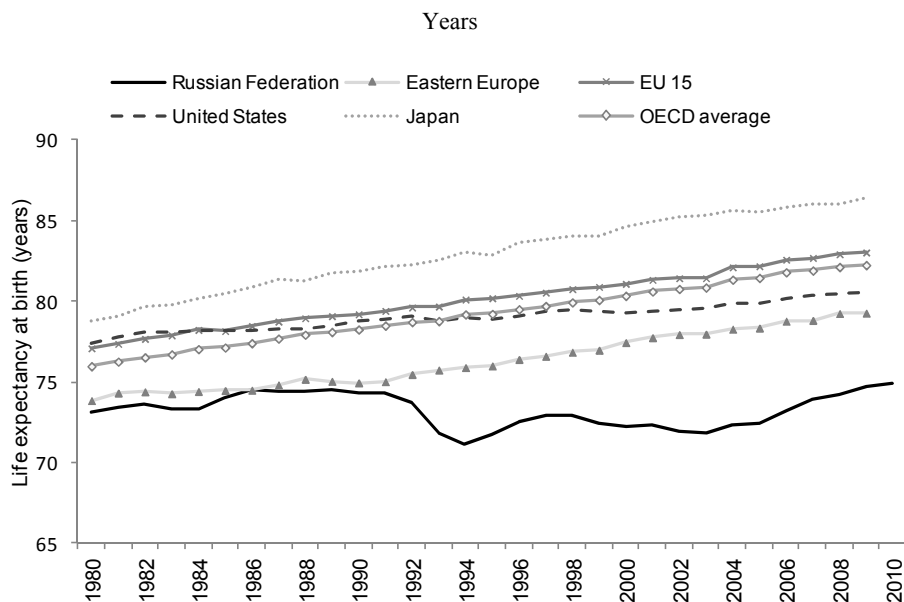
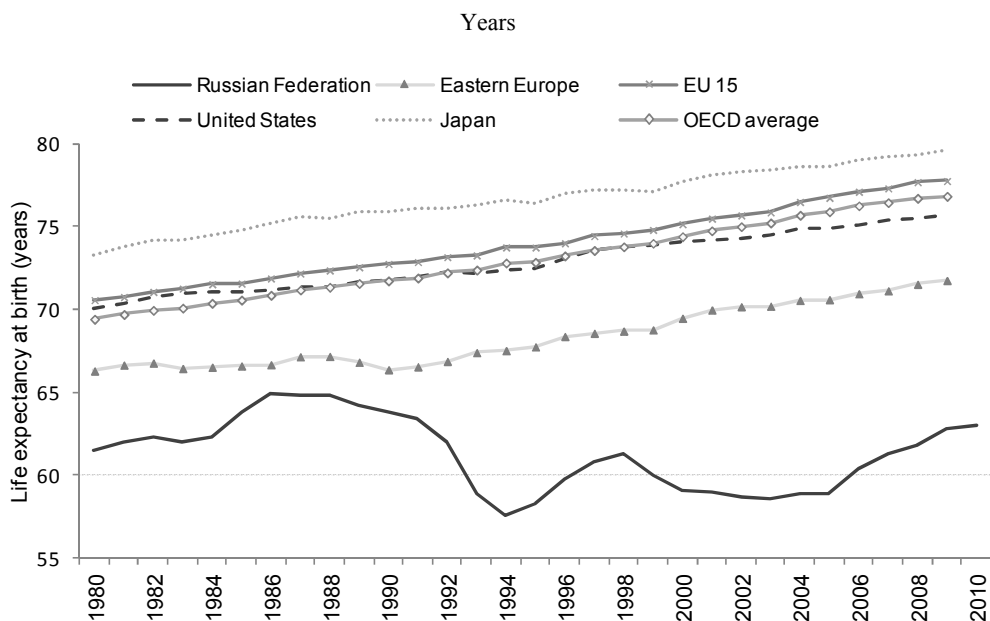


Figure 1.1b. Life expectancy of men at birth, Russian Federation and selected OECD countries, 1980 to 2010



Note: Data on the eastern European OECD countries include the following countries: the Czech Republic, Hungary, Poland and the Slovak Republic.

Data on the EU-15 include the following countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom.

Chile, Estonia and Slovenia are not included in OECD average.

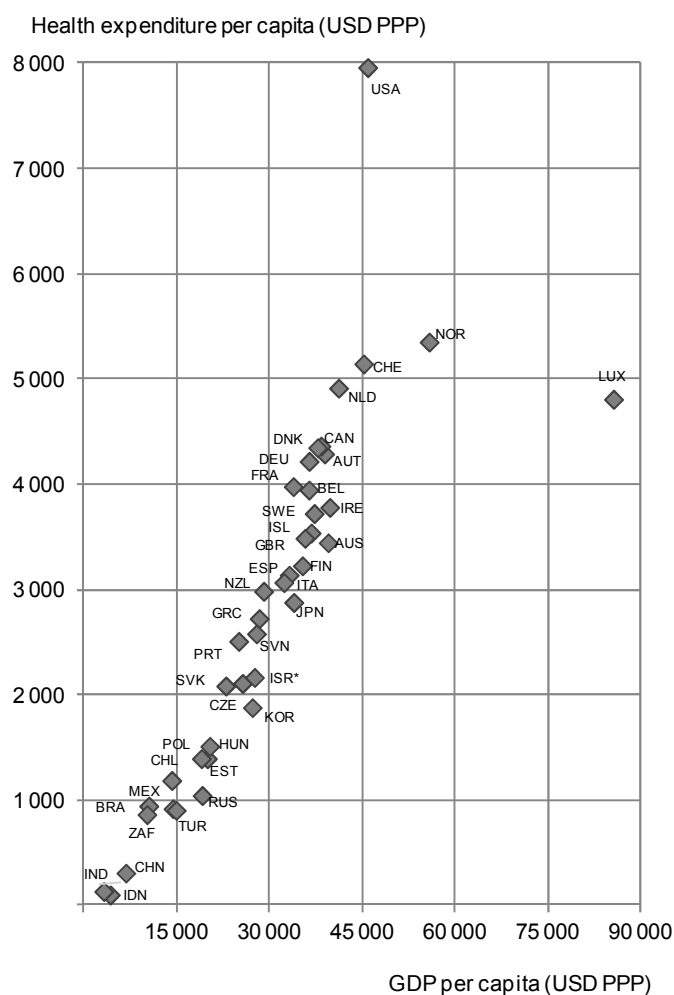
Source: OECD Health Data 2011 and Rosstat, MHS estimates for 2010.

After 1994, life expectancy improved in the Russian Federation. However, the second crisis that began in mid 1998 led to a sharp increase in poverty. Shortly thereafter, mortality increased and male life expectancy dropped from 61.0 in 1998 to 59.7 years in 1999, while female life expectancy dropped from 72.6 to 71.9 years. Life expectancy broadly stabilised during the following five years at this low level. Nonetheless, this trend has been substantially reversed since 2004 and male/female life expectancy is now 63.0/74.9 despite the recession of 2008-09 (see Figure 1.1).

The economic size and structure of the health sector

Total health expenditure in the Russian Federation was estimated at 5.6% of GDP in 2009 (WHO, 2012). This compares with an OECD average of 9.6%. Nonetheless, the levels of total health spending in the Russian Federation are not out of line with other middle-income countries once one controls for GDP per capita (Figure 1.2).

Figure 1.2. Total health expenditure per capita and GDP per capita, 2009

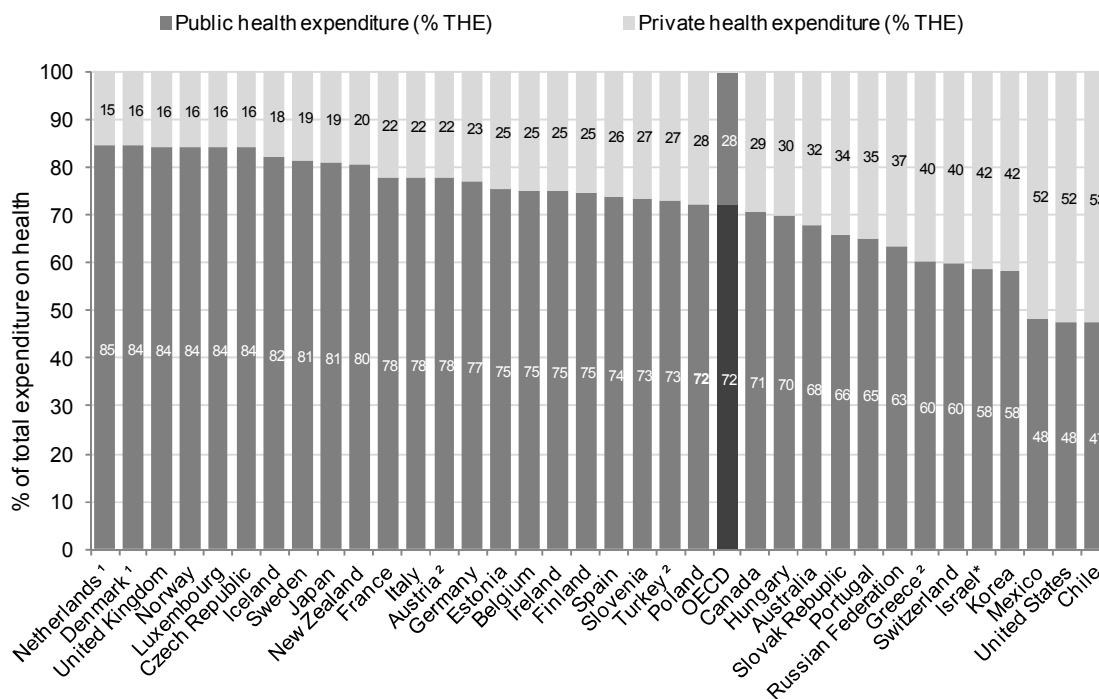


* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2011; WHO Global Health Expenditure Database.

Public spending represents roughly 63.4% of the total (3.6% of GDP), well below the OECD average of 72%, and the private sector spending, at 36.6%, is well above the OECD average (Figure 1.3). This pattern of spending has strong implications for access to health care (see Chapter 3).

Figure 1.3. Share of public and private spending in total health care spending in 2009, Russian Federation and OECD countries



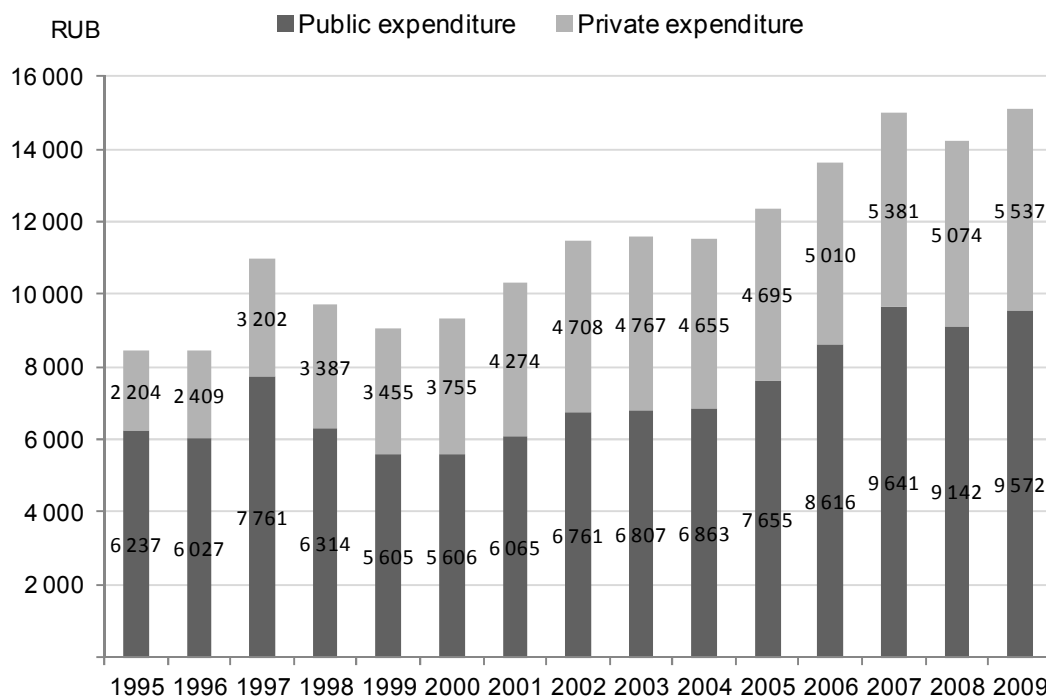
1. 2007; 2. 2006.

THE: Total Health Expenditure.

* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2011 and WHO Global Health Expenditure Database 2012 for the Russian Federation.

Health care expenditure in the Russian Federation has been rising in recent years on the back of rapid GDP growth and increased federal spending (Chapter 2), which in itself has increased overall spending by an amount totalling around 1% of GDP but spread over three years. On a real per capita basis, total spending was still only 38% above the pre-crisis peak of 1997 by 2009. More importantly, public spending has risen by only 23% over the same period while private spending has risen by over 73%, suggesting that households are being asked to pick up an increasing share of the bill for health care, potentially with knock-on effects on access (Figure 1.4). A major part of private spending goes on pharmaceutical drugs, together with lesser amounts going to formal and informal payments for hospital and other services.

Figure 1.4. Public and private expenditure per capita in the Russian Federation, 1995-2009

Source: WHO Global Health Expenditure Database 2012, and OECD.stat 2012 for GDP deflator.

Time-series data in Table 1.2 indicate that total health spending as a share of GDP reached a high of 7.3% in 1997 (mainly from higher public spending), before declining sharply over the following three years reflecting the sharp fall in oil prices and the financial collapse. Private expenditures on health have tended to move to offset partly the fluctuations in public expenditure. For example, as public spending started to rise again in 2005-06, the share of private spending in GDP tended to fall. While there has been little increase in spending as a share of GDP in recent years, that does not mean that spending has stagnated. In fact, total health spending increased by over 30% in the three years to 2007, partly reflecting the increased expenditure under the National Priority Programme “Health” (NPPH) (see Chapter 2).

Available data indicate some major divergence from OECD patterns in the structure of spending. The Ministry of Economic Development (2008) estimated that 60% of health care spending was for inpatient care in 2007, compared with 34.2% for the OECD average.⁵ Further support for the predominance of inpatient care is provided by the large number of beds, high rate of hospitalisation, long average length of stay and the large share of doctors who work in hospitals. In addition, the number of general practitioners – on which it appears that a new model of primary care is to be built (see below) – represents under 5% of the total number of doctors in 2004, and they are concentrated in very few regions (mainly Samara, Veronezh and the Chuvash Republic).

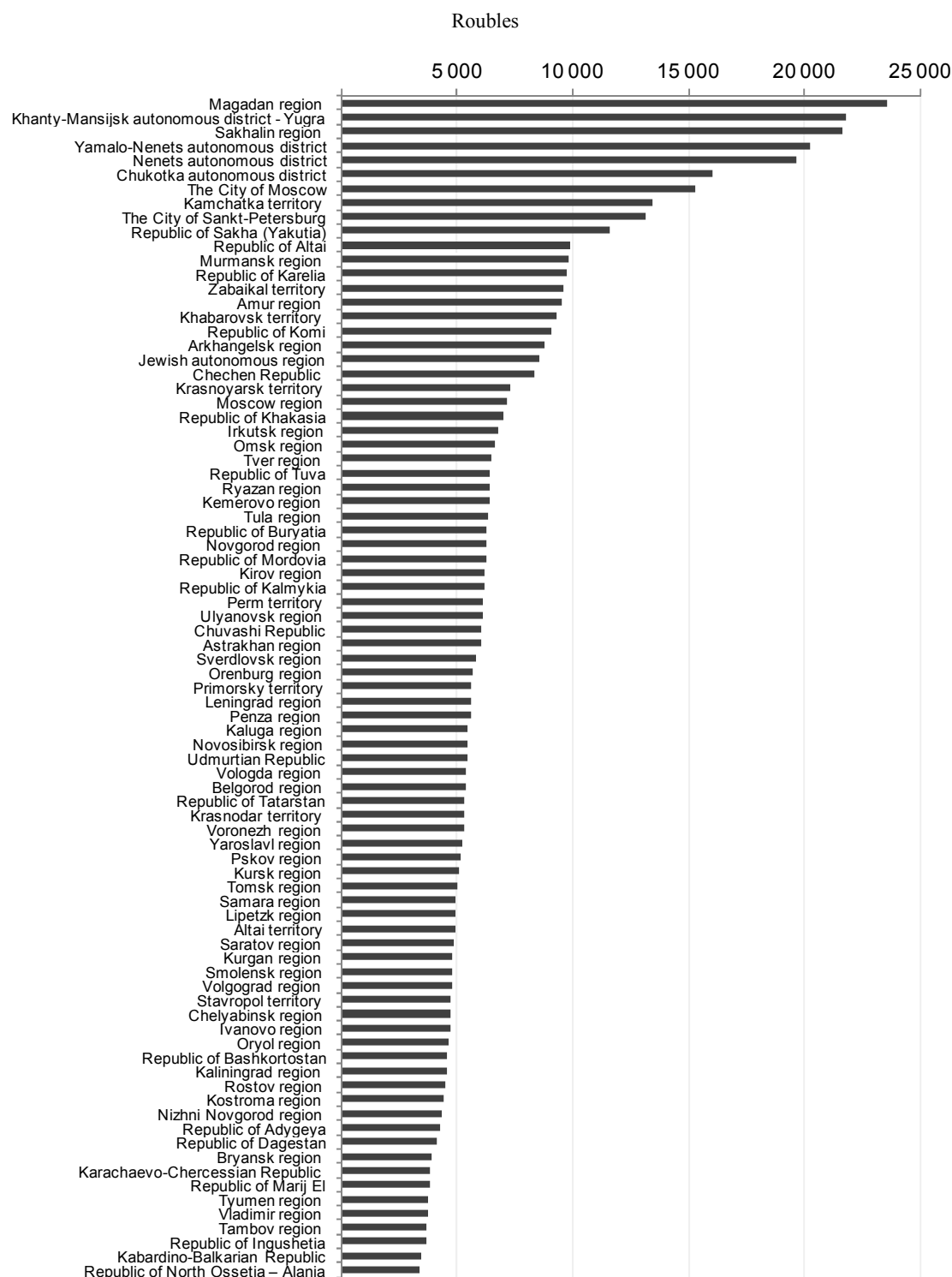
Table 1.2. Public and private expenditure devoted to health, Russian Federation, 1995 to 2009

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total expenditure as a share of GDP (%)	5.6	5.8	7.3	6.8	5.7	5.4	5.7	6.0	5.6	5.2	5.2	5.3	5.4	4.8	5.6
Public expenditure as a share of GDP (%)	4.0	4.0	5.0	4.3	3.6	3.2	3.3	3.5	3.3	3.1	3.2	3.4	3.5	3.1	3.6
Private expenditure as a share of GDP (%)	1.6	1.8	2.3	2.4	2.2	2.2	2.3	2.5	2.3	2.1	2.0	2.0	1.9	1.7	2.0
Public expenditure as a share of THE (%)	70.7	68.2	68.5	63.8	62.5	59.9	58.7	59.0	58.8	59.6	62.0	63.2	64.2	64.3	63.4
of which Federal and territorial MHI funds (% public funding)	34.5	35.7	30.7	36.5	35.8	40.3	39.5	40.5	39.6	39.4	42.0	42.3	38.7	38.7	38.7
Federal and territorial budgets (% of public funding)	65.5	64.3	69.3	63.5	64.2	59.7	60.5	59.5	60.4	60.6	58.0	57.7	61.3	61.3	61.3
Private expenditure as a share of THE (%)	29.3	31.8	31.5	36.2	37.5	40.1	41.3	41.0	41.2	40.4	38.0	36.8	35.8	35.7	36.6
Public health expenditures as a share of total government spending (%)	9.0	8.7	10.5	9.6	9.3	9.6	9.6	9.5	9.4	9.7	10.1	10.8	10.2	9.2	8.5
Annual growth of real spending by financing agent (% previous year)															
Total health	-0.2	29.7	-11.8	-11.8	-6.9	2.9	10.0	10.4	0.5	-0.9	6.9	10.1	10.1	-5.5	6.2
Public spending	-3.5	28.5	-18.9	-18.9	-11.5	-0.3	7.7	11.0	0.2	0.4	11.2	12.3	11.7	-5.3	4.6
Federal and territorial MHI funds	-0.1	10.3	-3.6	-13.1	-13.1	12.3	5.6	13.7	-2.1	-0.1	18.6	13.1	2.3	-5.3	4.6
Federal and territorial budgets	-5.3	38.6	-25.6	-10.6	-10.6	-7.4	9.2	9.2	1.8	0.8	6.3	11.7	18.6	-5.3	4.6
Private spending	9.1	32.6	5.5	5.5	1.7	8.3	13.3	9.7	0.8	-2.7	0.5	6.5	7.2	-5.8	9.0

THE: Total health expenditure.

Source: WHO Global Health Expenditure Database, 2012.

Figure 1.5. Public health care expenditure per capita by region in 2009



Source: Institute for Health Economics, Higher School of Economics. Estimations based on federal treasury data and federal MHI fund data (personal communication, unpublished).

In 2009, there were wide differences in public health care spending per capita by region, ranging from a high of RUB 23 600 in the Magadan Region in 2009 to a low of RUB 3 430 in the Republic of North Ossetia – Alania (Figure 1.5). These differences reflected partly different social choices by regions in terms of the use of general (non-earmarked) equalisation grants from the central government. But they also showed the great difficulties facing the Russian authorities in ensuring access to the basic Guarantee Package for health care services across the country.

From 2013, the financing system will change according to the Law on Mandatory Health Insurance adopted in 2010. The government will estimate each year the amount of money needed to provide free access to health care goods and services included in the Government Guarantee Package for the average beneficiary of health insurance. For 2011, this amount of money is 18 300 RUB. Regional governments will be asked to pay this amount of money for the non-working part of the population and this will be a condition to obtain further transfers from the federal government if needed. The global budget needed for each region will be computed as the product of the number of people insured (working and non-working) and by the amount per capita set by the government and this will be complemented by transfers from the federal level (federal MHI fund and central government) where needed. This reform is expected to equalise the regional differences in health spending and increase spending in the poorest regions.

The organisation of the health care system in the Russian Federation

One of the great achievements of the Soviet system (Box 1.1) was the creation of a network of care arrangements over a wide area, a factor that may help explain the large number of hospitals, beds and health care professionals. But it also reflected an emphasis on controlling communicable diseases through the hospitalisation of the sick, which may partly explain the peculiar pattern of supply in which primary care was neglected and greater emphasis was placed on treatment by specialists in a hospital environment.

However, the Soviet system has proven to be poorly adapted to the epidemiological shift towards chronic diseases which, in most of the OECD area, relies more on ambulatory care supported by greater use of pharmaceutical drugs. The system has also suffered from a long period of financial neglect, leading to a widespread obsolescence of medical equipment, lack of drugs and medical materials and the deterioration of buildings. In addition, low salaries have de-motivated staff. Under these circumstances, it is perhaps not surprising that the system has not been able to provide required levels of care and achieve the desired results in terms of health outcomes (World Bank, 2005; MOH, 1997⁶).

Box 1.1. The legacy of the Soviet period: the Semasko model

Before the reforms of 1991-93, health policy and the oversight of the implementation of that policy were entirely vested in the Ministry of Health of the USSR. The ministry also oversaw third-level hospitals that it owned and the Academy for Medical Science, as well as national targeted programmes such as vaccinations, and TB.

The Soviet Union was the first country in the world providing free *health care* for all. The widespread supply of services across the country reflected the soviet-era objective of bringing health care services to all parts of the country and the number of hospital beds was steadily increased. The planning of the system was quantitative. A formula was used to fix the required number of hospital beds, doctors, specialists and nurses in a district or region, taking into account the demographic and epidemiological characteristics identified through the san-epid system (see below). Pay of hospital staff was financed directly from the ministry. Although doctors and nurses were, in principle, required to take courses to maintain their skills, these were rarely enforced. Budgets varied on the basis of standardised mortality rates, with little adjustment to take account of local conditions and needs. Successive budgets normally followed the historical patterns and there was little change in the structure of spending over time.

“Quality” control was also input-based to the extent that the federal ministry often defined, for each treatment, what was needed in terms of hospital stays and complementary tests. Before the devolution of powers, the central Ministry of Health also had regulatory oversight for: pharmaceuticals, medical technology, standards for medical staff and medical institutions and the training of medical professionals. Norms and regulations were set at the national level.

The State Sanitary Epidemiology Service or san-epid system was a key instrument in overseeing the system. Its regional and local offices provided information on problems of communicable diseases or environmental conditions. It also undertook vaccination programmes at a local level. The Russian Federation has a long history and tradition of extensive anti-epidemic and environmental health activities and programmes. Such activities were successful in reducing the incidence of morbidity and mortality from, infectious diseases for decades. A major priority in the work of the state sanitary and epidemiological service has been the introduction of a social-hygienic monitoring system, the evaluation and forecasting of population health, as well as the assessment of environmental risks.

The decentralisation of powers

A key feature of the current health care system has been the progressive decentralisation of the system during the 1990s. This was formalised in the 1991-93 reforms with the regions taking over responsibility for financing, as well as responsibility for wages and salaries, control of costs, oversight of quality and training institutions (Mathivet, 2006).⁷ The Federal Health Ministry did retain responsibility for system-wide oversight and setting the broad goals of policy. It also maintained control over norms for treatment, and for education programmes of medical professionals and the control and licensing of drugs. Nonetheless, the decentralisation has limited the capacity of the federal authorities to oversee the system and, given that it no longer controls the budgets in the regions, it has limited power or leverage to influence regional decisions. In addition, while the authorities still collect data on health status or other indicators of need, they do not have the fiscal capacity to re-channel much in the way of ear-marked resources to those parts of the country which have the greatest need. The decentralisation has meant that much of the responsibility for regulatory oversight has been taken over by local providers and administrations.⁸ The place of the san-epid system in enforcing sanitary standards remains – although under a new name – and its capacity to impose compliance is said to have been weakened (World Bank, 2004).

Until recently, the health sector operated under a thicket of very general federal laws, old instructions of the Ministry of Health (sometimes issued in the 1980s) and new orders of the federal ministry and regional ministries or departments of health which aimed at clarifying the gaps in the current legislation. This regulatory structure has made the emergence of a nationwide health system with similar coverage and health benefits for all more difficult (Tragakes and Lessof, 2003). The new Law on Compulsory Medical Insurance, came into force on the first of January 2011, permits the central government to take a stronger role in guiding the development of the system, for example by introducing similar standards of quality of health care and increasing levels of financing in all of the constituent parts of the Russian Federation.

The introduction of the Mandatory Health Insurance funds

The Russian authorities opted in the early 1990s to make the transition to an insurance-based system, the key aim being to place the financing of health care on a more stable footing. The Law on Medical Insurance was also intended to ensure the established principle of free provision (Article 41 of the 1993 Constitution). At the same time, it was intended to restructure the system of provision to make it more efficient and more responsive to patient needs. The first Law on Medical Insurance in the Russian Federation was adopted in 1991 and

led to the creation of a Federal Fund for Mandatory Health Insurance (FFMHI), as well as territorial funds in each of the Russian Federation's constituent regions.

The Mandatory Health Insurance (MHI) system was intended to promote both efficiency and patient choice by enabling patients to choose among competing medical insurance companies which, in turn, would act as informed buyers of medical services. Thus, MHI funds would be channelled to health care providers via public or private insurers which would have incentives, both to work for better patient care (in order to attract clients) and to press providers for greater efficiency (to hold down costs). Health care providers would have to compete for the custom of insurers, who would contract with them to purchase health care services. The introduction of this purchase-provider split was also expected to facilitate the restructuring of care, as resources would migrate, in principle, to where there was greatest demand, allowing for a reduction in excess capacity in the hospital sector and stimulating the development of primary care. Finally, it was intended that insurance contributions would supplement budget revenues and thus help to maintain adequate levels of health care funding.

However, the results to date of this major systemic reform do not appear to be those expected, possibly because the play of market forces has been extremely limited. This in turn has reflected a failure to resolve problems with financing, competition and micro-level incentives (Gontmakher, 2009; Chubarova, 2008). This is discussed further in Chapter 3.

The basic package of free health care: the Government Guarantee Package

The Guarantee Package Programme defines the scope of free services to which residents are entitled. It was formally defined for the first time in 1998 and is defined annually by ministerial order (Box 1.2). Arrangements introduced in the late 1990s provide for the involvement of the federal and regional governments and MHI funds in planning provision and matching commitments for free health care with available resources. The Government Guarantee Package establishes a minimum set of services that all regions are expected to provide (per capita spending in primary care, hospital bed-days, etc.), although the coverage of free health care can be widened if individual regions wish and this has led to some differentiation in access to free care between richer and poorer regions (MHSD, 2007). However, there is no assurance that care included in the basic package is available or that it meets minimum quality standards.

The Guarantee Package Programme was also intended to facilitate a shift in provision away from inpatient care and towards greater outpatient care (see below). Under the programme, the federal government sets utilisation targets for provision which define the minimum package of services for the regions and also serve as targets for this restructuring process. The regions are obliged to develop territorial programmes complying with the minimum norms set by the federal authorities. However, given the limited change in the pattern of supply, the degree of compliance is probably low (Tompson, 2007).

Box 1.2. The Guarantee Package Programme for 2010

Free services to be covered by the *MHI funds* include: primary care and specialised (excluding high tech) care, including pharmaceutical drugs used for inpatient care, provided to patients with:

- Contagious and parasitic diseases, excluding venereal diseases, tuberculosis and AIDS;
- Cancer, endocrine system diseases, skin diseases;
- Nutritional disorders and nervous system diseases;
- Blood diseases, immune system pathology, heart and circulatory diseases;

- Eye, ear and respiratory diseases;
- Pathologies of the digestive system, all types of injuries and poisonings;
- Bone and muscle diseases;
- some types of congenital disorders, birth defects ;
- Pregnancy, delivery, postnatal and postpartum periods and abortions; and
- Some other diseases.

The following services are to be funded through the *federal budget*:

- Additional primary care in specialised medical centres owned by state (e.g., the Russian Academy of Science Centres, the Federal Biomedical Agency);
- Specialised care in Federal Specialised Centres listed by the MHS;D;
- High-tech care;
- Mass check-ups;
- Medical care for the certain groups of patients covered by federal laws;
- Emergency care, primary care and secondary care for the employees in the industries with dangerous labour conditions;
- Pharmaceutical drugs for patients with neoplasm of lymphoid and blood-forming tissue based on the list of drugs approved by the Government of the Russian Federation; and
- Pharmaceutical drugs for patients with malignant lymphoid growth, haematoplastic and related tissues growth, haemophilia mucoviscidosis patients, pituitary dwarfism patients, Gaucher disease patients, multiocular sclerosis patients, as well as to those after transplantation of organs and/or tissues, in accordance with the list of pharmaceuticals approved by the Government of the Russian Federation.

The following services are to be funded through *regional budgets*:

- Specialised air ambulance services;
- Secondary care provided to patients with socially significant diseases, including: skin and venereal diseases, tuberculosis, AIDS, mental problems and drug addiction;
- High-tech care in regional medical centres in addition to that planned in federal budget);
- Pharmaceutical drugs for outpatient care for certain categories of patients which are entitled to free drug provision or 50% discount for drugs for patients with haemophilia, cystic fibrosis, pituitary dwarfism, Gaucher's disease, and for patients after organ and/or tissue transplantation based on the list of drugs approved by the Government of the Russian Federation; and
- Pharmaceutical drugs for outpatient care for certain categories of patients which are subject to 50% discount for drugs.

The following services are to be funded through *municipal budgets*:

- Emergency care [excluding specialised (aviation)]; and
- Primary care provided to patients with socially significant diseases, including: skin and venereal diseases, tuberculosis, AIDS, mental problems and drug addiction.

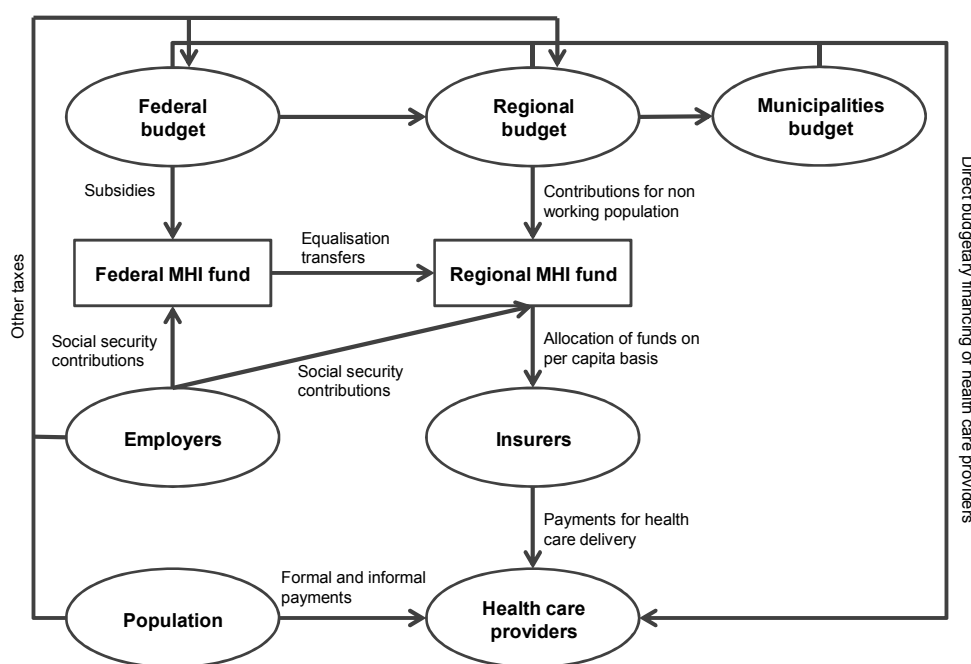
Source: Government Order No. 118, issued 2, October, 2009, www.minzdravsoc.ru/docs/mzsr/letters/163.

Financing the health care system

The Russian Federation has a multi-tiered health care financing system that includes budgetary funds (from federal, regional and local budgets), extra-budgetary funds (Mandatory Health Insurance, pensions and social insurance) as well as private resources (households' direct payment for care and voluntary health insurance) and international assistance.

The main sources of financing are taxes raised by all levels of governments which feed into their general budgets, social contributions paid on payrolls, out-of-pocket payments by households and, to a lesser extent, premiums paid to private insurers for voluntary supplementary coverage. The broad outline of the organisation of flows of financial resources is shown in Figure 1.6.

Figure 1.6. Financing public health care in the Russian Federation



Source: Adapted from Tompson (2007), "Healthcare Reform in Russia: Problems and Prospects", *OECD Economics Department Working Papers No. 538*, OECD Publishing, Paris.

Structure of health spending by financing agent

In 2009, 63.4% of total health spending was financed by the public sector (including different levels of government and Mandatory Health Insurance) while the private sector – mainly in the form of households out-of-pocket spending – paid for the remaining 36.6%.

The most important part of public funding came from resources allocated by federal, regional and municipal governments (38.8% of total health spending) and the remaining 24.6% were channelled through health insurance funds.⁹

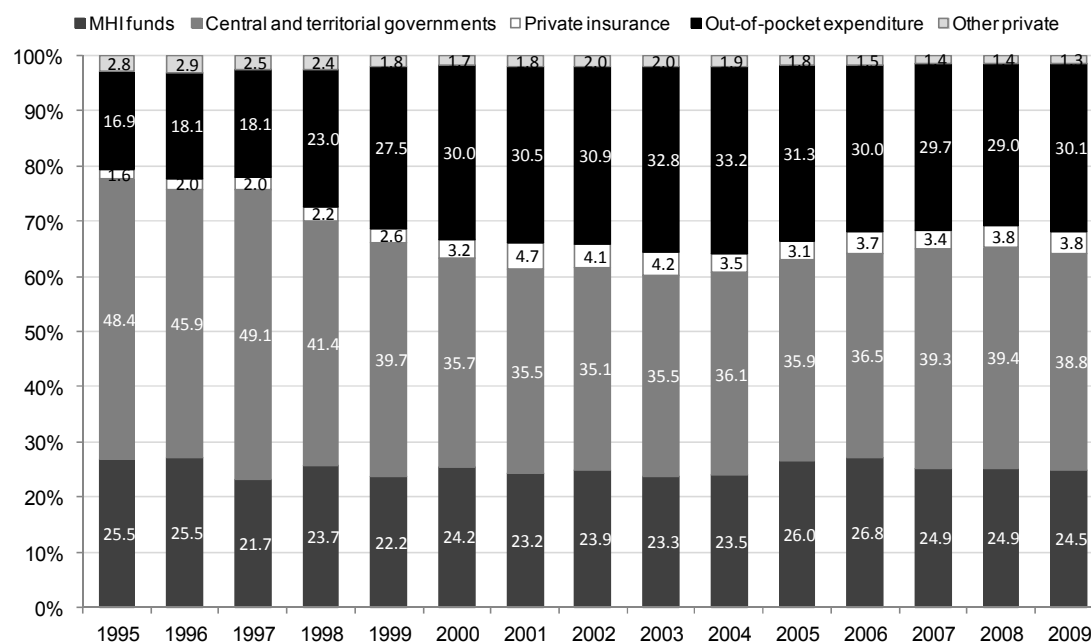
The federal authorities finance the separate health care facilities run by the Ministry of Defence and other ministries, federal-level tertiary hospitals, training, research and public health activities although financing of these entities will be integrated into the Mandatory Health Insurance system from 2015. The regional/municipal authorities finance the cost of health care

not covered by the MHI system including emergency services, special programmes of a public health nature and certain high-cost interventions (Box 1.2). Regions also pay contributions to MHI funds on behalf of the non-employed directly from their own budgets. In 2006, the respective shares of federal, regional and municipal governments in government budget allocated to health care (and sport) were: 14%, 68% and 18% (Kraan *et al.*, 2008).

Households' direct payment for health services account for 82% of private payments for health (*i.e.* 39% of total health spending), a relatively high level by international standards. These payments include (Shishkin *et al.*, 2003):

- Payments for services that are not covered by the Guarantee Package, sometimes referred to as “chargeable health services”. To help resolve problems of insufficient financing of public providers, the federal government allowed provider institutions to charge for certain types of medical care from 1996. They include: payments for drugs and medical devices in out-patient care; medical examinations and tests that a patient needs to receive this or that formal certificate (*e.g.*, to obtain a driver's license, regular occupational health screening certificate, certificate requested by prospective employer, etc.); hotel/auxiliary services at hospitals (single or double room with a TV set, refrigerator, etc.); medical interventions involving the use of advanced/modern technologies (*e.g.* endoscopy, MRI), as well as procedures performed by doctors at the patients' request; consultations by physician specialists without a referral; diagnostic procedures, including those “bypassing the waiting list” or additionally requested by the patient; additional treatments (acupuncture, massage); high-quality prostheses; a personal nursing station and, cosmetic/plastic surgery.
- Informal out-of-pocket payments for health services paid directly to providers.

Figure 1.7. Contribution of private and public expenditures to total health expenditure, Russian Federation, 1995 to 2008



Source: WHO Global Health Expenditure Database, 2012.

Voluntary health insurance plays a minor role in total health financing, with a contribution of 3.8%.¹⁰

Between 1995 and 2008, the structure has not been stable. The private share in total health spending increased up to 41% until 2001-03 and then decreased to 36% in 2008. The share of budgetary funds decreased from 46.3 to 40.1% while the share of MHI funds increased slightly from 24.4 to 25.4% (Figure 1.7).

Sources of financing

The main sources of health financing are, thus: general taxation, social contributions and out-of-pocket payments.

Resources allocated to health by the different levels of government are financed from their general budgets, with resources coming from their own tax revenues and from transfers (grants) from higher to lower levels of government. Grants are of three types: equalisation grants (non-earmarked); subsidies; and subventions (both earmarked). The latter covers the financing of delegated functions and federal mandates. The respective shares of own tax revenues and grants in regional/local budgets vary with the wealth and the tax base of the region/municipality. In 2006, the share of grants accounted for 16% in regional budgets on average and for 30% to 80% of municipal revenues (Kraan *et al.*, 2008). There are no earmarked grants for health financing.

The MHI system is financed by a payroll tax. Until very recently a Unified Social Tax (UST) was collected to finance several branches of social security (including pensions and health insurance). The UST rate for health was 3.1% of the wage bill. Of this amount, 2% was allocated to regional MHI agencies to finance the health care of the working population. The remaining 1.1% went to the federal MHI who then used it to correct partly for regional differences in financing capacity.¹¹ In 2010, the UST was replaced by a new insurance contribution paid directly to social security funds. The contribution rate for Mandatory Health Insurance increased to 5.1% of the wage bill in 2011.

Regional MHI funds also receive regional budget contributions for the non-employed. However, very often the regions are unwilling pay these contributions and this has led to smaller share of MHI revenues in total public health spending than was initially anticipated. To tackle this problem, the federal authorities set a minimum contribution that regions should provide for each non-employed person in 2007. However, only a little over 40% of insured persons are working and many of these are paid under “grey” schemes, so avoiding paying at least some of the contributions which are due and imposing a high burden on regional budgets (Figure 1.6).

Even with the increase in contribution rates, the additional funding may still not be adequate to finance the Programme of State Guarantees from MHI funds across all regions. On the revenue side, the lack of financial resources from the MHI in the richer regions has been compensated by more generous contributions to MHI funds for the non-working population or by directly financing a large share of the cost of health care providers from regional budgets. At the other extreme, poorer regions receive transfers from the federal MHI fund but these are often insufficient to close the financing gap arising from low levels of employment and wages. As a result, the structure of financing health care differs considerably across regions. As noted, there are also significant cross-regional differences in the services that are covered by the regional Guarantee Package, with richer regions often having wider coverage of health care provision *e.g.* for better oncology and cardiovascular disease treatments, for drug provision and for bonuses for medical professionals, etc.

The current “dual financing” arrangements – *i.e.* with funding from the MHI contributions and directly from the budget – can create perverse incentives for providers (see Chapter 3.)

The situation should improve if the MHSD manages to shift to full payment for care through the MHI system by 2013 in accordance with the new law.

Channelling funds to providers – the role of the insurance system as intermediary

The 1991-93 reforms intended that the regional MHI funds would be distributed to private insurers on the basis of the number of their insurees. These insurers would then pay the providers for the care received by their insurees under the Government Guarantee Package. The number of private insurers has progressively increased and they are now present in around three quarters of the regions. Where this is not the case, this role of payer has been undertaken by the regional MHI fund or the local branches of the regional fund. At its inception, the MHI system was expected – through its purchasing practices – to take an active role in the shift in provision of care away from in-patient care towards ambulatory services. This has not occurred and the insurers appear simply to channel the funds from the regional MHI fund to the providers after adding in their own operating costs (estimated to be around 3-4% of fund income on average).

More generally, regulations sharply constrained competition among both insurers and providers. In the insurance market, the employer chose the insurer – thereby limiting individual choice – and the regional authorities chose the insurer for the non-employed. In provider markets, the insurance funds must contract with *all* providers, thereby limiting any selective contracting and levels of reimbursements are set by a committee¹² and applied to all insurers. Only one region (Perm Krai) has free choice of competing insurers for the non-working population. In general, poorer regions are less likely to have private insurance arrangements, partly reflecting the lack of management capacity (Tompson, 2007) but certain richer regions (Leningrad) follow the same practice of a single purchaser.

The 2010 Law on Mandatory Health Insurance introduced changes to be implemented from 2013 where all funds will pass through MHI funds and allow insurance companies to contract selectively with providers. Although prices of services will remain regulated at the federal level – with possible modulations at regional level – selective contracting and patient choice of provider are expected to encourage providers' competition on the basis of the quality of care.

Health-service delivery

While a network of primary/first-level care was established during the Soviet era, the main approach to care until recently has been to refer primary-care patients to specialists and this is often accompanied by excessive hospitalisation and lengthy hospital stays. While a number of reforms have been attempted, and experiments made in a number of regions, the structure and ownership of provider institutions has remained largely unchanged since the end of the soviet period.

The supply of health care services

The supply infrastructure delivers care through a hierarchy of facilities at specific administrative levels and differs somewhat depending on whether the patient lives in a rural or urban environment. The basic administrative unit at the bottom of the hierarchy is the “uchastok” (catchment area for a district doctor) which, in rural areas, covers a population of approximately 7 000 to 30 000 persons. Each “uchastok” can, of course, have more than one doctor. According to the Ministry of Health and Social Development, a single doctor provides care for 1 700 patients (a general practitioner cares for 1 500 patients, and family doctors – for 1 200 patients). In exceptional cases, a single doctor provides care for 2 000 patients. In

practice, however, 26% of the districts serve more than 3 000 people. Even in Moscow the size of the assigned population exceed 3 500 in one out of three districts (Sheiman and Shishkin, 2010).

In rural areas, primary-care needs are met by the health post, which is often staffed by nurses or medical assistants (*feldshers*). Problems that cannot be handled at the local level are referred to a rural health centre, hospital or ambulatory, normally employing a general physician/internist or therapist (first-level internist/general physician) and a first-level paediatrician in addition to nursing staff. These centres provide a mixture of primary and routine secondary care and often have a small number of inpatient beds (20-25). More complex cases are referred to “rayon” or district polyclinics or hospitals. These offer specialist secondary services on either an outpatient (polyclinics) or inpatient basis (hospitals) and these feed into the regional polyclinics and hospitals, which in turn could refer patients to federal-level tertiary institutions.

The urban population is in principle covered in the same way except that the primary-care givers work out of polyclinics. But as each polyclinic tends to employ consultants who offer specialist outpatient services, access to specialists appears to be more direct. Patients often refer themselves directly to hospital specialists as the perception of outpatient care – even at a specialist level – remains poor.¹³

The move towards primary care

Improving primary health care is a major policy concern in the Russian Federation and new models of care are under development. Although it is difficult to judge the progress that has been made and the specific policies that have been introduced, experiments described in Chapter 3 (Box 3.1) indicate the broad direction of change and the progress that has been made in at least two regions.

These new policies aim to further development of primary care in both rural and urban areas through the modernisation of existing supply (and particularly of equipment), permitting more acute care in an ambulatory environment. Cooperation between inpatient institutions and accident and emergency departments is to be enhanced. This, combined with the development of rural midwifery centres and general practice departments in parallel, should result in a complete chain of health care in both rural and urban areas.

In order to raise the accessibility and the standard of outpatient medical care, a three-tier system of primary health care has been developed by the federal authorities.¹⁴ The third (or in reality the first level of contact with patients) is made up of well equipped municipal outpatient clinics offering primary health care services on an ambulatory basis.¹⁵ The size and composition of the medical staff will be determined by population size and patterns of morbidity of the local population attached to a health care institution.

The second tier will be made up of inter-regional outpatient centres offering specialised outpatient medical care for areas of care where demand/need is the greatest. At this level, a wide range of diagnostic procedures and special X-ray studies, including CT and MRI will be offered.

The first tier will provide very specialised consultation and diagnostic services for patients from outpatient institutions with difficult medical problems. These institutions will also have a “continuing education” role for health professionals aimed at keeping care quality at a high level.

One of the main functions of outpatient departments is to enhance preventive care. To this end, outpatient clinics are implementing measures to: increase the population coverage of

periodic preventive examinations, particularly for the employed; and, visits to health centres promoting healthy living (*e.g.* reduced substance abuse).

In order to reduce the levels of care in hospitals and optimise the provision of medical care to the public, outpatient departments are developing methods to reduce inpatient care. Such outpatient services will also take over some part of medical care that previously fell under emergency care services by developing their own acute medical care departments. As a result, emergency medical care should only involve cases that are life-threatening or health-threatening to the patient, which will help reduce the calls on emergency service teams. Taken together, these measures should facilitate a reduction in the number of day-and-night beds and a redistribution of the volumes of medical care in favour of primary health care institutions.

To improve patient satisfaction with primary health care arrangements, particular attention is to be paid to developing pre-hospital admission departments employing mid-level medical staff. This department will set appointments, conduct or arrange for the necessary tests; issue prescriptions; and, fill out dispatch sheets for medical and social services. The aim is to relieve doctors of administrative tasks, thereby strengthening the overall cost-efficiency of the system.

Services in the area of public health and prevention

As noted, the san-epid system has played an important role in collecting epidemiological data, managing outbreaks of infectious disease and regulating sanitary and environmental conditions (Box 1.1). During the soviet era, the system had a broad mandate that included a social-hygienic (*i.e.*, local) monitoring system, sanitary control, infectious disease control, occupational health, and public health information. The strengths of the system stemmed from a wide network of facilities, trained personnel, and principles of monitoring and control of infectious diseases. But they also contributed to the emphasis on hospital care because hospitals were used to isolate patients with infectious disease. In 2004 the responsibility for prevention was transferred to a new executive agency, the Federal Service on Human Rights Protection and Human well-being (*Rospotrebnadzor*). It continues to collect epidemiological data, fights outbreaks of infectious diseases and regulates various sanitary norms and standards, as well as controlling compliance with compulsory requirements of the Russian Federation. It also oversees consumer protection.

Recent legislative and regulatory efforts in the area of public health have focused on issues such as: preventive vaccination; safe environment; social-hygienic monitoring; product safety, while renewed attention is being given to communicable diseases (tuberculosis control, acute intestinal infections, viral hepatitis, malaria, HIV, influenza, and sexually transmitted infections), the quality and safety of food products and safe drinking water.

However, some key elements are either missing or underdeveloped and this is limiting the capacity of the system to respond fully to the new challenges, particularly in the light of the development of poverty and more specific health problems found among certain groups such as prisoners and individuals with poor living conditions (*e.g.* the homeless) (Bobrik *et al.*, 2005).

Ownership of care facilities

Ninety-five percent of all medical facilities are publicly owned, mainly at regional (largely hospitals) or municipal (mainly polyclinics and emergency care clinics) levels. While there are 20 000 private medical entities, they are mainly dentists' offices and small functional diagnostic centres and they tend to serve patients on a private basis. Ownership of hospitals and polyclinics is, however, almost exclusively in the public sector.

Legal uncertainty about the security of leases purchased from the state has discouraged any large-scale shift to private ownership of medical care. The tax position for not-for-profit or “trust” hospitals also currently remains unclear, as does the tax position of charitable institutions. There is also general hostility from state bodies to the encroachment of non-governmental organisations into their traditional spheres of activity.¹⁶ A substantial widening in the role of the private sector seems likely to occur only when they can be paid out of MHI funds and the funds of the associated private insurers. In this context, the new 2010 Law on Health Insurance now provides for equal right of participation in the MHI system for all medical institutions regardless their ownership structure.

Pharmaceutical drugs

In 2007, outpatient pharmaceutical spending accounted for 18% of total health expenditures in the Russian Federation, marginally larger than the OECD average (17%). Private spending represents 78% of this amount, which is well above the OECD average (40%) and in line with Mexico. Private spending is mainly out-of-pocket, given the small size of the private health insurance sector.¹⁷

While pharmaceuticals used in inpatient care are, in principle, fully covered for hospitalised patients, pharmaceuticals used in ambulatory care are not included in the basic benefit package to which all citizens are entitled. Thus, the vast majority of patients have to pay the full price of pharmaceutical treatments.

Public programmes have been implemented in the last few years to cover outpatient pharmaceuticals for some categories of the population. First, a programme of free drug provision for vulnerable population groups was launched in 2005 to cover the costs of ambulatory treatments for the disabled, war veterans and victims of Chernobyl (*cf.* Chapter 2). It covers around 500 “essential drugs”, selected from the WHO “Essential Drug List”.¹⁸ Second, the Federal National Priority Project Health implemented in 2006 covers the costs of vaccines included in the national programme of preventive vaccines, as well as medicines used for the prevention and treatment of HIV/AIDS, hepatitis B and C and cancer. Other federal targeted programmes pay for drug treatments for so-called “socially significant diseases”, including tuberculosis, diabetes, psychiatry and medications for children. Finally, the so-called “7 diseases” federal programme, implemented in 2008, pays for very high-cost medicines used to treat rare diseases (Pharmexpert, 2009).

In terms of purchasing, the federal government purchases directly all drugs used in federal programmes, as do regional and municipal governments for drugs used in polyclinics and hospitals for health care services falling under their competency (see Box 1.2). Public procurement takes the form of descending-price auctions. Since April 2010, the prices of drugs included in the Essential Drug List are regulated at the federal level, with adjustments to take into account logistic constraints in some regions (Pharmexpert, 2009).

Most drugs used in the public sector are purchased at the regional and municipal level (90% of the overall volume). However, due to the high prices of some drugs financed from the federal budget, federal funds accounted for 62% of public spending in 2009, concentrated on 6% in volume terms (Pharmexpert, 2009).

Public drug spending has never been sufficient to fill completely the obligations under the Government Guarantee Package (*e.g.* free drugs in hospital care) and the share of private spending on drugs has remained high over the period. Since the year 2000, it has remained stable at roughly 60% of total drug spending, a level that is roughly double the share observed in eastern European countries. In principle, most diseases requiring costly drugs (for example, cancer) should be financed from the MHI system during hospitalisations. Nonetheless, surveys show that very often patients pay for them out-of-pocket. Survey results from the

Public Opinion Foundation (FOM, 2007) suggest that about 30% of oncology patients pay for the drugs themselves or via other family members. FOM surveys suggest, as well, that only 45% of patients receive all the drugs they need and for high-cost treatments, this share falls to only 22%.

Pharmaceutical sales have steadily increased since the transition began, probably reflecting an accumulated backlog in drug imports during the soviet period and the subsequent penetration of western drug firms into the Russian market. However, per capita consumption of pharmaceuticals remains comparatively low: with USD 113, it is four times lower than in Germany, France and Canada (DSM, 2010). Prices of drugs have tended to increase, most recently reflecting the depreciation of the rouble (Marquez and Bonch-Osmolovskiy1, 2010).

Since 2010, prices of drugs included in the Essential and Vital Medicines List are regulated by the MHSD. For drugs not included in this list, prices are not regulated at the federal level but maximum manufacturer prices are registered at the federal level, while at the regional level the size of wholesale and retail markups to manufacturers' actual sales prices have been restricted (Pharmexpert, 2010).

Drugs are largely imported. With the transition to a market economy in the 1990s, there was a collapse of local production as a result of sharp increases in the prices for inputs used in domestic production combined with increasing competition from foreign producers. By the late 1990s, domestic Russian production had declined sharply (Tragakes and Lessof, 2003). Production appears to have recovered more recently but the volume of domestic production is focused on less expensive generic drugs often using imported active ingredients.

Even so, the share of innovative drugs in total imports is not high and the largest share is made up of generics (Vacroux, 2009). There is a widespread expert view that almost all active ingredients for generics could be produced domestically. However, quality issues remain a problem: only 20 out of 600 Russian pharmaceutical companies comply with Good Manufacturing Practices (GMP) standards^{19,20} and only 120 plants have partly modernised their production process. The remaining firms continue to use outdated standards of production. The Pharmaceutical Act adopted in July 2010 aims to upgrade manufacturing practices.

Retail sales are performed through 63 600 pharmacy entities (pharmacies and kiosks), most of which are privately held (82% as of the beginning of 2011, according to *Roszdraznadzor* and the Ministry of Health and Social Development).

Payment arrangements

Paying doctors and nurses and the associated incentives

Health professionals are mainly employed in the public sector, where pay is low relative to the private sector (Gimpelson and Lukyanova, 2009).²¹ Official salaries are typically below the average wage²² and for nurses there have been reports that they are below the subsistence threshold. Until recently, salaries in the state or municipal-owned medical organisations have been, in theory, set according to unified tariff scale (UTS) for all budget organisations. Nonetheless, doctors can receive higher income because they have taken on administrative functions (*e.g.* head doctor), or because they have higher qualifications or years of experience. These criteria bear little or no relation, however, to performance.

In the light of this, a bonus scheme was introduced in the 1980s such that hospital and polyclinic managers were able to offer performance pay. Tragakes and Lessof (2003) indicate that bonus payments can be as high as 20%, but there are cases where it is much higher.²³ However, they are little used to reward performance and they are most often given across-the-board regardless of the level of productivity of individual staff members. In addition, health

professionals in general and specialists and hospital doctors in particular often demand under-the-table payments from patients for their services.²⁴ Thus, there is a flow of payments going to individual doctors, which should, in principle, be paid to the institutions (as chargeable services) or not at all.

Low salaries for nurses may, however, partly reflect the level of training which is roughly equivalent to a licensed vocational nurse (two years of training) in the United States. Perhaps partly because of this, nurses have limited responsibilities in the system and all substantive decisions of care are made by doctors. Recently there have been some increase in the relative wages of health professionals and these developments are detailed in Chapter 2.

Payment of medical institutions

The three levels of government and MHI funds contribute to the financing of health care services according to their respective responsibilities, as defined in the Guarantee Package Programme (Box 1.1).

There are wide differences across regions in the balance between the MHI and the budgets of the regions and municipalities depending on the amount of funds actually passing through the hands of the MHI. For example, in the Khanty-Mansi Autonomous Okrug, MHI expenditures were only 18% of total health care spending in 2009 while in the Republic of Tatarstan, it was 89% (Federal MHI Fund, 2010). This “dual-source financing” arrangement can lead, as noted, to confusing incentives for providers and may be one of the reasons for so little improvement in health care system efficiency despite the new incentives facing providers (see Chapter 3).

Focusing first on payments to providers from the budget, the law governing budget organisations limits the fungibility of financial resources between different budgetary-line items. This means that polyclinics – and especially hospitals – have only limited flexibility in how funds are spent.²⁵ This restriction limits the capacity of providers to adapt and find new and more innovative approaches to finance and supply care or to shift resources to where there is greatest need. This can raise particular difficulties for hospitals where it may be hard to predict costs under individual line-items. For example, where the cost of pharmaceutical drugs exceeds the budget within the budget period, hospitals may be unable to re-channelling funds entered under other budgetary lines towards this need. Budget surpluses cannot be carried forward to the next budgetary period. At the primary-care level, there are difficulties in moving towards arrangements such as fund-holding (which is often regarded among the academic community at least, as providing better incentives for financing primary care) because such arrangements are not supported by existing legislation.

The difficulty in assessing the impact of payment arrangements on incentives is compounded by the wide range of different payment methods employed and the fact that a number of different approaches can be used in individual regions at the same time. As regards the MHI system, Shishkin (2007) finds that there are as many as seven forms of payment used to finance outpatient care, while six methods are used to pay for in-patient care (Figures 1.8 and 1.9). Reliance on line-item budgets, global budgets and actual reimbursement of expenditures often eliminates incentives to economise. While matters are improving gradually and may well have changed since 2006, fee-per-outpatient visit is still widely used, as is pay per bed-day in the hospital sector. Both forms of payment tend to encourage over-treatment, and the former minimises any incentive for primary care providers to focus on prevention.

Only four regions employed an element of fund-holding in respect of primary-care providers and mixed-payment systems – which combine capitation and fee for services for achieving specific targets (e.g. child vaccinations). In the hospital sector, only ten regions employed cost-and-volume contracts based on anticipated-care needs. The problem here is not

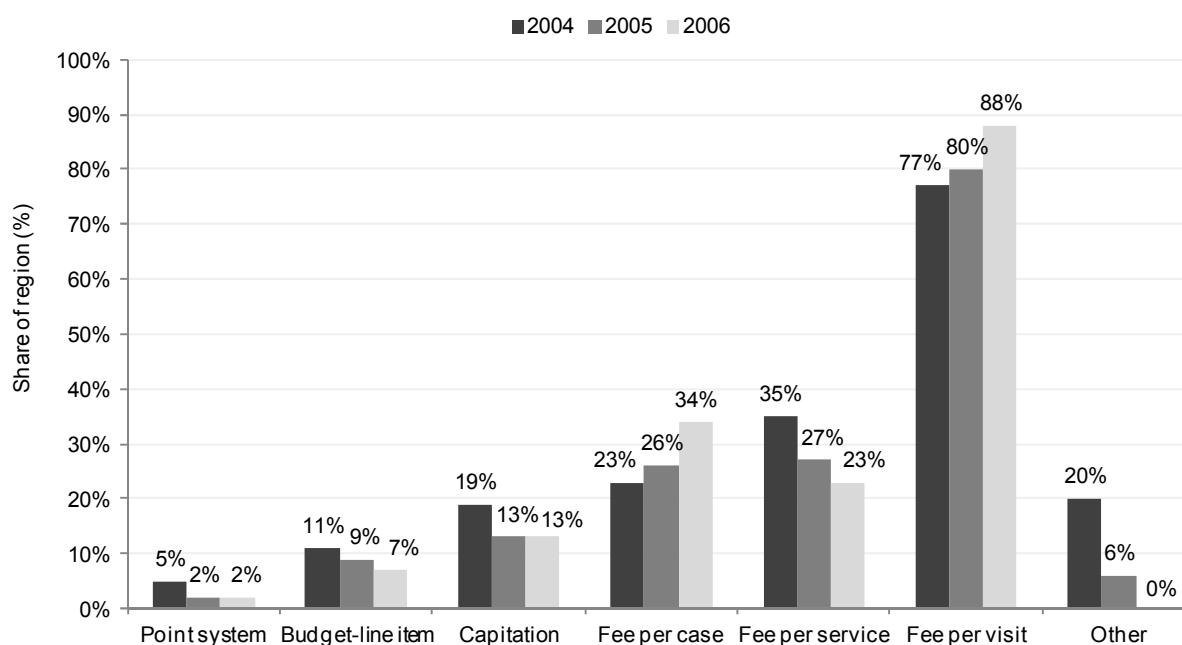
a lack of awareness of incentive problems, but a lack of administrative capacity: regions often tend to adhere to forms of payment that are easier to monitor and administer rather than seeking to experiment with payment aimed at enhancing performance (Tompson, 2007).

At the same time, financing from the regional or municipal budget tends to be on the basis of size and staffing with little reference to volumes of care actually provided. Thus, incentives to reduce costs and improve efficiency embedded in payments from the MHI system may be weakened if this leads to reduced budgetary allocations for providers that have made efforts to economise on inputs or because costs have otherwise been reduced.

Private payments for chargeable services

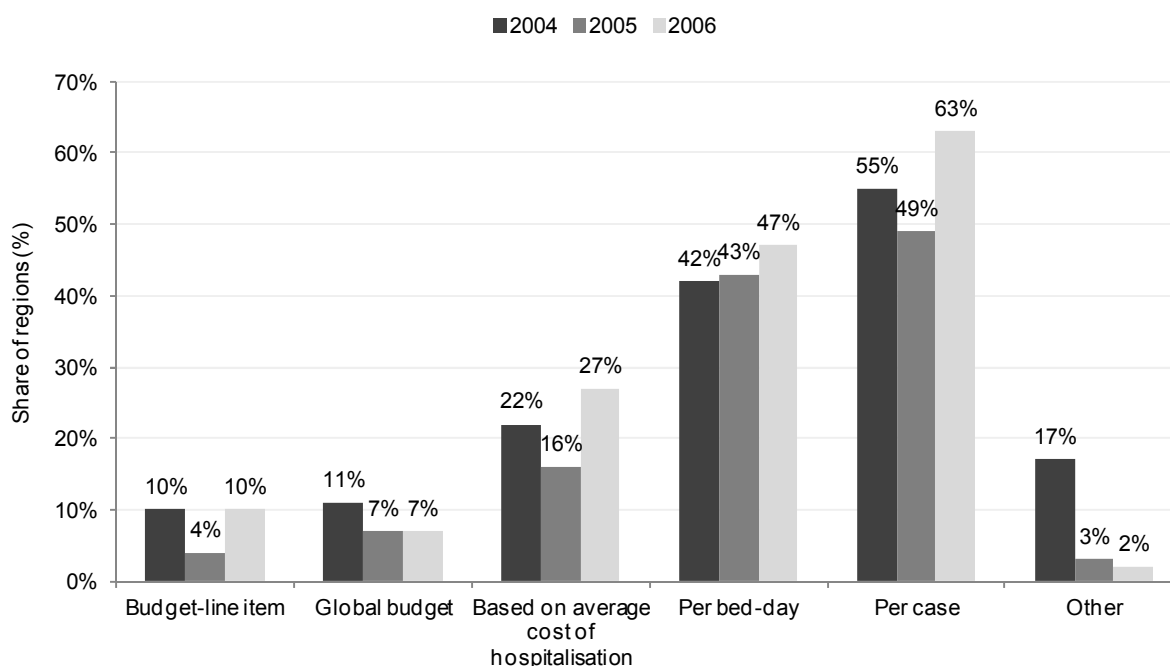
To help resolve problems of insufficient financing of public providers in 1996, the federal government allowed provider institutions to charge patients for certain types of medical care. This was to provide greater flexibility in setting the salaries of medical staff (*e.g.* bonuses) and to allow investment in equipment and renovation. A significant part of the income of polyclinics and hospitals now comes from this source. There can be wide variation across providers concerning what is chargeable and the prices charged for services such as high-tech imaging. For example, Vishnevskiy (2007) finds that prices for the same medical services provided in separate federal health facilities differ by many times. For example, the maximum price for a computed tomography of the brain in Moscow exceeds the minimum price by four times. For coronarography, it is 12 times, and for angiography, it is 15 times. As a result, there have been calls for fixing prices for these services across state, regional and municipal-owned medical organisations at low levels to protect low-income groups.

Figure 1.8. Methods of paying for outpatient care through regional MHI funds, 2004-06



Note: Different methods may be used for different providers in the same region.

Source: Independent Institute for Social Policy (2007), “Organisation and Financing of Health Care in the Russian Regions in 2006”.

Figure 1.9. Methods of paying for inpatient care through regional MHI funds, 2004-06

Note: Different methods may be used for different providers in the same region.

Source: Independent Institute for Social Policy (2007), “Organisation and financing of health care in the Russian regions in 2006”.

Ensuring quality of care

Professional qualifications and quality control

The education and training of physicians and nurses appears to have changed little from the soviet era. Undergraduate medical education of physicians consists of six years of coursework in medical institutes or universities, with students entering directly from upper secondary school. The majority of nursing students receive their education through vocational education in medical colleges. Individuals enter technical training in nursing at an early stage in their education (for example, aged 15 to 18). Higher nursing education is provided by the faculty of Higher Nursing Education in the Moscow Medical Academy.

Before beginning practice, graduates of a medical university have to complete at least a one-year “internship” but structured specific clinical curricula during this period are often lacking. Specialisation requires an additional two years of training. At the end of the course of study, doctors receive certificates indicating that the holder completed the required course of study and this gives them the right to work as either a district doctor or as a specialist, depending on their curricular choice and level of study. However, the actual professional licensing for activity requires that the student has worked in a one year internship (or two years for those becoming specialists) in a hospital. Medical associations play almost no role in assessing professional qualifications.

Certificates issued by medical universities have to be confirmed every five years. This normally requires the doctor to follow additional courses through an official system of

continuing medical education or structured learning in the form of 2-3 month courses every 3-5 years to obtain a “qualification upgrade.” However, this appears to be more often honoured in the breach than in the observance.

Medical training has been improving, aided by recent investment in equipment and technology. A number of institutions are developing new standards that are based on the latest models of training. According to the ministry, the education standards of the Russian Federation’s universities have been updated to include international principles of evidence-based medicine in recent years.

The speed at which this new information will feed through the system will depend on the number of new doctors entering the system and on ensuring that providers and payers insist that individual doctors take the required refresher courses. In this context, there has been rapid development of telemedicine and medical simulation, which are both seen as important elements of the Russian Federation’s continual training and professional education programmes in medicine. Such upgrading of skills is important. As in most other countries, substantial differences in practice patterns can exist across regions (Danishevski *et al.*, 2008).

Regulatory oversight of the quality of care and consumer protection

At the beginning of the transition, the main responsibility for overseeing the health care system and its quality belonged to the regional authorities and regional branches of – what was then – the san-epid system. Since the introduction of the MHI system, the private health insurance companies have also played a growing role in the control of the quality of medical services provided under the Government Guarantee Package programme although cost control has been a driving objective as well (see Chapter 3).

Oversight of state and private medical institutions and other quality control issues is now mainly the responsibility of two state bodies: the Federal Service for Supervision of Consumer Protection and Human Welfare (*Rospotrebnadzor*); and the Federal Service on Surveillance in Health Care and Social Development (*Roszdrazhnadzor*). As noted above, the former inherited the san-epid system and it continues to play the main role in the assessment of the epidemiological situation in the country (although, its role in assessing the epidemiological situation in the regions appears to have become less central to its mandate). In addition, it has taken on responsibility for consumer-rights and protection. For example, it oversees the functioning of private hospitals and clinics under the Law on Consumer Rights Protection and Prevention Policies (alcohol and tobacco consumption, AIDS/HIV and immunisation). The latter (*Roszdrazhnadzor*), in principle, oversees the operation/quality of municipal- and state-owned hospitals and clinics, together with regional departments of health and insurance companies under the regulations of the MHSD. It is, therefore, key to the issue of the quality of health care services (Box 1.4).

Medical institutions have long been subjected to a licensing (accreditation) procedure. Similar rules were set for medical services, the accreditation of medical organisations, and the certification of doctors in 2001. The new regulatory body charged with taking this forward, the Federal Service on Surveillance in Health Care and Social Development was only set up in 2004. Up to now, the main activities of this new federal agency remain the surveillance of pharmaceutical activity, certification of domestic production and import of drugs and medical equipment. But it has responsibilities in over 30 different areas raising the issue of the adequacy of financing of this institution given the breadth of its mandates. Responsibility for the registration of pharmaceutical was transferred to the ministry in 2010 (see Box 1.4).

Box 1.4. Responsibilities for regulatory oversight of the health care system (*Roszdraznadzor*)

- Organisation of control and surveillance in health care and social protection of population (including medical care provision, pharmaceutical drugs circulation, clinical trials of pharmaceutical drugs, prosthetic and orthopaedic aids).
- Quality control of pharmaceutical drugs and medical and rehabilitation equipment, as well as control of medical and social services provision for the population and medical and social rehabilitation of disable people.
- Licensing of:
 1. Professional activities in health care sector;
 2. Production, import and circulation of pharmaceuticals drugs;
 3. Production of medical equipment;
 4. Production of prosthetic devices;
 5. Circulation of narcotic drugs and psychotropic substances.
- Accreditation of medical organisation and social aid organisations.
- Until September 2010, this agency was responsible for registration of pharmaceutical drugs and medical and rehabilitation equipment, price registration of vital and essential medicines. From that date, the responsibility for the registration of medicines and prices for vital and essential medicines has been transferred to the MHSD.

Source: Roszdraznadzor's website, www.roszdraznadzor.ru, consulted on 11 April 2012.

Notes

1. The subsistence minimum in the Russian Federation is a value estimate of a consumer basket (approved by Federal Decree) and compulsory payments and dues. The consumer basket includes a minimum set of food and non-food goods and services, which is necessary for the good health of the population and adequate to ensure their normal activities in life. In 2009, the monthly value was RUB 4 630 (USD 150) for the country wide average. But this level varies across the country depending on relative prices.
2. Wages have been a key factor contributing to the large numbers of poor people. The minimum wage fell from 22% of the minimum subsistence level in 1992 to 8% in 1998. As a result, over 60% of workers in agriculture, health care and culture received wages substantially below the subsistence level at the end of the previous decade. Additional factors initially affecting poverty levels have been wage arrears and informal payments in many enterprises and the level of unemployment although the latter has progressively decreased during the current decade (before the current crisis).
3. This movement in an *absolute* poverty measure was accompanied by a marked widening in the *relative* measures of income distribution. The distribution of income widened sharply: a Gini coefficient rose from 0.289 in 1992 to 0.422 in 2007 (Rosstat, 2008). In much the same period (1990-2005) the average Gini coefficient in five major OECD countries (France, Germany, Sweden, the United Kingdom and the United States) rose from just under 0.3 to 0.31. The largest increase was for the United States where it rose from 0.349 to 0.381 (data on an after-tax and transfer basis).
4. The number of constituent parts is subject to change over time as a result of amalgamation. In this report, the word “region” is often used as a synonym of “constituent part”.
5. www.economy.gov.ru/wps/wcm/myconnect/economylib/mert/welcome/pressservice/eventschronicle/doc1217949648141 and *OECD Health Database*, 2009.
6. Cited in World Bank (2005).
7. The key pieces of legislation were the “Law on Protection of People’s Health” (1993) and the “Law on Health Insurance” (1991).
8. This, however, raises possible conflicts of interest: since the system of provision is largely owned by the regions and municipalities, these institutions are also those enforcing the rules.
9. Other social funds (e.g. pension funds) contribute marginally to the financing of health care as well.
10. Private voluntary health insurance is financed by premiums paid by corporations/employers on behalf of their employees.

11. Funds from the federal MHI fund are redistributed according to population size and structure (*i.e.* the share of non-the non-working population in the total) and the deficit of the regional basic package programme. Since 2008, the budget of the federal MHI fund is approved by law.
12. The committee includes representatives of regional governments, the regional MHI fund, the private insurance companies and providers.
13. In addition, many large firms and some ministries had their own health services oriented towards occupational health. However, these have tended to disappear given that the firms are also paying the social security contributions, which give the workers access to care directly. There is also an array of curative and rehabilitative sanatoria aimed at ensuring rest and rehabilitation or longer term treatment of certain disorders and to prevent invalidity (Kadyrov and Linnakko, 2007).
14. Procedure for the Provision of Primary Health Care (draft order of the Ministry of Health and Social Development of Russia).
15. Services that this level is expected to include: local therapeutic services, including specialist doctors, preventive care departments, photofluorography, X-ray studies, electrography, health schools, medical and social care departments, laboratory diagnostics and Health Centres, day hospitals and acute care.
16. In the Region of Perm, where private providers and greater competition are being encouraged, the authorities are experimenting with contracting out of certain services such as laboratory analysis or diagnostic equipment. However, the providers they serve remain in the public sector.
17. From unpublished WHO-SHA data, 2010.
18. See www.who.int/medicines/publications/essentialmedicines/en/, accessed on Nov. 15, 2010.
19. Statement by the head of Roszdravnadzor.
20. GMPs are guidelines that provide a system of processes, procedures, and documentation to assure the product produced has the identity, strength, composition, quality, and purity that it is represented to possess. In the case of drugs, these have been established by the U.S. Federal Drug Administration and are now a widely used international standard.
21. Anecdotal evidence suggests that monthly doctors' salaries in the Russian Federation average USD 430 to 510 USD while nurses make an average of USD 230 to USD 315 per month. Rosstat estimate of monthly salaries in the public sector (hospitals and polyclinics) was USD PPP 580.3. By way of comparison, monthly salaries in Spain – where the majority of physicians are salaried employees – are USD PPP 5 800 for GPs (*OECD Health Data*, 2011).
22. According to Rosstat (2009a), in 2008, the average wage was RUB 13 800 in the health care services sector and RUB 18 637 in the overall economy.
23. This information was given to the OECD Secretariat mission team by a head doctor.
24. Tragakes and Lessof (2003) argue that the specialists and hospital doctors have more access to hospital resources and this allows them to increase the wage differential with respect to GPs or feldschers (medical assistants).
25. Such problems have also been found in numerous OECD countries (Docteur and Oxley, 2004).

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Chapter 2

Recent health policy developments in the Russian Federation

This chapter provides a short critical overview of recent developments in Russian health policy and the progressive shift away from shorter run policies towards the resolution of deeper structural issues. This chapter regroups these measures into five broad categories: i) restoring the capacity of the health system to provide quality care; ii) reducing mortality through prevention; iii) enhancing access; iv) financial sustainability, and v) more systemic reforms. Thus, under each heading more than one programme can be at play. This discussion demonstrates that the health care debate is evolving rapidly to palliate some of the problems of existing arrangements.

Restoring the capacity of the health system to provide high-quality care

Investing in new equipment

After several decades of neglect, medical institutions at all levels and in all regions urgently required new equipment and renovation of health care facilities. The obsolescence of medical and transport equipment had reached high levels by 2005, such that an estimated 65% of medical equipment and transport vehicles had reached the end of their useful lives. As a result, the capacity to supply care had become increasingly compromised. Available finance for high-cost treatments such as cancer represented only 30% of the estimated needs of the population and only 17 to 22% of the population had access to high-tech care (*e.g.* imaging equipment) when they needed them (Emeshin, 2006). In such circumstances, heavy investment in health care equipment was needed and the National Priority Programme “Health” was launched to palliate some of these problems (Box 2.1). As a result, around 30% of the funds allocated to the NPPH were budgeted for the purchase of new medical equipment and medical transport vehicles for municipal, regional and federal medical organisations.

While some experts have argued that centralised purchases resulted in more equal provision of medical equipment across regions, especially for the less-developed areas, others have claimed that the tenders organised at federal level were not always transparent.¹ With limited information on the existing supplies of medical equipment across regions, the capacity of the federal ministry to identify the needs of municipalities and regions was also limited. Anecdotal evidence suggests that a number of polyclinics and hospitals in smaller towns and rural areas received very sophisticated medical equipment which they did not need or were unable to use because there were no trained specialists (Sheiman and Shishkin, 2010). Despite these concerns, the investment in new equipment was probably essential to achieve the needed refurbishment of the health care system.

Three new high tech medical centres were constructed under the NPPH in “more distant” regions² over the period 2006-08 and there are plans for the construction of new high-tech medical centres in each region (mainly oriented towards cardiovascular diseases – which, as noted, – are the leading cause of mortality). It is less clear that the benefits of these new institutions are comparable to those arising from the purchase of new equipment just described.³ Retraining of the staff for new centres was included in the Project, financed from regional budgets. While there is little in the way of published reports on the implementation of the Project, the authorities have indicated that the first three centres are now fully staffed and operating.⁴

Since the beginning of 2009, the financing of national projects from the federal budget has been falling, particularly for longer-term programmes such as the planned building of 14 high-tech centres. The federal government is now trying to shift the responsibility onto the regions by increasing their contribution to the financing of both the construction and the purchase of equipment, which could also be interpreted as using federal funds to “buy” regional compliance with programme goals. At the beginning of 2009, the dates for the completion of the remaining high-tech centres were changed and overall control of the construction has been delegated to a state corporation (*Rostekhnologii*).

Box 2.1. The National Priority Programme “Health” (NPPH)

The federal government launched the National Priority Programme “Health” (NPPH) at the end of 2005, aimed at injecting an emergency funding increase for health care over the period to 2008. It was regarded, at the time of its inception, as a temporary measure aimed at modernising the health care system and strengthening primary care.

Main investments of the NPPH have been concentrated on the following areas (see Annex A, Table A.2 for more details):

- Increased pay for selected categories of medical staff (mainly primary care doctors and nurses);
- Additional funding for primary care provision (including training of professionals);
- Diagnostic equipment for outpatient facilities;
- Construction of high-tech centres;
- Financing of high-tech medical services; and
- Development of prenatal centres.

At the beginning of 2009 the decision was taken to continue the project until 2012. The financing will come from the federal budget, the regional budgets, the MHI Fund and the Social Security Fund. The economic crisis has not affected the level of financing of the project, indicating the continuing high priority given to health and health care issues by the authorities. In 2010, the level of financing of the project remains similar to 2009 level and the main components left unchanged. But from 2009, the NPPH has given greater importance to prevention issues and the programmes have been restructured into four broad groups.

- Development of healthy lifestyles;
- Development of primary care and better prevention;
- Improvement of access to secondary and high-tech care and increase in the quality of these types of medical care; and
- Improvement of health care provision to children and pregnant women.

Specific measures to meet the wider goals include: population screening for TB and treatment of TB patients; prevention measures to improve medical treatment of oncology patients; development of network of perinatal centres; and medical examinations of children in orphanages.

Diagnostic equipment and emergency vehicles for hospitals located along main highways are being increased in an effort to reduce loss of life due to traffic accidents.

An important innovation has been the introduction of prevention and treatment programmes for cardiovascular disease and cancer which remain the two most important causes of mortality in the Russian Federation. Cardiovascular and oncology programmes in 2008-09 included: retraining of medical staff; introducing new methods of (early) diagnosis; new medical treatment protocols; new equipment for diagnosis and treatment; upgrade of ambulance crews; financing of planned number of patients in federal or regional centres.

Each year such programmes are put in place in a limited number (12-14) of regions. Federal financing for projects is provided under conditions of co-financing from regional budgets. In 2009, 6 out of 12 regions did not fulfil their financing obligations for cardiovascular programmes. In this context, regions must now develop programmes on cardiovascular and/or oncology diseases at the regional level.

Five hundred prevention centres were opened in 2009-10 throughout the Russian Federation to provide information and personal advice to the population on healthy lifestyles.

Funds allocated to the NPPH increased regularly starting from RUB 87.9 billion in 2006 to RUB 157 billion in 2011, which represented 0.1% of the total public spending on health each year (see details in Annex A, Table A.2).

Better salaries for primary-care doctors

With 56% of primary-care polyclinic posts going unfilled and 30% of existing district doctors (*terapevty*) failing to confirm their certificates (diplomas) during the past five years, there was – and continues to be – concern over the provision of care and its quality at the primary-care level.

Salaries were increased under the NPPH for three groups of medical staff: district doctors and nurses; emergency-care doctors and nurses; and doctors and nurses in maternity hospitals. The largest increase in salaries was for primary-care doctors, which increased by RUB 10 000 (USD 310) per month for district doctors, district paediatricians or GPs and RUB 5 000 (USD 155) for nurses working with these doctors.⁵ On average, salaries at the primary care level were increased by a factor of 1.6 between 2006 and 2010. This figure varies between the richer and the poorer regions. In poorer regions, the initial level of basic wages was lower and the additional federal transfers sometimes led to more than a doubling in salaries. In total, salaries were increased in primary care for about 75 000 doctors and 83 000 nurses. The number of district doctors increased as a result of the higher salaries but the hoped-for shift of specialists to primary care was not as large as the authorities had expected and some primary care posts still remain unfilled. Salaries are projected to further increase by 41% for doctors (to reach RUB 28 000) and 36% for nurses during 2011 and 2012.⁶

It was initially intended that the increase of salaries should be linked to improved quality of care through increased training of primary-care providers. However, in practice, salaries were increased for all district doctors and nurses despite the fact that only 23% of the doctors in primary care attended retraining courses during the previous three years. According to the views of chief doctors in polyclinics and experts from regional departments of health, there was no change in the quality of health care provision except where there was a switch to a GP model, which required several months of training of district doctors before being allowed to provide care under the new arrangements. In practice, the increase of the salaries appears to have been regarded by doctors as a compensation for many years of underpayment and not as an incentive for providing better treatment of patients or upgrading their qualifications and training certificates. Indeed, surveys indicate that doctors (in at least two “developed” regions) consider that a “fair” salary should be two to three times higher than their current level (Shishkin, 2008; Gimpelson and Lukyanova, 2009).

The wage increases in the primary-care sector distorted wage relativities with regard to specialists and other groups that did not benefit from the salary hikes. Indeed, the increases may have exacerbated the problems of low wages in the public health care sector more generally.

Until recently, the Russian Federation used the Unified System for Payment of Labour to fix salaries in the public sector. This system employs the United Tariff Rate to pay employees allowing little flexibility in salaries across staff or across institutions. In 2008, the government introduced a reform of wages and salaries setting in the public sector. The new approach allows greater flexibility to hospital managers, who will be able to decide on the number of employees and their remuneration level under a pre-determined budget envelope.

Reducing mortality through better prevention and better care

New and existing prevention programmes

Poor effectiveness of spending and health care supply may have arisen from placing inadequate weight on prevention policies. Although the Russian Federation has had a long tradition in this area, inadequate attention has been given to chronic diseases, which now makes up the bulk of morbidity both in the Russian Federation and elsewhere. Recent

progress has, nonetheless, been made towards setting the policy agenda in this area. In 2008, the State Research Centre for Preventive Medicine published a “Strategy for the Prevention and Control of Non-communicable Diseases and Injuries in the Russian Federation” but – at the time of publication of this report – this document has not been followed up by a detailed action plan promised at the time the strategy was presented.

As developed further in Chapter 3, chronic disease has become the most important factor in explaining the high levels of mortality in the Russian Federation. In the light of this, the Russian authorities have put in place programmes focusing on reducing mortality from these causes.

The Federal Target Programme for Preventing and fighting Socially Significant Diseases (2007-12) was implemented for the period 2002-06 and carried forward into the period 2007-12 (Box 2.2). The following activities are funded under this programme: improvements in methods of prevention, detection, treatment and rehabilitation for “socially significant diseases” (tuberculosis, oncology, diabetes, HIV, viral hepatitis B and C, etc.). The programme also covers construction and refurbishment of specialised health care institutions, as well as the purchase of medical equipment and pharmaceuticals.

The initial NPPH, implemented in 2005-08, placed relatively little emphasis on prevention issues. The extension of this programme for the period 2009-11, in contrast, includes specific measures aimed at promoting healthy lifestyles but also prevention and treatment programmes for cardiovascular diseases and cancer.

The key legislation which brings these policies together is, perhaps, the Federal Concept (action plan) for Demographic Policy in the Russian Federation through 2025. The goals of this key programme are to increase average life expectancy to 75 years by 2025, improve the quality of life, and increase the population to around 145 million persons by 2025. To achieve these challenging goals, the following targets were set: a decrease of mortality rates by 1.6 times and a rise in fertility rates by 1.5 times accompanied by increased in-migration and increased prevention and enhanced access to care *e.g.* high-tech medicine. The Federal Concept is replicated at the regional level and the regions are expected to comply with mandatory sets of measures aimed at improving population health.

Box 2.2. The Federal Target Programme for “Socially Significant diseases”

The Federal Target Programme for Preventing and Fighting “Socially Significant Diseases” was developed over the 2002-06 period. This programme included vaccination, screening and treatment for HIV/AIDS, tuberculosis, hepatitis, cancer, diabetes, and psychiatry. This programme was extended for the period 2007-12.

The key objectives of the programme are to decrease the levels of morbidity, disability and mortality as a result of so-called “socially significant diseases”; and increased life expectancy and quality of life of patients with targeted diseases. The programme finances the building and renovation of specialised medical centres, as well as the purchase of new equipment, materials for laboratory analyses and pharmaceutical drugs for the patients of these centres. It also promotes improvements in prevention, diagnostics, treatment and rehabilitation for targeted diseases.

Total spending for 2007-11 was planned for around RUB 80 billion, with roughly half from the federal budget and half from regional budgets. Construction and renovation represent about 30% of the total budget. At the same time, regional governments are supposed to develop regional programmes aimed at reaching the goals under the “demographic concept” (action plan) mentioned above and are required to transmit information on fertility, morbidity etc. They also co-finance number of target federal programmes from regional budgets.

Source: <http://fcp.vpk.ru/cgi-bin/cis/fcp.cgi/Fcp/ViewFcp/View/2007/214/>, accessed on 17 November 2010.

Mass check-ups

The NPPH programme also included mass check-ups for persons in the age group 35-55 which form the core of the workforce (Box 2.1). Initially, this programme covered 15.9 million public sector employees and 10.9 million persons who work in jobs with harmful or hazardous working conditions (Sheiman and Shishkin, 2010). Introduced as a prevention measure, this programme was also organised in such a way so as to increase the remuneration of specialists and, by so doing, to compensate, in part, for the distortions created by the salary increases in primary care discussed above.

Over 32 million persons were examined, more than 10 million cases of disease were detected – with over 150 000 individuals with illnesses at late stages of development – and over 3 million persons with risk factors for developing disease were identified (MHSD, 2010). However, the benefits of mass check-ups are not easy to assess. Check-ups were not always carried out completely reflecting a lack of specialists at the municipal and preventive treatment institutions.⁷ While they were organised in the polyclinics geographically closest to the location of the employer, the results of check-ups were not necessarily sent to the district doctors of the polyclinic located in the areas where patients lived, so it is not known if the patients who needed it received adequate treatment after the check-up receive the necessary care.

Judging whether these policies have been cost effective is difficult given: the short time horizon of the programme (three years); the lack of information on the share of those diagnosed with a medical problem for the first time; and, whether those individuals undertook the necessary care. In addition, there may have been an opportunity cost to the degree that resources were diverted from the normal demands for care, making specialist outpatient doctors less available for ordinary patients.

Maternal and neonatal care and the “childbirth certificate” programme

This programme provided additional funding for medical care for women during pregnancy and childbirth and children’s clinics have been included in the programme since 2007. Issuing childbirth certificates was the mechanism for payment of the target population. Available funds were channelled to medical institutions permitting higher salaries for medical workers in maternity hospitals. Childbirth certificates permitted women to choose their institution, there-by introducing an element of competition to the system. The share of women under this programme has increased substantially (78% of pregnancies). While there has been a trend decline in maternal and infant mortality since 1994, there has been a further fall in maternal mortality and perinatal mortality by 13% and 10.8% respectively between 2005 and 2008.

Addressing risk factors: substance abuse and risky behaviour

The federal authorities have also moved forward in the area of prevention using a more integrated approach. Existing laws have been strengthened and several new laws have focused on the problem of high rates of mortality associated with chronic disease, accidents and substance abuse. This has, in part, been driven by the growing awareness by the federal authorities of the impact of poor population health on longer-term demographic trends.

In this context, recent laws are focusing more tightly on specific diseases and problems but in a more integrated fashion, the overarching goal being to reverse the downward trend in the size of the population. Three areas of policy concern are: the recently-passed Law on Tobacco and Smoking; legislation to limit alcohol consumption; and, the continuing efforts to reduce traffic deaths and injuries.

Tobacco addiction

Tobacco is an important public health problem and, as noted, contributes heavily to mortality in the Russian Federation (MHSD, 2008a and 2008b).⁸ Smoking continues to rise and the increases during the last five years were mainly observed among women, children and teenagers. Forty percent of women who are smoking continue smoke during pregnancy. Anti-tobacco legislation has existed for some time⁹ but has been largely ineffective in limiting tobacco addiction (Levintova and Novotny, 2004).

Possibly in the light of this, the Russian Federation ratified the WHO framework convention on tobacco control in 2008 and adopted an anti-tobacco law in 2010. The government aims to reduce the number of smokers from a current 40% of the population to 25%; reduce the share of passive smokers by 50%; and, ensure that anti-tobacco campaigns reach at least 90% of the population by 2015.

In October 2010, the federal government adopted by decree a concept (*i.e.* strategic action plans) for the national anti-smoking policy over the period 2010-15). Key measures to reduce tobacco consumption include: a step-by-step ban on tobacco advertising, the progressive establishment of tobacco-free zones in public places; a gradual increase in tobacco taxes to the average level of European countries by 2015; regulation of the content of tobacco products; packaging and labelling; anti-tobacco information campaigns; and smoking cessation programmes. Smoking will still be allowed in bars and restaurants but in specially equipped rooms with an implementation lag of two years to allow installation. There are few restrictions on where cigarettes can be purchased. Shops will now need to obtain a license to sell tobacco products which can be withdrawn if tobacco is sold to minors. Nonetheless, the sale of tobacco products will be allowed in small shops and kiosks. Currently more than 50% of cigarettes are sold in such outlets, where children and minors normally buy their cigarettes there. However, the current law probably will need to be strengthened to keep in line with provision in the WHO framework convention on tobacco control.^{10,11}

Alcohol abuse

A “State Policy Concept (Action Plan) for Reducing the Scale of Alcohol Abuse and Preventing Alcoholism among the Population of the Russian Federation for over the period to 2020” has been presented to the Duma. The main objectives underlying the Action Plan are: to reduce the level of alcohol consumption; improve the effectiveness of alcohol addiction programmes; and, to tighten regulation around alcohol production. More specific measures include: an increase in taxes on alcohol consumption combined with price minima;¹² limitations on the hours during which alcohol can be bought and on types of shops allowed to sell alcohol products; the elimination of illegal production; a complete ban on advertising; and the development of prevention programmes. According to the Action plan of the Government Commission on alcohol market regulation of July 2010, regional programmes are being developed and implemented in the subjects of the Russian Federation in order to reduce alcohol consumption and prevent alcohol addiction. These programmes take into account regional patterns of alcohol consumption (*i.e.* the share of rural population) and need to be co-ordinated with regional educational and health care programmes. Recent developments in October 2011, have redefined beer as an alcoholic beverage rather than a foodstuff.¹³ Excise taxes on vodka are to be increased from around RUB 254 per litre in 2012 to RUB 500 in 2014.

Road safety

While road safety is not under the sole responsibility of the MHSD, it has a large impact on premature mortality. The Russian Federation continues to have one of the highest road death rates in the European area (ECMT/CEMT, 2006), despite some downward trend since

the beginning of the decade. The Federal Target Programme on Road Safety for the period 2006 to 2012 is aimed at reducing the number of traffic injuries deaths and by one third of the 2004 level in 2012. The key measures include: improving driving skills through better teaching in driving schools; encouraging safe driving behaviour; controls on vehicle safety; renewal of emergency vehicles and the establishment of trauma centres on main arteries and more general improvement in the safety of the road network. The total budget of the current programme is around RUB 50 billion, 75% of which is to be for capital investments. Sixty percent of the budget will be paid for by the regions. This programme builds on two earlier plans (for the periods 1996-98 and 2002-10) with broadly the same aims. However there has been lack of visible progress under the earlier programmes. This has partly reflected the continuing increase in the number of motor vehicles in the Russian Federation. But lack of success under earlier programmes has also partly stemmed from a lack of financing to carry out the programmes successfully and continuing lack of compliance by drivers with safe driving practice. Drinking and driving remains a particular problem.

Healthy living

As noted, promoting a healthy lifestyle is becoming a key area in the transition from a health care system focused on cure to an approach based on healthier lifestyles and prevention. A number of policies have been put in place. Over 500 health centres were opened as part of the implementation of NPPH. These receive anyone who wishes to be examined and obtain information on health risk factors and personal advice on leading a healthier lifestyle. Data from the authorities suggest that these have been widely used (with over 2 million contacts in 2009 and 2010). An additional 190 centres have been opened for children. Preventive examinations and health assessments of the public have begun to play a more important role in this specific context. These measures are being echoed by programmes at the regional level. By mid-2011, the constituent parts of the Russian Federation adopted 208 regional programmes and sub-programmes to form a healthy lifestyle for the population of the constituent parts of the Russian Federation.

Information and communication work amongst the public has also increased. An internet portal *Zdorovaya Rossiya* (Healthy Russia) was set up in 2009 accompanied by a centralised telephone helpline service where free advice and information is given on the principles of healthy eating, the risks of smoking and methods of giving up tobacco and the function of health centres. The average number of calls to the hotline in 2010 during a background load was up to 5 000 calls per month and during the advertising campaign it was up to 35 000 calls per month. The website is visited by up to twenty thousand people per day. Since the beginning of the year, more than 1 200 content items have been published on the site.

Key messages for the advertising campaigns have been: the value of good health and the need for a responsible attitude towards one's own health and the health of other family members. Key dimensions are healthy eating; an active lifestyle; and early preventive examinations of adults and children. It also stresses reducing substance abuse, informing the public of the function of the free health centres and the opportunity they provide to achieve rapid diagnoses/evaluations. Television advertising campaigns have become more widespread and are reaching a wide spectrum of the population.¹⁴

Enhancing access to care

Providing better access to pharmaceuticals

Several programmes have been implemented to improve access to pharmaceuticals for some segments of the population.

As noted, before 2005, free drug provision in the ambulatory sector existed for only very limited groups of the population (*e.g.* disabled veterans of the Second World War) and for a limited list of drugs. The most recent efforts at the federal level to improve access to drugs began in 2005 when the federal government launched a programme on free drug provision for targeted groups, mainly persons officially defined as disabled, war veterans and Chernobyl radiation victims. The main aim of the programme was to improve substantially the quality of health care provision for these population groups. To this end, the federal authorities made a list of essential pharmaceutical drugs which were free for the defined target groups.

Table 2.1. The programme of free drug provision for vulnerable population groups

	2005	2006	2007	2008	2009	2010
Number of people entitled to benefits, million persons	14.5	16.3	16.9	16.9 ¹	16.8	16.8
Number of beneficiaries of social package, million persons	12.6	8.4	7.7	5.5	5.1	4.3
Share of beneficiaries among those qualifying for benefits, %	87.1	51.4	45.6	33.0	30.4	25.6
Total cost of prescribed drugs under the programme, billion roubles	44.0	74.9	55		42.2	45.0
Federal budget spending, billion roubles	48.3	39.1	71.9			
Planned spending	48.3	29.1	34.9			
Additional spending		10.0	15			
Financing of 2006 deficit from 2007 funds			22			
Drugs for seven diseases under NPPH				33.0		
Federal MHI fund		5.0	27.1	30.9		
Of which Financing from 2006 deficit from 2007 funds			8.8			
Total public spending on the programme, billion roubles	44.0	44.1	99	75 ²		

1. MHSD estimations; 2. Planned spending.

Source: IET (2007), *Rossiiskaya ekonomika v 2007 godu: Tendentsii i perspektivy* (Russian Economy in 2007. Trends and outlook), Institute for the Economy in Transition, Moscow.

This programme has faced serious cost over-runs. In 2005, the government had allocated RUB 48 billion for the programme which was six times more than in 2004. Over-runs occurred in 2006 when the costs exceeded budget estimates by 2.5 times (Table 3.1). These cost over-runs reflect two key factors:

- This programme formed part of the wider federal policy aimed at the monetisation of benefits. This allows individual beneficiaries to choose between a package of social services or drugs and a cash equivalent.¹⁵ As a result, those persons who did not foresee needing expensive drugs over the year obviously tended to choose a cash equivalent.
- At the same time, those who stayed in the programme were prescribed progressively more expensive drugs by doctors – *i.e.* the average cost of each prescription was increasing over time. This, in turn, reflected incentives by drug companies to encourage doctors to prescribe more expensive drugs.¹⁶

In 2008, the federal government delegated the organisation of the purchase and distribution of free drugs to the regions and channelled the funds for this programme to the regional MHI fund from the federal MHI. Possibly as a result, public dissatisfaction with this programme has increased as the percentage of eligible persons receiving free drugs dwindled from 87% in 2005 to 33% in 2008 as the restrictions on prescriptions were tightened and the free-drug option became less attractive (IET, 2007)¹⁷ (Table 2.1).

Since 2006, the National Priority Project Health has covered the costs of treatments for HIV/AIDS, hepatitis and cancer, as well as a number of vaccines. Other federal targeted programmes pay for drug treatments for so-called “socially significant diseases”, including tuberculosis, diabetes, psychiatry and medications for children. In 2008, a federal programme was introduced to cover very high-cost medicines used to treat seven rare diseases.¹⁸

Sustainability of the financing of the health care system

The impact on the logic of financing health care

The increased financing from the federal level without introducing other structural reforms has resulted in a further weakening of the insurance principle underlying the existing system of the health care-system financing. In the period after the 1998 crisis, the MHI system took on a progressively larger role in financing the public health care system. But the sharp increases in federal financing from 2005 have reversed this trend. This tendency could be interpreted as a partial return to the budget-related financing of the health sector and revived discussion on the relative efficiency of the insurance model. It also demonstrates the continuing tension between the federal government's goal of full financing through the insurance system and its apparent unwillingness to relinquish control over health spending in the public sector. This may also reflect the (not unreasonable) underlying aim of the federal authorities for a stronger policy role in guiding the system. However, the 2010 legislation on the Mandatory Health Insurance system appears to have strengthened the role of the insurance system.

In sum, federal programmes increased the overall resources available for health and succeeded in achieving a major modernisation of parts of the health care system including increased availability of pharmaceutical drugs. This, in turn, may have contributed to the recent falls in mortality and lengthening of average lifetimes. However, given the rather short time since the introduction of these programmes, it is probably too early to judge the final outcome. Surveys (conducted by the Levada Center) show that the share of the population indicating that quality of health care provision had improved during the past year went up from 11% in 2002 to 20% in 2008 (Table 3.3).

Increase financing of the Guarantee Package (increase in contribution rates)

In late 2010, the existing unified wage tax was replaced by a social insurance contribution. The contribution is to be paid directly to the Mandatory Health Insurance in each region. As noted above, the tax rate will increase to 5.1% with 2.1% going to the federal MHI fund for redistribution to other regions and 3% to the regional funds. The impact on revenues is difficult to judge as the tax base is subject to an annual earnings cap of RUB 415 000 for each employee. This should, nonetheless, lead to some overall increase in revenues and an increase in overall importance of equalisation transfers to the regions. These funds should increase the financing of the Government Guarantee Package but is unlikely to be sufficient to completely close the financing gap.

Future institutional development

The “Concept” and the need for greater focus on incentives

In 2008, the authorities presented a discussion paper highlighting some of the key problems with the existing health care system and potential reforms: the “Plan for the Development of the Health Care System 2020” (Box 2.3). A wide range of proposals and policies were discussed, many of which are embodied in the legislation adopted by the Duma at the end of 2010. The concept leaves unanswered a number of important questions. For example, it does not address the issue of the best way of paying for providers so as to maximise incentives for enhanced system efficiency (Sheiman and Shishkin, 2010). While health care policy appears to be evolving rapidly to resolve a number of important issues discussed in this chapter, longer-term success will depend on how easily a competitive model can be introduced into health care and insurance systems and sustained over time.

Box 2.3. The Plan for the Development of the Health Care System up to 2020

The *Plan for the Development of the Health Care System* or the “*Concept Health*” (MHSD, 2008a) was developed as a part of the Long-term Plan of Social-Economic Development 2020 issued by the Ministry of Economic Development in the autumn of 2008 and widely discussed during the subsequent year. This text identified a number of key problems of health care provision at all levels of the system. In an important shift in approach, the “*Concept*” set key goals to be reached by 2020 as well as intermediate timing of individual policy areas. These goals are consistent with goals of the *Demographic Concept 2025*: the return to positive population growth; increases in average life expectancy; reductions in overall mortality and, more specifically, infant and maternal mortality; a shift in behaviour towards more healthy lifestyles and increases in the quality and accessibility of health care. Some of these goals – particularly those relating to population growth and the overall mortality rate – appear ambitious.

The main directions of health care system reforms proposed in the “*Concept*” are:

- Develop prevention programmes and associated “public health campaigns” to encourage healthy lifestyles (including reduced tobacco and alcohol consumption, changes in diet, etc.19);
- Reorganise the system of health care provision (including strengthening primary-care provision, increased efficiency of secondary and high-tech care, and the development of rehabilitation and long-term care centres);
- Increasing the role of the medical community in regulating the system through greater management independence of provider institutions and by changes to their legal form;
- Specify the basic package more clearly and create efficient methods of managing and controlling spending on the package;
- Expand the system of free drugs provision to all patients in primary care;
- Ensure improved qualifications of doctors and nurses and the introduction of a new system of salaries based on quality-of-care provision; and,
- Introduction of electronic systems of management and information transfer in hospitals and polyclinics.

In terms of the policies needed to achieve these laudable goals, the “*Concept*” foresees:

- A gradual transition to “single-source” financing through the MHI system with minimal direct transfers to providers from either the regional or federal budgets;
- Bringing the financing of emergency and high-tech care into the MHI system; currently emergency care is financed from municipal budgets and high-tech care is financed from regional or federal budgets; and
- A reform of primary care on the basis of the experiences in a number of CIS and former eastern bloc countries and Russian regions. These show that a shift towards a general-practitioner model is the most effective way to strengthen primary care and increase the overall cost efficiency of the health care system.²⁰

New legislative developments

The main propositions of the New Federal Law N 326-FZ on 29.11.2010 “On Mandatory Health Insurance in the Russian Federation” are summarised in Box 2.4. This new law aims at strengthening the insurance model of health care financing and increasing the role of markets in the payment of providers.

Key problems that the new legislation attempts to resolve are: the lack of choice of insurer; payments to providers that fail to cover costs; lack of effective insurance coverage for the non-working population; the absence of a legal status for the federal MHI fund and regional MHI funds; lack of portability of insurance across regions; and the absence of a legal basis for overseeing the medical insurance sector.

Box. 2.4. Legislation aimed at improving the functioning of provider and health insurance markets

The new legislation on Mandatory Health Insurance considerably strengthens the competition in the health sector and defines better the legal status for all organisations involved in the process of health care provision in the MHI system:

- Patients have the right to choose and change their insurer;
- Patients have free choice of provider (hospital, polyclinic and doctor) accredited to the MHI system;
- Information on all medical organisations (*i.e.* hospitals and polyclinics) and medical insurance companies must be publically available in all regions (on internet sites of regional MHI funds);
- Medical organisations of any ownership type can join the MHI system on notification basis without approval from the regional authorities;
- Portability (unification) of personal MHI cards across regions;
- Introduction of electronic personal medical records;
- Uniform MHI contributions for the inactive population across the Federation;
- Introduction of payment incentives to encourage providers to improve quality of care and the respect of patient rights (including fines and penalties);
- Entitlement to compensation in cases of damages caused by inappropriate behaviour of a health insurance fund or a health care institution;
- Single source financing through MHI system based on a full-cost tariff (capital expenditure excepted), with the introduction taking place over a 2011-12 transition period;
- The MHI system will cover “emergency care” from 2013 and high-tech health care from 2015;
- Introducing new financial requirements and levels of reserve funds in the MHI system and in medical insurance companies to ensure the financial stability of the system;
- In 2011-12, funds will be allocated for modernisation and will be spent on:
- Strengthening of the material and technical capacity of the state and municipal care institutions of the public health system. This includes a guarantee of the completion of construction of facilities started in previous years.²¹ It also includes maintenance and capital renovation of state and municipal institutions of the public health system and the purchase of medical equipment.
- Introduction of new and more modern information systems in health care aimed at shifting to insurance MHI cards of a uniform type. This will include universal electronic cards supported by federal electronic applications as well as the implementation of new telecommunication systems for the electronic transfer of documents and the introduction of the patient medical histories in electronic form; and
- Introduction of standards for medical health provision, improving the ambulatory health care, including the health care provided by doctors and specialists.

Notes

1. The Federal General Prosecutor's Office has checked the tenders for buying equipment under the NPPH. They revealed that the prices in tenders were unjustifiably high, often by as much as 50%. For example, during the last three years RUB 3 billion were spent on new tomographic scanners. For this money, twice as many tomographic scanners could have been purchased. Charges have been brought in around 70 cases, <http://medportal.ru/mednovosti/news/2010/10/13/mri/>.
2. All three centres are situated in the European part of the Russian Federation (two in the Volga Federal district and one in the South Federal district).
3. Some experts have claimed that existing federal medical centres in Moscow and Saint Petersburg could easily increase the amount of high-tech surgery per year if they receive additional financing and equipment.
4. www.rost.ru/main/docs/z42.indd.pdf
5. Many regions had already given salary bonuses to individual groups of doctors. These were partly withdrawn when the federal funds for salaries were introduced such that the net increase in wages was smaller in some cases.
6. Communication from the Ministry of Health and Social Development.
7. According to *Roszdraznadzor* the check-up was incomplete in more than 20% of the cases (cited in Sheiman and Shishkin, 2010).
8. Almost 40% of Russians, or 43.9 million people, currently smoke, exposing 80% of the population to tobacco smoke. Between 53% and 80% of men, 13% and 47% of women smoke in various regions across Russia. Among teenagers, between 28% and 67% of boys and 15% and 55% of girls smoke (Global Adults Tobacco Survey, 2009).
9. The 2001 Federal Law on Limiting Smoking.
10. www.svobodanews.ru/content/article/2176126.html.
11. Reforms in October 2011 will progressively lift excise taxes on cigarettes from RUB 460 per 1 000 units in from the first of January 2012 to RUB 1 040 (from 2014) (roughly 30 US cents) which remains very small by international standards.
12. News reports suggest that the price of a half litre bottle of vodka will progressively rise from RUB 98 to RUB 180 (USD 6.1) in 2014.
13. Beverages with an alcoholic content of under ten percent were formerly not classified as an alcoholic beverage.
14. The MHSD estimates that campaign were seen by more than 92% of residents of towns and cities with a population of more than 100 000 people, which equates to approximately 60 million people, of which 27.7 million were between the ages of 18 and 45.

15. Starting from 2005, those eligible for federally financed social assistance could choose whether to get in-kind social services or to monetise the amount of social services they are eligible for. In the latter case they become “recipients of monetary payments”. Those who choose not to convert the eligibility for social assistance into a monetary benefit are eligible to get the so called “social package”, *i.e.*, they are entitled to get a set or a subset of social services including provision of vital medicines, medical products, specialised clinical nutrition products for disabled children, vouchers for health resort treatments, free suburban railway transport, as well as intercity transportation to treatment centres. The amount of monetary payment to different eligible categories is defined by federal laws and indexed every year. It is paid in full in the case the person chooses to monetise the full social package, or partially if only some of the components are monetised. The costs of the components of social package are defined by the federal legislation and are also indexed annually. As of 1st April 2008, the cost of social package is set to be RUB 549, with medical treatment, medicine provision and sanatorium-and-spa components cost of RUB 488, and transportation component cost of RUB 61.
16. In fact, a review of prescribing by the federal MHI indicated that 7.5% of prescriptions were not in line with the medical condition of the patient.
17. An additional side-effect was the increase in the number of visits to district doctors because prescriptions were valid for only one month, with consequent increases in waiting times.
18. Haemophilia, cystic fibrosis, pituitary dwarfism, Gaucher’s disease, myeloid leukaemia, multiple sclerosis, and immo-suppression associated with organ or tissue transplantation.
19. For example the target for tobacco was a reduction in use by 25% and the consumption of alcohol by 9%.
20. Kyrgystan, Moldova, Estonia, Samara Oblast and the Chuvash Republic. See also World Bank (2010).
21. *E.g.* For those projects where the progress at a technical level have reached a stage where at least 80% of the total budget of the project has been carried out/or spent by the building contractor.

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Chapter 3

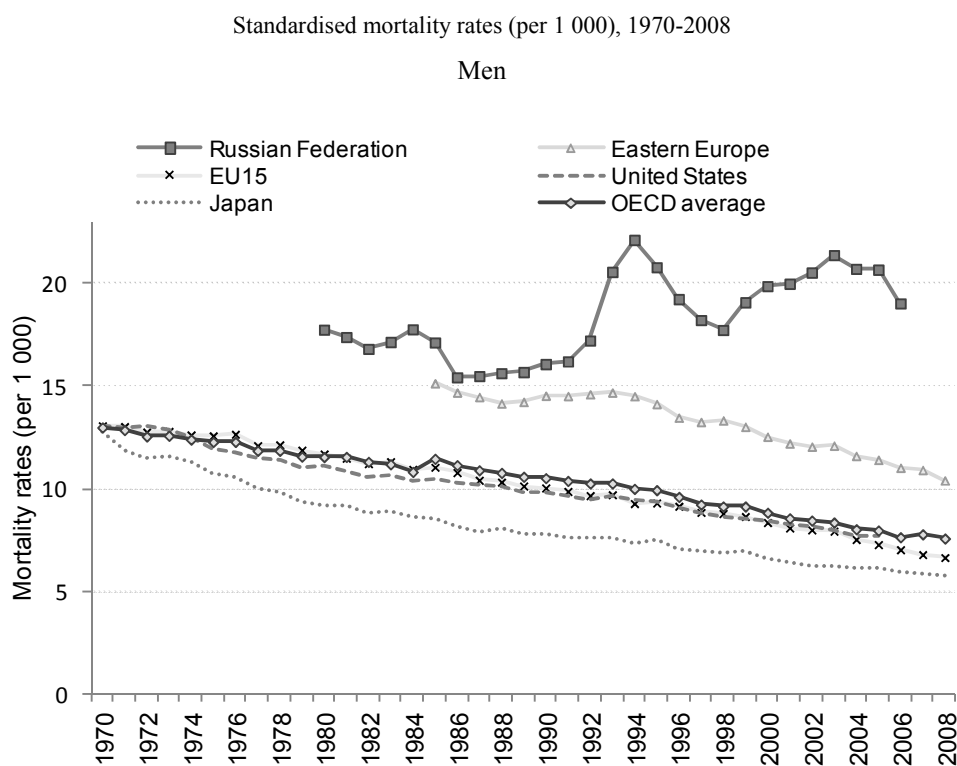
The performance of the Russian health system

This chapter first examines how the Russian Federation compares internationally over a range of health-related indicators. It then looks in more detail at the performance of the health system as seen from four different vantage points that broadly correspond to the key objectives of health systems. The first objective concerns ensuring that patients can access the care that they need under the Government Guarantee Package on a timely basis. The second concerns the quality of care and whether it is adapted to patient needs. The third key goal concerns the resources allocated to the public health care system and whether this is sustainable over the longer haul. The final key issue concerns the scope for easing any overall resource constraints on the public health care system through improved efficiency of health care provision. The chapter concludes with a discussion of policies that can help improve system performance.

Health status in the Russian Federation in an international perspective

Compared internationally, the Russian Federation has very high levels of mortality and short life expectancy, even when compared with countries with similar income levels, such as Chile, Mexico and Turkey (Figures 1.1 and 3.1). What is more striking in the Russian case has been the trends in mortality indicators, especially during the last three decades. While mortality has been constantly decreasing in other countries (Figure 3.1), it began to rise in the middle of the 1980s in the Russian Federation. It then increased sharply during the economic transition (from 1991 to 1994), especially for men. The declining trend observable in the following years was interrupted by the crisis in 1998 which appeared to be associated with another peak in mortality. A decline in mortality began from 2004.

Figure 3.1. Mortality rates over time: Russian Federation and selected OECD country groupings



Note: Data on eastern European OECD countries include the following countries: Czech Republic, Hungary, Poland and Slovak Republic.

Data on EU15 include the following countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherland, Portugal, Spain, Sweden and the United Kingdom.

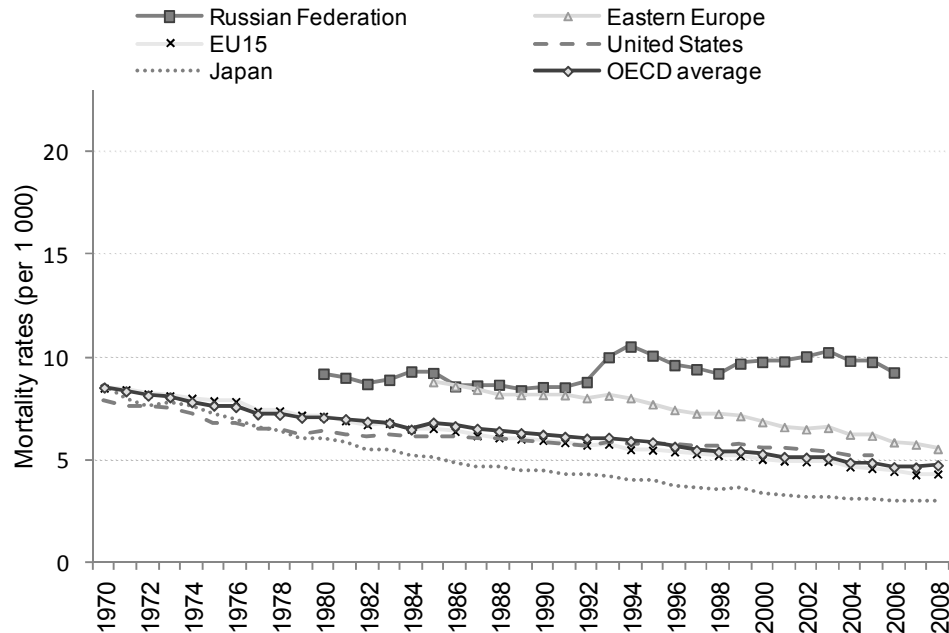
Mortality rates have been standardised to enhance comparability of data, using the structure of the OECD population in 1980.

Source: OECD Health Data 2010 and Rosstat.

Figure 3.1. Mortality rates over time: Russian Federation and selected OECD country groupings (cont.)

Standardised mortality rates (per 1 000), 1970-2008

Women



Note: Data on eastern European OECD countries include the following countries: Czech Republic, Hungary, Poland and Slovak Republic.

Data on EU15 include the following countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherland, Portugal, Spain, Sweden and the United Kingdom.

Mortality rates have been standardised to enhance comparability of data, using the structure of the OECD population in 1980.

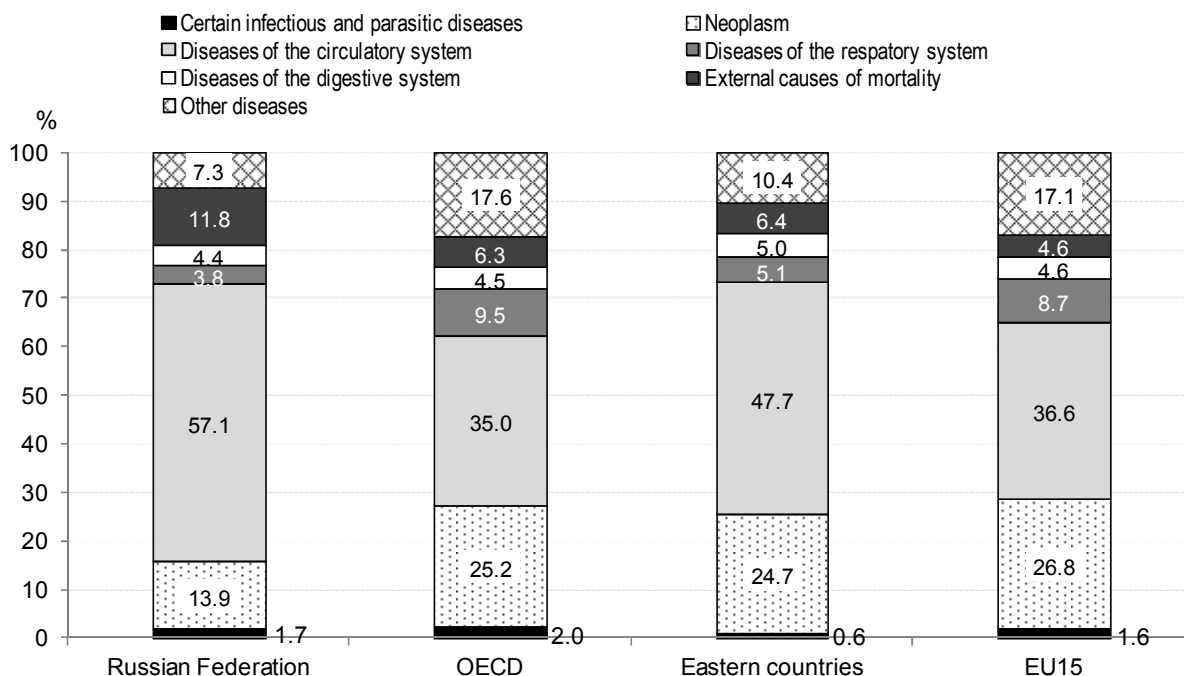
Source: OECD Health Data 2010 and Rosstat.

Key patterns of mortality

As noted, the Russian Federation is marked by a relative high share of deaths caused by cardiovascular diseases and by external causes. The former account for almost 57% of all deaths, against 35% in the OECD area; the latter contributes by 12% to overall mortality, against 6% in OECD countries (Figure 3.2). More importantly, the Russian Federation ranks first in the WHO European Region for premature mortality due to cardiovascular diseases as well as for external causes (injuries and poisoning) and fourth for premature mortality due to cancer.¹

Though non-communicable diseases (NCDs) and injuries impose the highest burden to the health of the Russian population, infectious diseases, and more specifically tuberculosis and HIV remain a problem. Similarly, infant and maternal mortality, though improving, could be further reduced. These issues will be addressed below.

As in all countries, there is a strong social gradient across a range of different illnesses and, in general, the poorest part of the population is affected the most. There are also wide geographic disparities – which is perhaps not surprising given the size of the country and the differences in wealth per capita across regions. Indeed, the Russian Federation cannot be considered as a homogenous territory with identical health profiles everywhere.

Figure 3.2. Shares of selected causes of mortality, Russian Federation and OECD, 2006

Note: Spain, Portugal, the Slovak Republic and the United States: 2005; Australia, Denmark, Germany, Israel*, Korea, Luxembourg and New Zealand: 2006; France, Italy, Mexico, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom: 2007. The OECD average excludes Belgium, Canada, Chile and Turkey.

Data on eastern countries include the following countries: the Czech Republic, Hungary, Poland and the Slovak Republic. The EU15 comprised the following 15 countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom.

Mortality rates have been standardised to enhance comparability of data, using the structure of the OECD population in 1980.

Source: OECD Health Data 2010 and Rosstat.

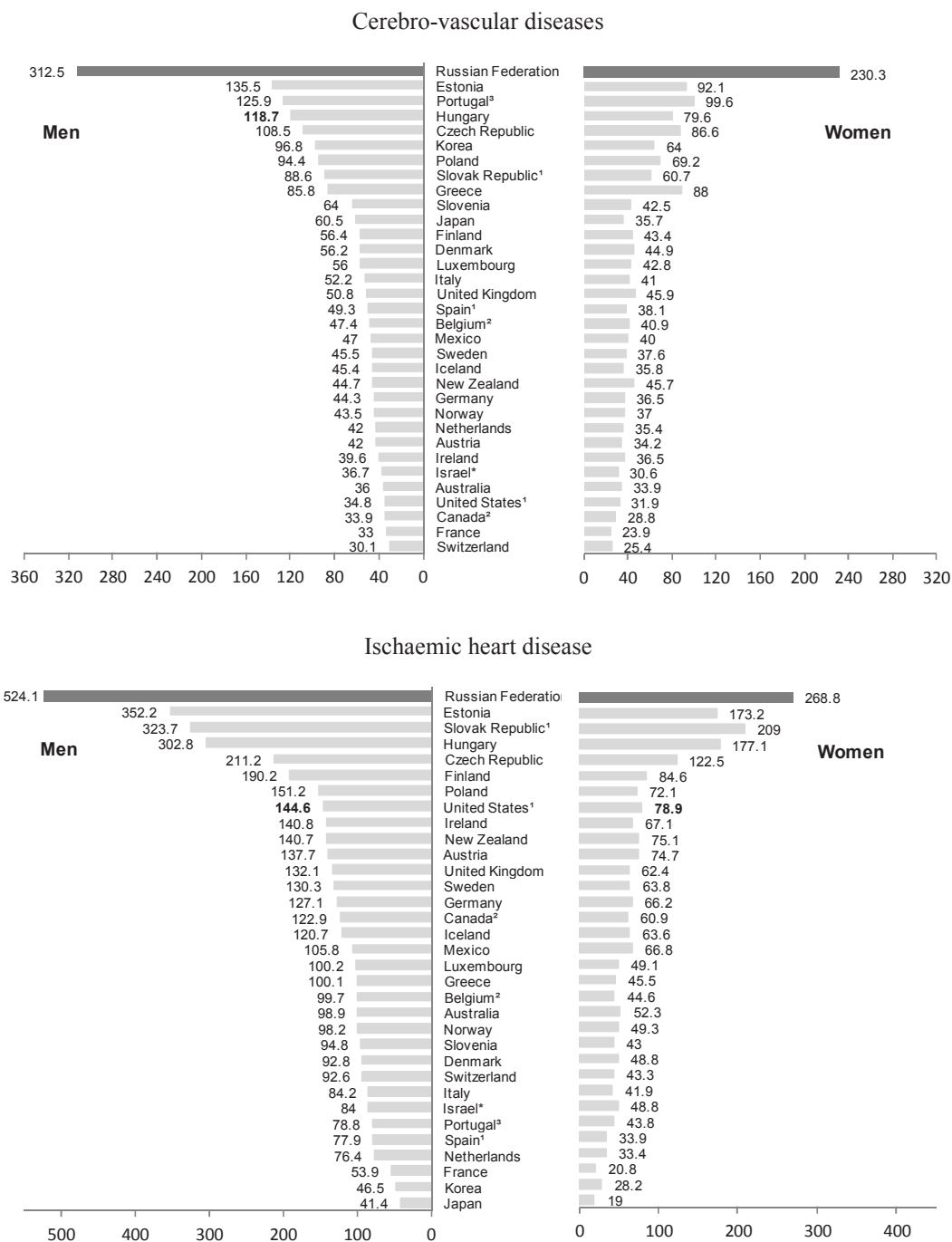
The high burden of non-communicable diseases

Non-communicable diseases (NCDs) and injuries are particularly high in the Russian Federation. Taken individually, different categories of NCDs and injuries make up the ten leading causes of death in the Russian Federation and account for 90% of deaths in the Russian population as a whole (Rosstat, 2008).

Mortality due to cardiovascular diseases is exceptionally high in the Russian Federation by comparison with OECD countries. Standardised mortality rates (SMR) for cerebrovascular diseases and ischaemic heart diseases are twice as large as the OECD average and are ten times larger than the best performing OECD countries (Figure 3.3).

Cancer is the second most important cause, partly because it tends to be more lethal in the Russian Federation, with a large number of deaths in the year after diagnosis, particularly for men (World Bank, 2005).

Figure 3.3. Standardised mortality rates for cerebro-vascular and ischaemic heart diseases, Russian Federation and selected OECD countries, 2006



Note: Mortality rates have been standardised to enhance comparability of data, using the structure of the OECD population in 1980.

Deaths per 100 000 population.

1. 2005; 2. 2004; 3. 2003.

* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2010 for OECD countries and WHO Database for the Russian Federation.

The role of risk factors

Many non-communicable diseases appear to be associated with lifestyle factors. According to various estimates, alcohol kills – either directly or indirectly – half a million persons per year while smoking is estimated to kill between 330 000 and 500 000 persons. Almost 24 000 persons die in traffic accidents per year (MHSD, 2008; and Rosstat, 2009a).

The Russian Federation has one of the highest smoking rates among men: in 2009, 60% of males smoked – more than twice the rates in the United Kingdom and the United States – while the same rate was 22% for women (GATS, 2009).² Some declines in smoking by men in recent years, particularly among the better educated, have been more than offset by rapid increases among women and adolescent men (Bobak *et al.*, 2006).

The levels of overall alcohol consumption are reported to be not much different from other European countries, but are probably underestimated significantly.³ In addition, it is most often consumed as spirits (*e.g.* vodka) and there is a high prevalence of binge drinking. According to the RLMS,⁴ about three quarters of the Russian population consume some kind of alcohol, with more being consumed on average by males in all age groups and in the persons belonging to the 25 to 55 age group. There also tends to be wide differences in the type of alcohol consumed: the most frequently consumed is beer, followed by spirits which is consumed by 60% of men and 37% of women. Twelve percent of men and five percent of women drink homemade alcohol (CEFIR, 2010).

Mortality directly linked to alcohol consumption has been monitored by Rosstat since 2005. These data do not represent the total death toll attributable to alcohol as they do not include injuries and violent deaths caused by alcohol or deaths from chronic diseases for which alcohol is a risk-factor. However, they enable policy makers and epidemiologists to monitor the impact of reforms and policies. According to Rosstat (2009b), the number of deaths directly linked to alcohol consumption decreased by 40% between 2005 and 2008. Nonetheless, 76 268 people died in 2008 due to over-consumption of alcohol.

Poor diet has been reflected in high levels of blood cholesterol. This, in turn, has contributed to higher levels of cardiovascular diseases and other ailments, and these effects may have become more marked with the transition to a market economy (Herzfeld *et al.*, 2009).

Injuries and suicides

Deaths from external causes are also exceptionally high in the Russian Federation. Many of them cannot be attributed to inefficiencies of the health sector. As noted, traffic deaths at 18.2 deaths per 100 000 (around 24 000 deaths in 2008) are about double that of the other G8 countries, even though there are fewer cars per capita in the Russian Federation.

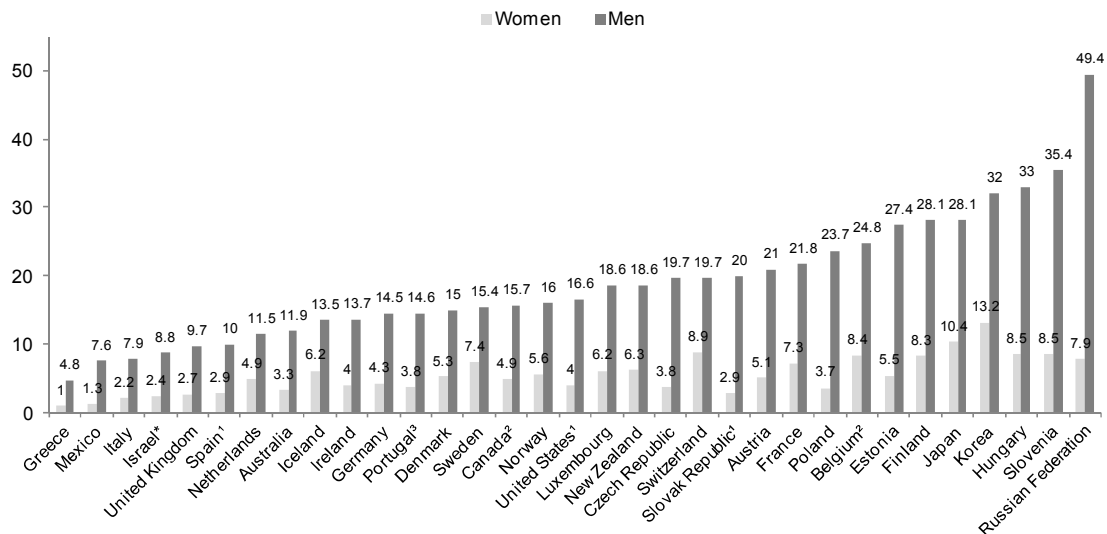
The standardised suicide rate in the Russian Federation is 2.7 times the OECD average for men and 1.5 for women (Figure 3.4). Suicides were particularly common during the transition period: in 1985, the suicide rate for men aged 40-59 years reached 96.3 per 100 000 population. While it has declined since then, it remains high for adolescents.

Alcohol poisoning has always accounted for a significant part of alcohol-related deaths. The mortality rate from poisoning reached its highest level in the beginning of the 2000s (Stickley *et al.*, 2007; and Rosstat, 2009b). It then almost halved between 2005 and 2008. However, its current level (16.9 deaths per 100 000 people, 28.4 for men and 7.0 for women) has not yet reached its lowest level experienced in 1988-89 (8.7), thanks to the anti-alcohol campaign launched by M. Gorbachev but interrupted a few years later. In 2008, poisoning still accounted for one-third of male deaths directly linked to alcohol and one-fourth of female ones. Death by alcohol poisoning is particularly frequent in rural areas and includes the

effects of local unregulated production which can contain solvents that are dangerous to health. However, the main problem is not local production. Rather it appears to be the consumption of large quantities of “good quality” spirits (vodka).

Violence, as measured by the homicide rate (Chervyakov *et al.*, 2002), in the Russian Federation increased rapidly during the 1990s, with much of the increase associated with alcohol consumption. This, in turn may have reflected the increase in stress as a result of economic and social dislocation over this period.

Figure 3.4. Standardised suicide rates per 100 000 population in selected OECD countries and the Russian Federation, 2008 or latest available year



Note: No data are available for Chile and Turkey.

1. 2005; 2. 2004; 3. 2003.

* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2010 for OECD countries and WHO Database for Russian Federation.

Remaining concerns about infectious diseases

As elsewhere, deaths from infectious diseases represent only a small fraction (1.7%) of total mortality. However, tuberculosis (TB) and HIV/AIDS remain problems of serious concern in the Russian Federation.

In 2010, around 109 900 people contracted tuberculosis and 21 800 died from it.⁵ The incidence of TB rose rapidly in the 1990s to reach a peak in 2000. Since then, the incidence rate has been declining to reach 77.4 per 100 000 people in 2010. Since 2003, the TB/AIDS Control Project in the Russian Federation, supported by the World Bank, WHO and other international partners, has improved detection and treatment of TB in the Federation (Marquez *et al.*, 2010). Three-quarters of TB patients now receive standardised treatment regimens – against less than half in 2004. Prevalence of tuberculosis – *i.e.* the number of people living with the disease in a given year – has decreased by 40% since 2000 and TB-related mortality has decreased by one-fifth from its highest level in 2005 (Rosstat, 2009a). Despite these improvements, the appearance of drug-resistant strains is becoming commonplace (Keshavjee, 2007; Stuckler *et al.*, 2008; Balabanova and Coker, 2008).

There has also been a significant spread of AIDS. In the decade to 2008, there was an increase in the number of infected people to just over 436 000 officially registered cases. However, international organisations consider that the number of actual infections – including undetected cases – is more likely to be comprised between 630 000 and 1.3 million (WHO, UNAIDS, UNICEF, 2009).⁶ The overwhelming number of infections is concentrated among individuals aged 15 to 49 who are the most economically-active and a growing share of these are women.

In 2008, 54 046 new cases were reported, 20% more than in 2007 (Vartanova *et al.*, 2010). Until recently, HIV transmission was broadly confined to drug users using syringes: in 2001, 93% of reported HIV cases were drug users and in some big cities, half of this population was infected by HIV. However, the proportion of cases reporting heterosexual contact as their only exposure increased from 6% in 2001 to 25% in 2004 (Burchell *et al.*, 2008).

Access to anti-retroviral drugs has improved since 2005, the percentage of registered patients in need of treatment who actually receive treatment has increased to 60% in 2008 (Marquez *et al.*, 2010). However, more pessimistic estimates consider that only 16% of patients who need treatment – including unregistered ones – actually receive it (WHO, UNAIDS, UNICEF, 2009).

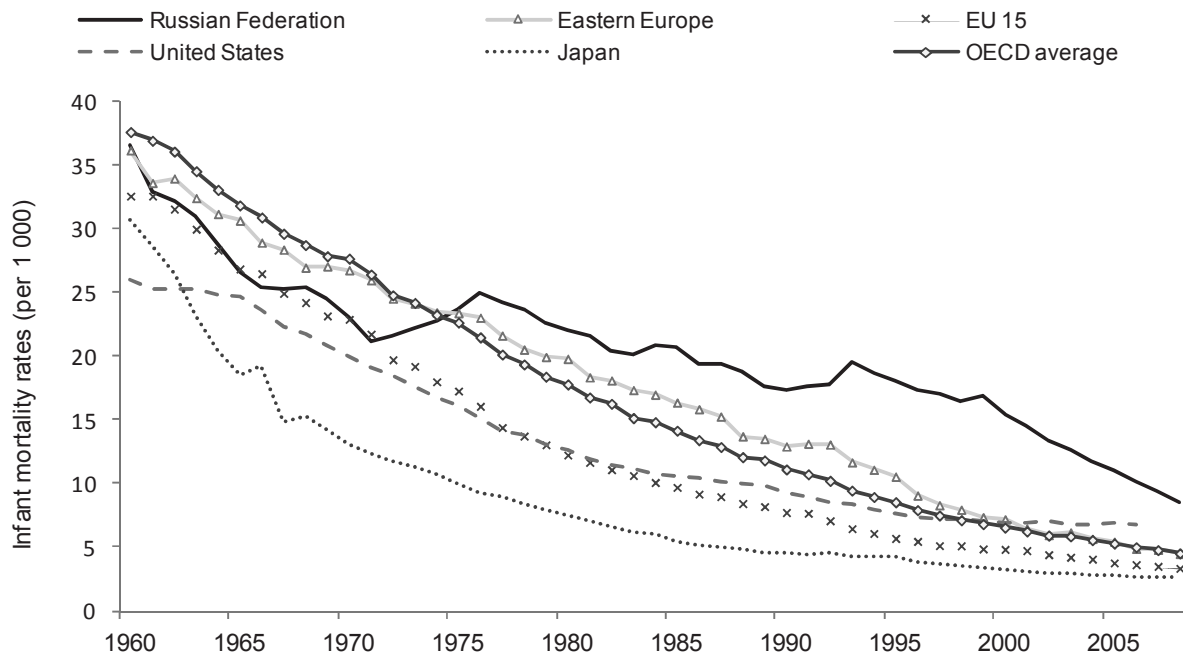
There are a range of estimates of the number of deaths due to HIV/AIDS. The same unofficial sources estimate as many as 40 000 deaths from AIDS per year.⁷

Until recently, prevention policies aimed at a better understanding of the nature and transmission modes of HIV were lacking. In 2007, only 34% of young people (15-24) had a proper understanding of HIV infections and how the virus is transmitted. As part of the NPPH, the government implemented about 400 prevention projects with the objective of improving understanding of at least 95% of young people. However, the epidemic is still spreading and more needs to be done in terms of information and education (UNAIDS, 2009).

Infant mortality and abortion

Infant mortality,⁸ which is often taken as a key measure of public health, has recorded a significant fall over the past 50 years. Up until around the early 1970s, the performance of the Russian Federation was in line with European countries and better than the United States and Japan. But by 1975 it had worsened substantially in relative terms and has since remained well above the other country groupings in Figure 3.5. However, it is now rapidly converging to the OECD average.

In practice, the Russian average hides wide variations across regions and geographical areas. For instance, infant mortality is lower in urban areas (7.5 per 1 000 live births in 2008) than in rural ones (10.1). Variations between regions are probably higher than in countries with more homogeneous territories: infant mortality ranges from 4.5 in the City of Saint-Petersburg (just below the IMR in the United Kingdom) to 17.0% in the Chechen Republic (the level of the IMR in Turkey). Some rural areas seem to deserve particular policy attention given that the level of the IMR is startlingly high. (For example, it is 38% in the rural areas of the Madagan region).

Figure 3.5. Infant mortality rates in the Russian Federation and selected OECD country groupings

Note: Data on eastern European OECD countries include the following countries: Czech Republic, Hungary, Poland and Slovak Republic.

Data on EU 15 include the following countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherland, Portugal, Spain, Sweden and the United Kingdom.

Source: OECD Health Data 2010 and Rosstat.

The abortion rate has been historically high in the Russian Federation with adverse consequences on women's health and maternal mortality (Zhirova *et al.*, 2004). Although the rate of abortion fell sharply and steadily from its highest level in 1993 (2.1 abortions for one live birth), it is still one of the highest in the WHO European region. In 2008, there were 0.81 abortions for each live birth in the Russian Federation compared with an average of 0.23 for countries of the European Union and 0.49 for CIS countries (WHO, 2010; Rosstat, 2009b). This progress is partly explained by the fact that the fertility rate has increased by 44% between 1999 and 2008 (from 30.9 live births for 1 000 women aged 15-49 to 44.6) which suggests that pregnant women are more willing to keep their babies. The new restrictions imposed on abortion in 2003 may have contributed to this fall (Parfitt, 2003), as have current policies providing social and psychological support to women seeking abortions.

Social gradient in mortality and morbidity

As is the case elsewhere, the patterns of mortality and morbidity have a strong social dimension in the Russian Federation (Walters and Suhrcke, 2005). Both the likelihood of chronic illness and the probability that illness leads to early retirement are negatively correlated with income (see World Bank, 2005 and 2008a). Mortality is higher among the "marginalised" social groups such as the unemployed, homeless, ex-prisoners, and migrant populations. The share of these groups in the total population increased during the transition to a market economy and this partly explains the sharpness of the increase in mortality during that period (United Nations in Russia, 2008).⁹

Mortality among young people is concentrated among the unemployed (55% to 70%) and unskilled labourers (20-30%). In contrast, the share of mortality among “socially adapted” groups aged 20-39 is extremely low (5-10%).¹⁰ The patterns of mortality between “marginalised” and “socially-adapted” groups are also quite different. For example, among the age group 20-39, the marginalised have a higher share of deaths from injuries, intoxications and tumours, as well as cardiovascular, respiratory and infectious pathologies. These people are also prone to deaths from external causes, – *i.e.* from accidental alcohol poisonings and suicides and traffic accidents (United Nations in Russia, 2008).

Life expectancy and healthy life expectancy

As noted, life expectancy in the Russian Federation has fallen from the mid-1980s when it peaked at around 65 for men and 74 for women (Figure 1.1). It then declined by two years for women and six years for men until 2004. These trends are in sharp contrast with the steady rise in life expectancy among OECD countries (and even with countries in central Europe). In 2008, the Russian Federation lagged behind the EU 15 countries by roughly 16 years for men and just under 9 for women.¹¹ Behavioural factors are estimated to account for more than half of the life expectancy gap between the Russian Federation and other developed countries (Andreev *et al.*, 2003).

In addition, the Russian Federation has lower healthy life expectancy and this is particularly so in the case of women where the gap with western European countries is very wide. Their average life expectancy at any given age is higher than that of Russian men but they also tend to spend much more of their lives in ill-health (Andreev *et al.*, 2003).

Nonetheless, life expectancy at birth has since recovered by 3.9 years for men and 2.4 for women over the period from 2004 to 2009 reflecting declines in death rates. While it is probably too early to judge whether this is a reversal in the trend, the recent improvements in mortality have been widely based across all age groups, a feature that contrasts with earlier periods of recovery in life expectancy in the 1980s and 1990s.¹² Furthermore, recent improvements in life expectancy have continued even during the most recent economic downturn.

Rapid economic growth in recent years and the increase in health expenditure may well have led to some improvement in health indicators over the current decade or may appear in the next decade with a lag (Table 1.2). For example, there has been a significant rise in the average life expectancy of persons diagnosed with chronic illnesses in the first half of this decade (Tompson, 2007).

Despite this improvement, the overall situation of mortality and life expectancy remains grim and a broad-based effort to improve the Russian Federation’s health outcomes is needed. Part of the responsibility for these very poor health outcomes has to do with the weak performance of the health care system in a range of dimensions (see below). But both the importance of mortality among the working-age population and the strong social dimension of mortality suggest that a central part of any strategy to improve performance must involve greater efforts in the area of prevention of chronic diseases and, underlying this, more healthy lifestyles. Sole reliance on the health care sector will not be sufficient.¹³

Assessing the performance of the Russian health system

As noted, this chapter examines in greater detail how the Russian health system performs in four dimensions of health care: access to care; the quality of care; the financial sustainability of the system; and efficiency in the provision of health care services and their impact on health outcomes.

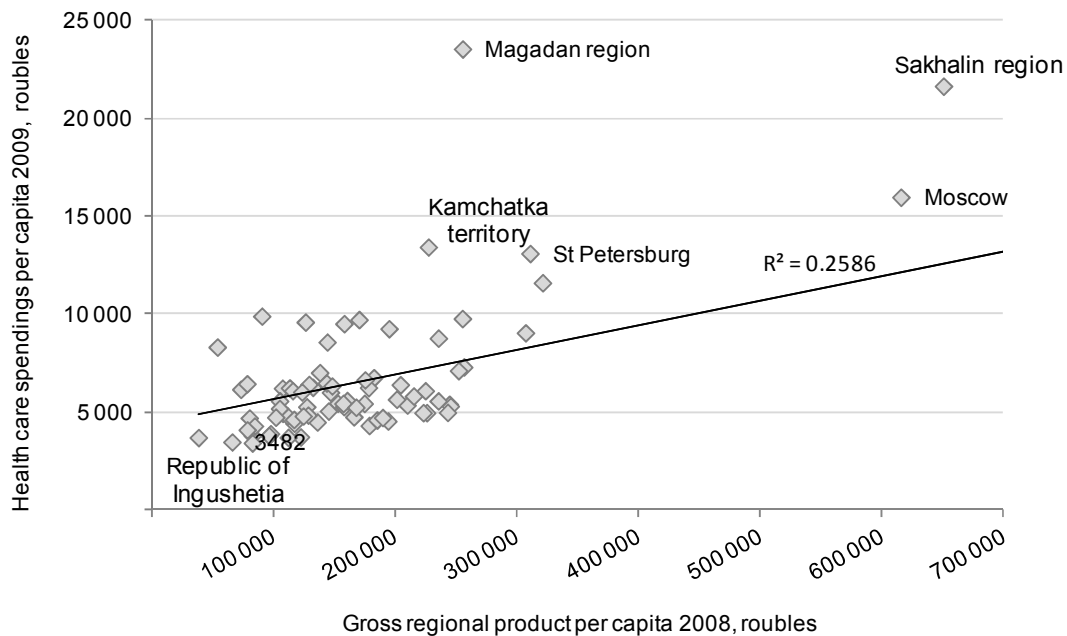
Access to care

The creation of a network of health care services was one of the important achievements of the Soviet period, providing at least minimum services to the bulk of the population. Russians have the right to free health care for a wide range of services as defined in the Government Guarantee Package and the Constitution. But the true degree of access differs in a number of dimensions and for a variety of reasons.

Regional inequalities

First, the regional capacity to provide free services differs because of variation in regional financial capacity. At the time of the reforms to the health system in the early 1990s, it was hoped that the new insurance system would lead to better access to care. In the event, regional differences in the access to care widened substantially as a result of regional variations in the level of economic activity and, as a consequence, the revenues of both the MHI system and regional and municipal budgets.¹⁴ Despite the attempts by the federal authorities to reduce inequalities through equalisation transfers from the federal MHI fund, the levels of per capita public spending (budget and MHI combined) varied from RUB 3 430 to 23 559 in 2009 and the differences were even larger for total health care spending (Figures 1.5 and 3.6).

Figure 3.6. GDP per capita and public health care spending by region



Source: Independent Institute for Social Policy and Rosstat.

These differences in resources have permitted richer regional governments to broaden the coverage provided beyond minimum levels specified in the Guarantee Package, which should, in principle, be reached by all regions.¹⁵ This has meant that patients in poorer regions have been obliged to increase private payments if they wish to receive care at the same level as provided by the richer regions. Available data suggest that the aggregate level of private spending has been increasing (Chapter 1). While there are no reliable cross-regional data on the level of private health care spending, some surveys suggest that the share of persons who did pay for private health care services is higher than average in:

- Richer regions where the population can afford to pay for better health care provision and, hence, enjoy greater provider choice; and,
- Less wealthy regions where public medical facilities are in poor condition and chargeable services in private clinics or parallel-health care systems are the sole source of health care services of reasonable quality (Shishkin, 2003).

Physical access to health care

Patterns of population density across the Russian Federation create additional challenges to the organisation of health care provision and can limit the scope for restructuring the system. As noted, such problems can arise for example where minimum level of provision is needed in rural areas, even though cost and quality would be better served in larger hospitals or polyclinic units. This can lead to low use of capacity and high costs per bed and per case. The situation is made worse when limited local supply combines with poor transport facilities and networks. Medical aviation was not well developed during the Soviet period and completely died out during the transition due to lack of financing. Patients with severe chronic conditions may require visits to specialist third-level services. In this case, transport costs may be prohibitive. While this may be changing – partly as a result of the NPPH – most of the high-tech medical centres are concentrated in the European part of the Russian Federation (more precisely in Moscow and Saint-Petersburg). Travel costs from Siberia and the Far East could exceed average monthly wage levels in these regions by several times. In addition, an increase in the permanent population in areas with extraction industries operating in extreme climatic conditions also poses particular problems because health care services are often lacking in such localities, diet is poor and pollution is extensive.

Access to health care in rural areas

A relatively large share of the population does not seek medical care in the case of a medical problem and this type of behaviour is more marked among those living in rural areas. This may reflect differences in the organisation of primary-care provision between rural and urban areas (see Chapter 1). Persons living in rural areas may not have doctors who they can consult and patients have to be satisfied with paramedical services which are limited in the care that they are allowed to provide. Surveys show that the access to health care in rural areas is worse than in urban areas, both in terms of the presence of medical facilities and in the quality of health care provision (Bremzen *et al.*, 2007) (Table 3.1). The widespread depopulation of rural areas – in the wake of the move to a market economy – has been reflected in the ageing of the remaining inhabitants who tend to have health problems of a chronic nature. At the same time, it has become more difficult for regions to maintain the system of health care provision in rural areas:

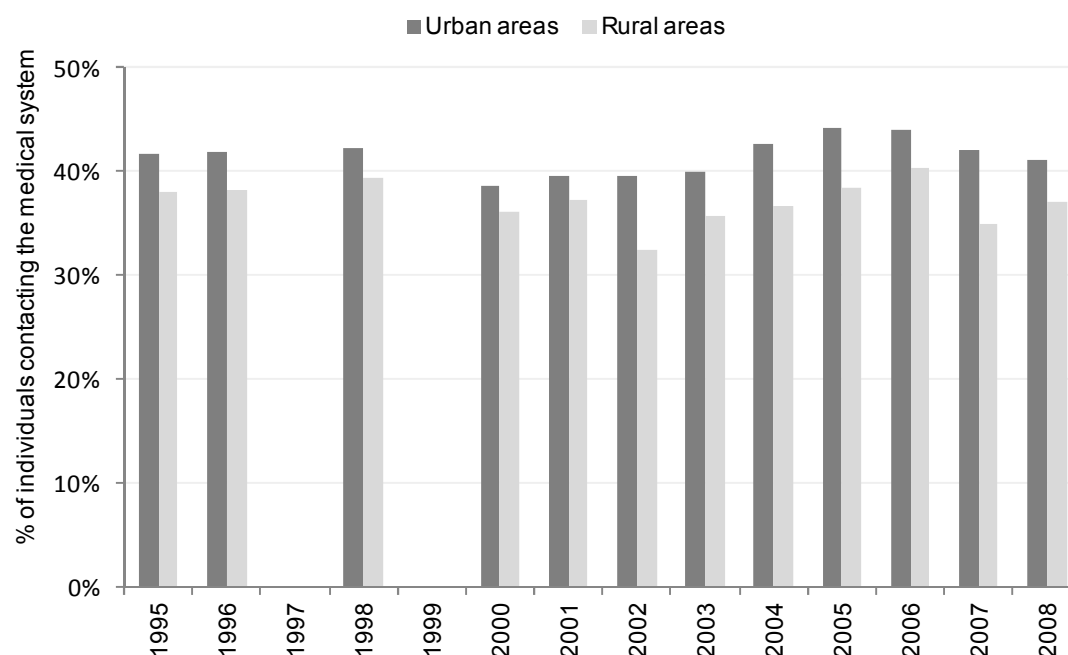
- Regional authorities are confronted with problems of attracting medical staff to rural areas. Many regions have special programmes for (young) doctors (including free housing, transport and additional bonuses). But results have been only partially successful; and
- Municipalities and regional authorities – who are, nearly always, the owners of paramedical offices and central district hospitals – do not have enough funds to renovate the medical facilities and quite often buildings are in very poor condition with equipment that is either broken or outdated.¹⁶

Table 3.1. Reasons for not receiving medical care during the past year, 2004

Reasons why the person did not see the doctor during last year, %	Urban areas	Rural areas
Did not have health problems	65.5	66.9
No medical professionals of required specialisation in the settlement	0.7	6.3
Difficult to make an appointment or get a referral to see doctor	3.4	1.2
The required medical services are chargeable and cannot pay for them	6.6	5.4
Other reasons	23.8	20.2

Source: “Reforming Family Healthcare: Estimating Potential Effects of a Shift to a General Practitioner (Family Therapist) System”, CEFIR.

As a result, the share of the rural population that goes to see a doctor if they have health problems is lower than in towns (Figure 3.7) and it leads to higher rates of hospitalisation after the first visit to the doctor in rural areas (Bremzen *et al.*, 2007). Current arrangements may lead patients to make contact with the medical system at a later stage of disease when costs of the episode of care may be higher.

Figure 3.7. Share of individuals contacting the medical system among people who experienced health problems in the last 30 days

Note: Survey was not conducted in 1997 and 1999.

Question in the RLMS survey: “What did you do to solve your health problems in the last 30 days? (For those who had health problems)”.

Went to medical institutions or health workers.

Did not go to health workers, but treated themselves.

Source: CEFIR estimations based on the Russian Longitudinal Monitoring Survey.

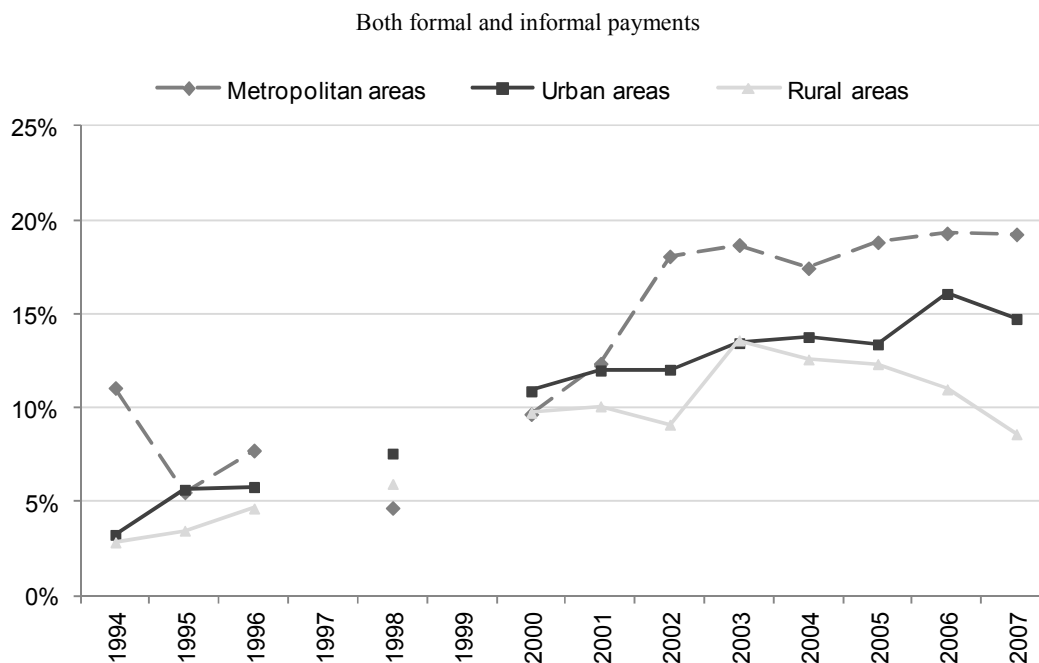
In addition, there has been a major shift in population from high-to-low unemployment regions and from rural to urban areas. These shifts can have implications for access to the government's basic package of health care as those individuals in transit or working in unregistered unemployment may not be covered adequately (Andrienko and Guriev, 2005).

In response to these patterns, a number of regions have started to develop a system of GP practices in the rural areas to replace the existing system of paramedical offices and there seems to be widespread agreement that such a policy could improve access to care. But the cost of constructing and equipping the centres is high and it remains difficult to attract doctors to these more remote areas, as in many other countries (Canada, Australia and some of the Nordic countries). For example, in the Yaroslavl region, the department of health has found it difficult to fill the vacant places in the newly-built GP offices in rural areas, even with 30% bonuses to the salaries and provision of free housing (Rese *et al.*, 2005). There is also a problem with pharmaceutical drug provision in the rural areas. A quarter of rural settlements do not have pharmacies and most of the paramedical offices do not have licenses to sell drugs to the population.

Access to care for different income groups and out-of-pocket payments

As noted, the aggregate share of private spending in total health care expenditure increased in the 1990s until 2001 and began to decline from 2003 (see Chapter 1). During this period, paid medical services became increasingly prevalent. According to the Russian Longitudinal Monitoring Survey, between 1994 and 2007, the share of the population which paid for medical services increased from 4% to 15% for doctors' consultation; from 8% to 26% for diagnostic procedures and from 30% to 50% for hospital stays (with a peak of 60% in 2002).¹⁷

Figure 3.8. Share of those who paid for an ambulatory care consultation by residential status, 1994-2007

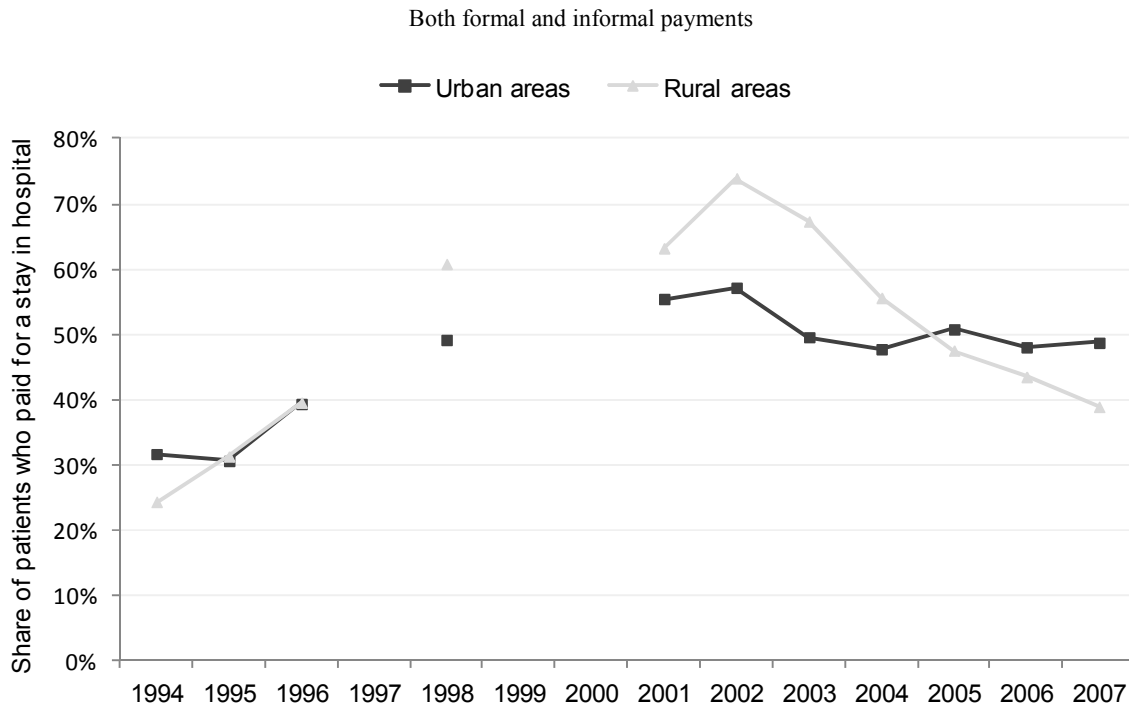


Note: Survey was not conducted in 1997 and 1999.

Source: CEFIR estimations based on the Russian Longitudinal Monitoring Survey.

In recent years, the behaviour in rural and urban areas has begun to diverge with a decline in the share of the rural population paying for visits to doctors, while the share of the population who paid for visits to a doctor in large cities remained stable and high (Figure 3.8). Roughly 50% of patients paid something for hospital stays, although the average size and distribution of the payment is not known (Figure 3.9).

Figure 3.9. Share of patients who paid for a stay in hospital, 1994-2007



Note: Survey was not conducted in 1997 and 1999; the questions on formal and informal payments in hospitals were stated differently in 2000.

Source: CEFIR estimations based on the Russian Longitudinal Monitoring Survey.

Patients usually pay for services:

- That are provided in addition to the basic package, such as: hospital hotel services (single room with amenities, TV, etc.); diagnostic procedures using advanced technologies; or,
- That could be obtained at no charge, but may be of better quality and received under better conditions (*e.g.* jumping queues or receiving more rapid referrals, etc).¹⁸

The data suggest that a significant share of individuals decide not to pay for additional services because they fear that their private costs will be too high. According to the RLMS, almost 43% of people would like to purchase paid services but choose not to do so for financial reasons (Table 3.2).

This effect appears to be more marked for low-income groups. With easier access to paid health care services, higher income groups may have had more opportunities for preventing disease and for getting treatment at an early stage of the illnesses. A Rosstat study (2009b) shows that the share of the population which has, for example, cardiovascular disease is almost twice as high (41.2%) among low income as it is among high-income groups (21.5%).

Shishkin (2007b) reports that the share of the population who paid for medical services increased the most for the higher income groups: the share of those who paid for visits to doctors was markedly higher in the fifth (the highest) income group than in the fourth quintile group. Nonetheless, the largest group paying for hospital care was in the first and second quintiles which suggest that lower income groups are most likely to face higher spending in the case of serious illness.

Table 3.2. People's perception of their need for medical services and their ability to pay for them

Share of population, in %				
Year	2005	2006	2007	2008
People planning on using chargeable services in the near future	6.0	7.2	6.8	6.9
People who would like to obtain chargeable health care services but are unable to do so for various reasons	47.7	47.1	46.6	44.4
<i>Of which: Because of financial restrictions</i>	45.4	45	45.4	42.9
<i>For other (non-financial) reasons</i>	2.3	2.1	1.2	1.5
Respondents who do not see a need for additional medical services	46.2	44.9	46.0	48.7
Total	100.0	100.0	100.0	100.0

Source: Rosstat household survey, www.gks.ru/bgd/regl/b09_44/IssWWW.exe/Stg/d2/10-26.htm.

Administrative barriers

In principle, the municipalities finance care for groups not covered by insurance in the case of medical emergency. In practice, some groups may fall through the cracks: illegal immigrants, individuals or families moving from one region to another (and who are not yet registered with the city that they have moved to) or who are working in the grey-market (Andrienko and Guriev, 2005). With a large share of the population working on an informal basis, this can have significant implications for population coverage under the Guarantee Package.

Access to high-tech medicine

High-tech medical services appear to be largely provided in federal centres that are often linked to medical research institutions, although certain types of imaging equipment and advanced surgery are also provided in a growing number of regional hospitals. Each year, the federal ministry allocates quotas for different types of costly treatments and both federal and regional hospitals receive federal funds for certain high-tech diagnostic procedures, surgery and other high-tech treatments. High-tech treatments outside the quotas are provided on a paid basis only. If the patient did not receive one of the places within the quota and cannot wait, she or he will have to pay for these services privately. Thus, it is difficult to evaluate the length of waiting lists or the transparency in the allocation of the federal quotas. It is not uncommon however, that low-income groups and inhabitants of remote areas have no access to these types of treatment at all.

While there are no reliable estimates of the volumes of different types of high-tech medical services needed to meet the needs of the population as noted above (see Chapter 2), the government has initiated a programme of construction of new high-tech medical centres in a number of regions under the NPPH as a means of – at least partly – compensating for the unmet demand. Nonetheless, the volumes of high-tech diagnostic procedures and surgery still appear insufficient, especially for low-income groups.

The quality of health care provision

Achieving quality-of-care objectives requires putting in place institutions that oversee the process of care and the quality of providers so that high-quality care is provided on a timely basis. At the level of institutions, this means ensuring that quality standards are met and that patients receive the care that they need rapidly and effectively and are treated with dignity. For individual health professionals, it means keeping medical knowledge and skills at a high level. Quality also means ensuring appropriate co-ordination of care such that patients are followed as they move through various care settings. For institutional providers, it requires enhanced systems of quality control for care and ensuring that patients are satisfied with the care they receive. However, quality is often highly subjective and difficult to assess in a quantitative manner.

Regulatory oversight and quality

The system of regulatory oversight of the public health care provision is complex and not always transparent. The strong role of the former san-epid system in overseeing health care provision and the epidemiological situation has been weakened by the increased role of regional authorities in formulating health care policy. The changing legal framework and the introduction of new regulatory bodies (see Chapter 2) in the health care sector resulted in blurred and overlapping functions across: different state agencies responsible for oversight; regional and federal authorities; and, insurance companies, leading to overlaps in their areas of responsibility. In recent years, the insurance companies operating within the MHI system have been the institutions most closely involved with controlling the quality of care provided by hospitals and polyclinics.

From the mid-1990s, there has been growing awareness on the part of the Ministry of Health and Social Development of the need for quality control and the standardisation of public sector medical services. In the light of this, the ministry introduced, in addition to the existing federal law, a system of internal and external controls. This was followed by requirements for the standardisation of the quality of medical services in 1998. From 2001, medical organisations have been subject to a licensing (accreditation) procedure and this was accompanied by definitions to be used for the certification of medical services and of doctors. However, there is little information available to the OECD Secretariat regarding whether these measures have been implemented in a widespread and consistent manner.

There have been continuing efforts to establish a unified system of quality standards of medical care beginning in the late 1990s. These protocols introduced requirements for the technology that doctors use to treat patients after diagnosis. A large number have been put in place and additional quality measures have been established in 30 of the regions (24 000 standards). This diversity could lead to some differences in the care provided across regions. The MHSD declared the need for developing the system of unified medical standards or protocols at the national level in 2008. Such measures should take into account existing international “best practice” treatment protocols adapted to the circumstances of the Russian Federation.

In practice, however, the control of the quality of medical services is usually organised at the level of individual medical organisations (the so-called “internal controls” or self-regulation); by regional authorities who are usually the owners of hospitals and polyclinics (thus raising potential conflicts of interest), or by the regional branches of the Federal Service on Surveillance in Health Care and Social Development (*Roszdraznadzor*). The policy of regional authorities in the sphere of quality control differs from region to region: some regions started introducing a unified system of medical standards while others still prefer to use the pre-transition approach which made the head doctors largely responsible.

This absence of a clear demarcation of the responsibilities and powers of federal and regional regulatory bodies over the quality of health care provision (plus the lack of qualified staff) has often led the authorities to delegate quality control to private insurers where they exist. These can fine medical care provider organisations for inadequate quality of health care provision or where regulations have not been complied with.¹⁹ Insurance companies have hired experts and organised inspections to fulfil this role. However the key objective of the insurers is to reduce their cost of treatment to the insurer rather than to improve the quality of care the patient receives *per se*.²⁰

According to the MHS, roughly half of the regions of the Russian Federation currently collect data about the quality of their medical care and more than 30% of all the regions were developing and deploying such systems by 2005. The introduction of electronic systems for collecting information on quality of health care provision at the patient level – through, for example, the use of electronic data files – has begun over the past several years but only in a limited number of regions. They have not yet received the support of the medical professionals. According to a survey of the Federal Service on Surveillance in Health Care and Social Development, three quarters of doctors found no sense in introducing such systems.

As regards health care professionals, the system for medical education may not have adapted to the shift towards chronic non-communicable diseases. More generally, the medical education system may not have fully embraced the international trend towards “evidence-based” medicine (EBM). Courses on international experience of EBM and the ways of organisation and management of health care provision are very seldom covered in the university medical programmes.

Thus, the federal authorities have taken several steps to introduce a unified system of accreditation for the medical institutions, the certification of doctors and quality control during the past ten years. But it is difficult to know to what degree the measures have been implemented. There has been a lack of coherence in introducing these systems and this has resulted in overlapping responsibilities of different regulatory bodies. In addition, regions have very different attitudes towards these issues, partly reflecting financing and the lack of individuals with skills in this area. As a result, the regional systems of control are *ad hoc*, the role of federal surveillance agencies is weak and neither regional authorities nor federal regulatory bodies have the administrative power to implement a coherent policy of improving the quality of health care provision.

Redress for malpractice

There does not appear to be a strong legal framework permitting patients to receive redress for malpractice. Malpractice leading to serious harm to a patient’s health or causing his or her death is punishable through the criminal courts, but the legal procedures are long and the court awards small. The legal framework for protecting patient rights for less serious cases of malpractice is not developed because these cases are simply not covered by the Administrative Code and a system of personal responsibility of doctors does not exist. In addition, the insurance companies very seldom inform the patients of the results of their planned inspections or reveal cases where there have been violations.

Patient satisfaction

Different surveys show that the Russian population is, in general, dissatisfied with the health care system. According to surveys (Levada Center), less than 20% of population are satisfied with the health care system in the Russian Federation and up to three-quarters of respondents answered that the quality of health care provision was either unchanged or falling (Table 3.3).

Table 3.3. Survey concerning the population satisfaction with the Russian health care system

Survey question: Are you satisfied with the health care system in Russia? (%)	2002	2003	2004	2005	2006	2007	2008
Yes/Rather yes	11	14	11	12	17	14	18
Uncertain	23	20	21	16	22	20	23
No/ Rather no	62	65	65	70	59	64	58
Found it difficult to answer	4	2	3	2	2	3	1

Survey question: How did the quality of medical services change during the last year? (%)	2002	2005	2006	2007	2008
Increased significantly	3	3	3	2	3
Increased slightly	11	19	20	21	20
Did not change	37	36	44	45	48
Decreased slightly	28	22	18	17	17
Decreased significantly	14	16	10	10	7
Found it difficult to answer	7	6	5	6	4

Source: Levada Centre, www.levada.ru/sites/default/files/levada_2009_rus.pdf, consulted on 16 April 2012.

A more detailed survey organised by one of the largest insurance companies (Svetlichnaya, 2008) showed that 60% of patients (in the MHI system) are satisfied with the quality of medical care provided, but 70-80% are not satisfied with the organisation of health care provision (time spent in the queues, work of the reception desk, etc.). At the same time, the share of patients who are satisfied with the quality of medical care can vary significantly, even within one region. For example, in the Moscow region, this share varied from 40% to 80% across different districts. The high intraregional variation in patient satisfaction could reflect the high concentration of care in one or two institutions – even in primary care. If the population is not satisfied, for example, by the district polyclinic, it cannot choose another provider. In any case, consumer satisfaction surveys should always be interpreted with caution since variations in satisfaction with care can reflect different levels of expectations.

The financial sustainability of the Russian health care system

The level and patterns of health care expenditure have been addressed in Chapter 1. This section first examines available information on the degree of underfunding in the Government Guarantee Package and then examines longer-term population trends that are likely to affect the level of spending in the future as the population ages.

Meeting the requirements of the existing Government Guarantee Package

Looking ahead, three sets of factors will affect the longer-term cost of the health care system. First, there is need to cover the full costs of the services included in the existing Government Guarantee Package for health care. There is general agreement that the current resources available to the government and the MHI funds are inadequate to finance the Government Guarantee Package as it was anticipated in the 1993 reforms. While the exact size of the additional financial resources is unknown, it may be substantial. Government estimates suggest that only 11 regions with 20.5% of the population (combined) had achieved full financing of the Guarantee Package in 2006 (Shishkin, 2007a). There were particularly severe shortfalls in the provision of high-tech medical procedures. The Ministry of Health and Social Development estimates that, in 2005, the system covered around 10% of the demand for coronary angiography and heart-valve replacement, about 7% of the demand for joint replacements and roughly 35% of the demand for treatment of congenital heart defects. However, it is likely that some of the latent demand has been satisfied as a result of the re-equipment programme under the NPPH.

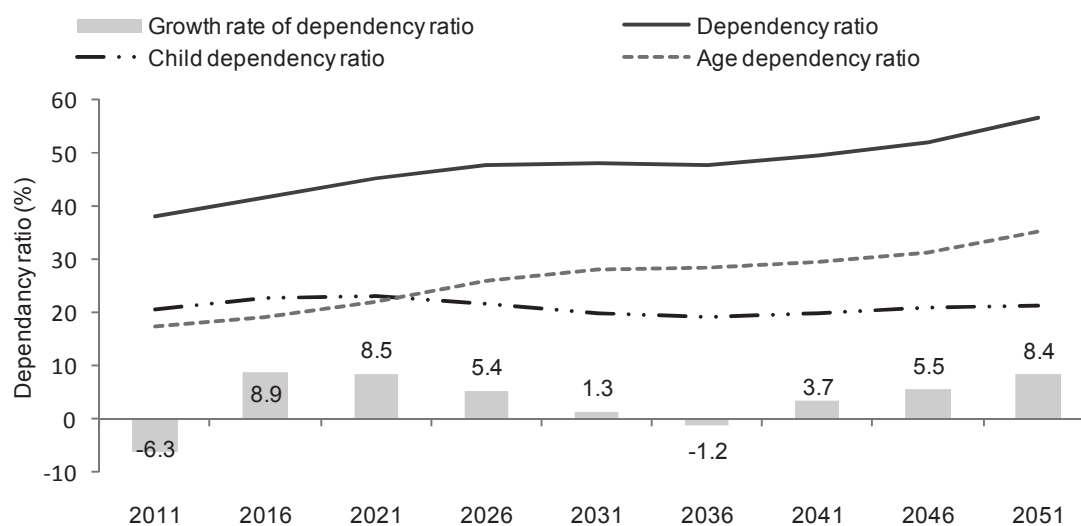
What is generally believed is that payments to providers from the MHI system tend to be currently small relative to the overall cost of services and inadequate to cover the cost of care included in the Government Guarantee Package. Vishnevskiy *et al.* (2007) suggest that the additional spending needed to cover the guarantee could lie in the range of 1-1½ percentage points of GDP.

As discussed in Chapters 1 and 3, an increase in health insurance contributions to 5.1% from 2011 would make an important contribution to filling any financial gap. With wide differences in financing and supply across regions, this would probably need to be accompanied by increased equalisation payments to the weaker regions from the federal authorities, something that the authorities are actively considering.

The impact of a declining workforce and a rapidly ageing population

Second, longer-term sustainability will also be affected by demographic changes over the coming decades. There will be a major shift in the age structure of the Russian population (Figure 3.10). The old-age dependency ratio is projected to rise significantly from around 18 now to 26 in 2026 and 35 in 2051. Dependency will increase sharply in the decade starting in 2015. The arrival of the post-war baby boom into the 65+ age group will boost the number of elderly people and the need for health care, as the prevalence of chronic diseases is correlated with age.²¹

Figure 3.10. Dependency ratio for the Russian Federation, 2006 to 2051



Note: Dependency ratio = $\{[(\text{persons } <15) + (\text{persons } 65+)] / (\text{persons } 15-64)\} \times 100$.

Child dependency ratio = $[(\text{persons } <15) / (\text{persons } 15-64)] \times 100$.

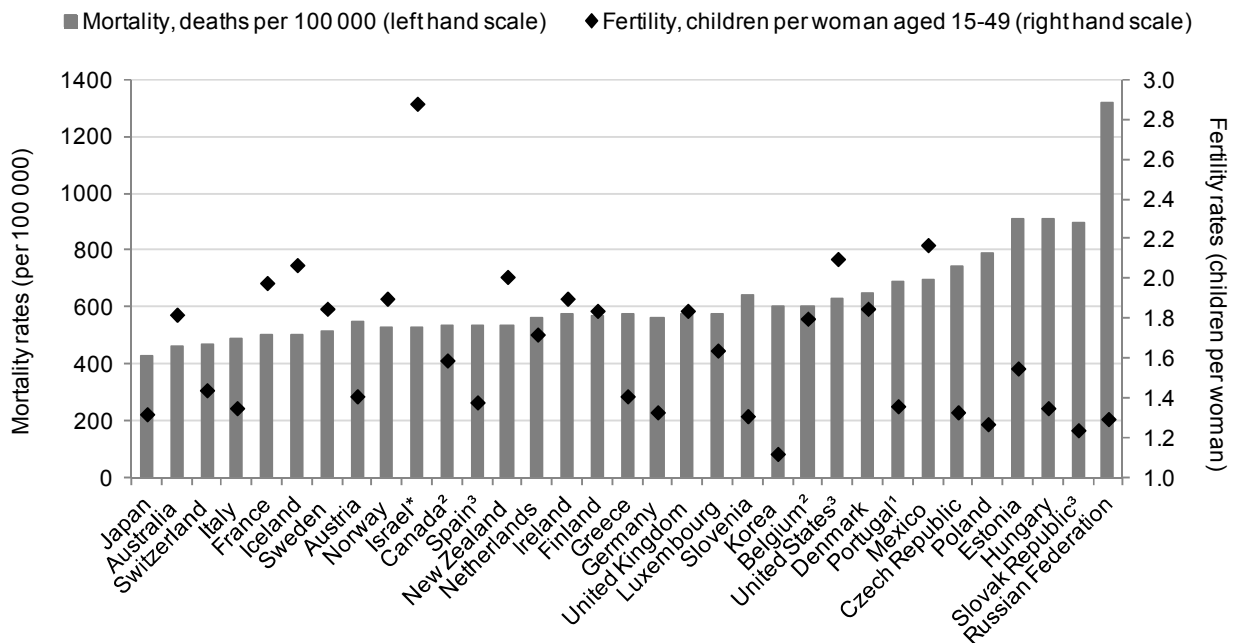
Age dependency ratio = $[(\text{persons } 65+) / (\text{persons } 15-64)] \times 100$.

Source: Estimations based on <http://demoscope.ru/weekly/app/progn01.php>

This shift is taking place against a background of a decline in the total population. For the past 16 years, deaths have exceeded births by a total of 12 million persons, partly offset by increased in-migration of 5.5 million persons (mainly of ethnic Russians living in the former states of the USSR). The inflow of ethnic Russians is not expected to repeat itself. The fertility rate has progressively declined and, despite some marginal recovery in the early years of this century and in 2007, it is still, at 1.3, considerably below the natural replacement level

of 2.14.²² The population of the Russian Federation peaked in 1992 at 148.5 million persons, and has now fallen to 142 million in 2007 (-4.3%) (Rosstat, 2008). In spite of the recent trend reversal in mortality, the capacity to finance the health care system and other social programmes for the elderly in the medium term will be weakened (Figure 3.11).

Figure 3.11. Mortality and fertility rates in selected OECD countries and the Russian Federation, circa 2006



Note: Data on Chile and Turkey were not available.

* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

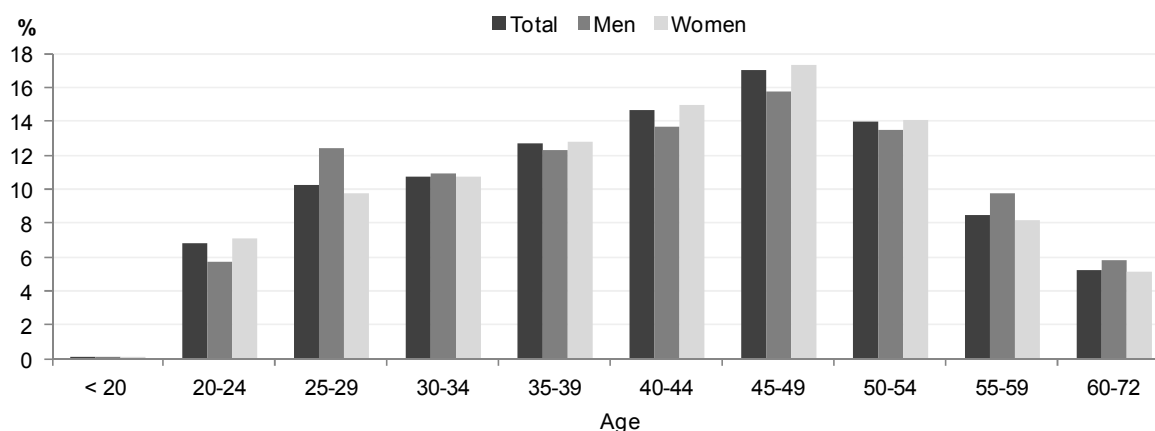
1. 2003; 2. 2004; 3. 2005.

Source: OECD Health Data 2010 for OECD countries and WHO Mortality Database for the Russian Federation, *The Demographic Yearbook of Russia 2007*, Rosstat.

If current patterns of mortality and fertility are maintained, the population could decline to around 122-125 million by 2025 and to as low as 100 million by mid-century depending on the projection. The size of the working-age population could also fall sharply and labour shortages seem certain to appear or to worsen from the early part of the next decade. By 2025, the working-age population is projected to fall at a rate of 1 million persons per year (United Nations in Russia, 2008).²³ However, these projected trends could be affected by recent falls in mortality, as well as the impact of measures included in the “Demographic Concept” (or action plan) for 2025 (see Chapter 2).

Attracting labour to the health sector

Another factor affecting longer-term costs of the health care sector concerns the labour market for health care professionals. The number of doctors in training has remained stable in recent years despite low wages (Gimpelson and Lukiyanova, 2009). Projections of doctor and nurse needs in a number of OECD countries suggest a growing penury (OECD, 2008). The size of the cohorts at an age when they enter medical school will progressively decline making it more difficult to attract people into the medical workforce. Similar problems seem likely to be encountered in the Russian Federation as well.

Figure 3.12. Age structure of physicians in the Russian Federation, 2008

Source: Rosstat.

More importantly, the Russian Federation, like many OECD countries, is confronted by a progressive ageing of the medical workforce (OECD, 2008) (Figure 3.12). As the older medical cohorts begin to retire, there may be a fall in supply of health care professionals just as the need for care increases. While this may not have immediate effects given the current high levels of doctors per capita in the Russian Federation, it will progressively lead to pressures in this segment of the labour-market. As in many OECD countries with low population density, problems of shortages of doctors in remote rural areas seem likely to intensify.

Low wages and salaries in the health sector

In the light of lower supplies of medical manpower in the future, higher wages, salaries and better working conditions are likely to be needed to maintain supply. *Ad hoc* increases of wages for primary care doctors and nurses under the NPPH (see Chapter 2) have certainly helped. But this effect is only temporary because the fillip to wages has not been accompanied by policies to address the longer-term issue of the level and pattern of wages and salaries.

The low level of health care spending when compared with OECD countries (Chapter 1) is at least partly explained by the low wages of doctors and nurses (Gimpelson and Lukyanova, 2009). It would seem unlikely that this can persist over the longer haul in a market economy. While the adherence to the Unified Tariff Scale has so far kept public sector medical wages below the median wage (even allowing for bonus payments), higher remuneration will be needed if the numbers of medical staff are to be maintained. Given the labour intensity of the health care system, this will inevitably lead to higher overall costs, unless efficiency in the provision of services can be increased. Spending pressures will also remain as a result of the unsatisfied demand for high-tech medicine.

The efficient and effective use of resources in health care

The key policy question facing the Russian authorities is why are health outcomes so poor – compared with OECD countries and other former eastern European countries – given the levels of health care resources which go into it. Part of the answer may relate to quality and access issues which have been dealt with in the other sections of this chapter. But a good portion of the difference in performance is related to issues of technical efficiency – *i.e.* how health care resources are organised and used – and allocative efficiency – *i.e.* the appropriate balance between different types of care such as prevention as opposed to cure.

Table 3.4. Supply of health care professionals and acute care beds, 2008 or nearest year available

	Doctors ¹	Nurses ¹	Acute care beds ¹
Australia	3.0	10.1	3.5
Austria	4.6	7.5	5.6
Belgium	3.0		4.3
Canada	2.3	9.2	2.7
Czech Republic	3.6	8.1	5.2
Denmark	3.4	14.3	3.0
Estonia	3.4	6.4	3.8
Finland	2.7	15.5	1.9
France	3.3	7.9	3.5
Germany	3.6	10.7	5.7
Greece	6.0	3.4	4.0
Hungary	3.1	6.2	4.1
Iceland	3.7	14.8	
Ireland	3.2	16.2	2.7
Israel*	3.4	5.0	2.0
Italy	4.2	6.3	3.0
Japan	2.2	9.5	8.1
Korea	1.9	4.4	5.4
Luxembourg	2.8	10.9	4.5
Mexico	2.0	2.4	1.6
Netherlands	3.7	10.5	2.9
New Zealand	2.5	9.7	2.2
Norway	4.0	14.0	2.5
Poland	2.2	5.2	4.4
Portugal	3.7	5.3	2.8
Russian Federation	4.3	8.1	9.3
Slovak Republic	3.0	6.3	4.9
Slovenia	2.4	7.9	3.8
Spain	3.6	4.8	2.6
Sweden	5.6	10.8	2.2
Switzerland	3.8	14.9	3.3
Turkey	1.5	1.3	2.2
United Kingdom	2.6	9.5	2.7
United States	2.4	10.8	2.7

Note: Data on doctor and nurses density include only active (practicing) doctors and nurses for the Russian Federation; professionally active for Canada; France; Greece; Italy and Turkey; and licensed to practice for Ireland; Netherlands and Portugal.

Data is not available for Chile. Data on nurses is not available for Belgium.

1. Per 1 000 population

* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2010 for OECD countries; WHO Database for the Russian Federation.

Assessing the degree of efficiency in the health care sector

At first glance, the Russian health care system appears to be relatively well-endowed with health care resources given its level of income. Although there may be problems of data availability and comparability, the supply of doctors and hospital beds shows the Russian Federation lies at the top of the range for OECD countries (see Tables 3.4 and 3.5). The number of nurses is also high but low when taken as a ratio of the number of doctors. This ratio would probably be even lower if one were able to adjust for skill differences across countries as the level of training and allowed scope of practice are purported to be lower than in many OECD countries (see Chapter 1).

Table 3.5. Physical resources in the health care sector, Russian Federation and selected European countries, 2008

	Hospital beds per 100 000	Average length of stay, all hospitals
Czech Republic	730	10
Estonia	570	7.9
Germany	820	9.9
Hungary	700	10.5
Italy ¹	380	7.7
Latvia	746	9.5
Lithuania	684	9.6
Poland ²	660	6.2
Russian Federation	924	13.1
EU average	531	8.7

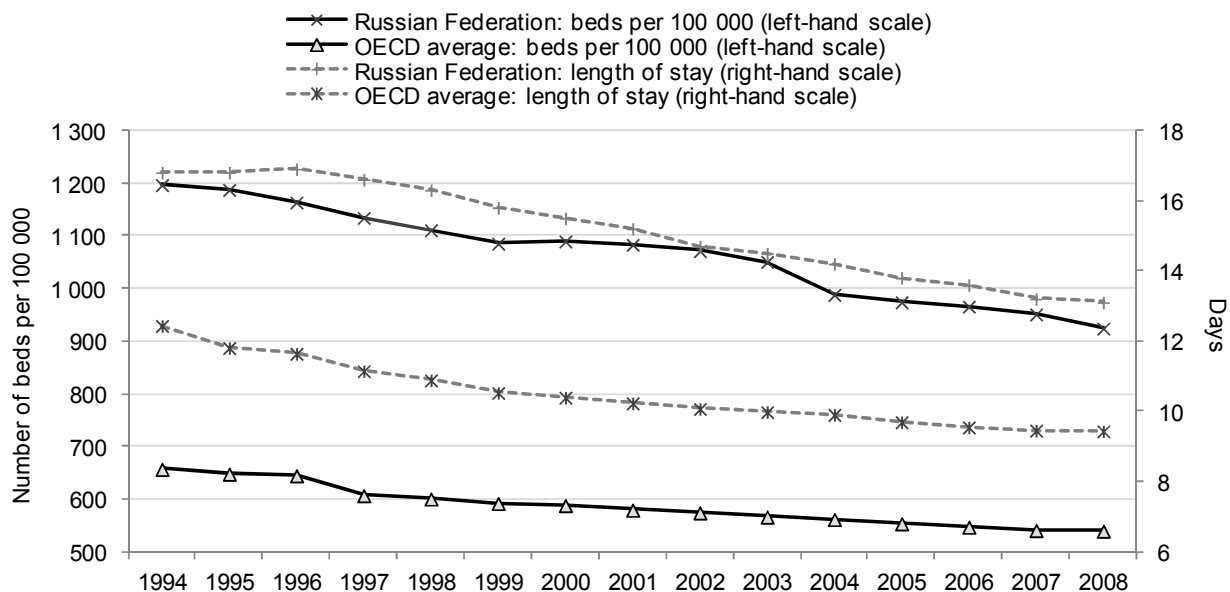
1. Data is provided for 2006.

2. Data is provided for 2007.

Source: WHO Database and Ministry of Health and Social Development of the Russian Federation.

Time-series data at the national level point to a marginal rise in the number of doctors per capita and a trend fall in the number of beds (Figure 3.13). There appears to be little decline in the very high average lengths of stay in hospital (which are roughly twice that of western European countries (Marquez *et al.*, 2007) or in the (very high) share of the population that is hospitalised over the course of a year. These results suggest that there has been little change in approach to providing health care in the Russian Federation despite the widespread view that a switch to primary and ambulatory care is more in line with the emerging patterns of disease. According to Vishnevskiy *et al.* (2007), roughly 30% of hospitalisations are unnecessary (particularly in therapeutic, neurology and gynecology wards) and care would be less costly and more cost-effective if carried out on an ambulatory basis.

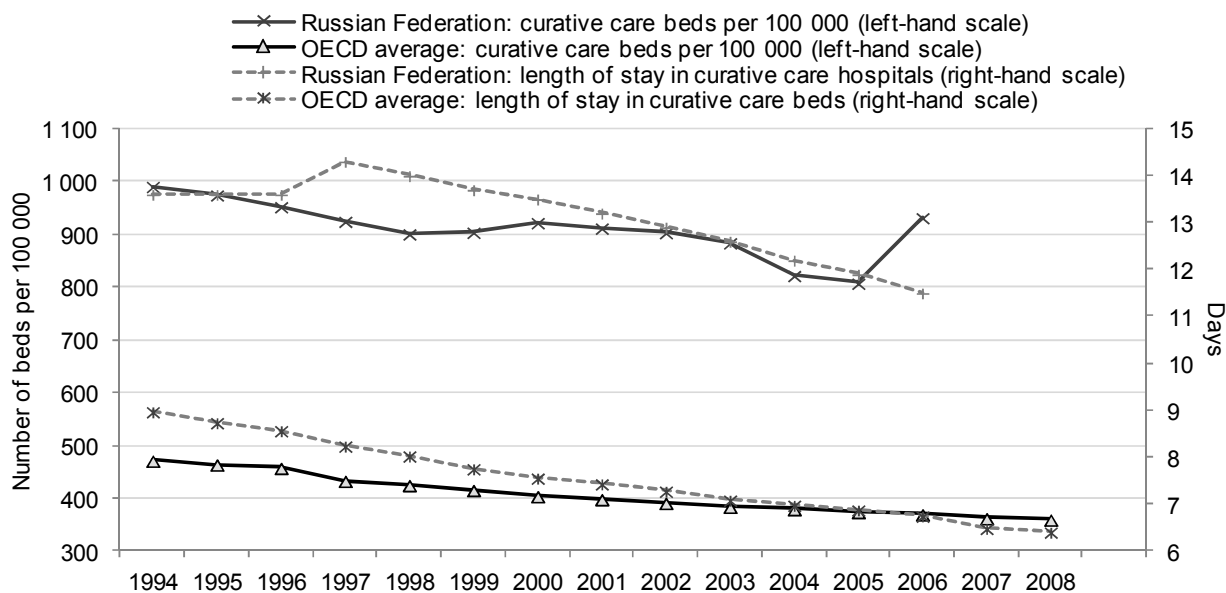
Figure 3.13. Hospital beds per 100 000 and average length of hospital stays in the Russian Federation, 1991-2008



Note: Total number of beds.

Source: WHO Database and OECD Health Data.

Figure 3.14. Curative (acute) care beds per 100 000 and average length of inpatient curative care stays in the Russian Federation, 1994-2008

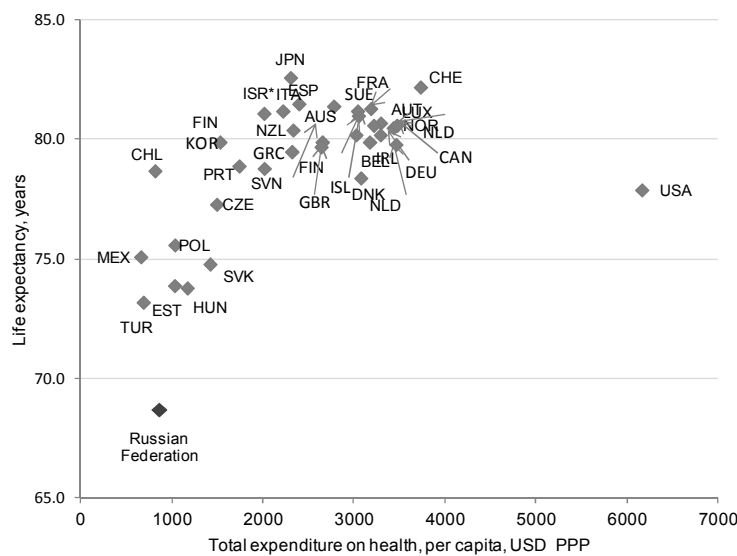


Note: Data excludes Chile, Iceland and New Zealand.

Source: OECD Health Data 2010 and WHO Health for All.

There are doubts as to whether the Russian health system is getting good value for the resources it spends. The ratio of the expected lifetimes at birth to health care spending per capita indicates that the Russian Federation performs poorly when compared with OECD countries (Figure 3.15). Similarly, there is no strong relationship between public health spending and life expectancy at birth at the regional levels: regions with high levels of health care spending do not necessarily perform better than low spending ones (Figure 3.16).

Figure 3.15. Life expectancy and total health expenditures, 2008

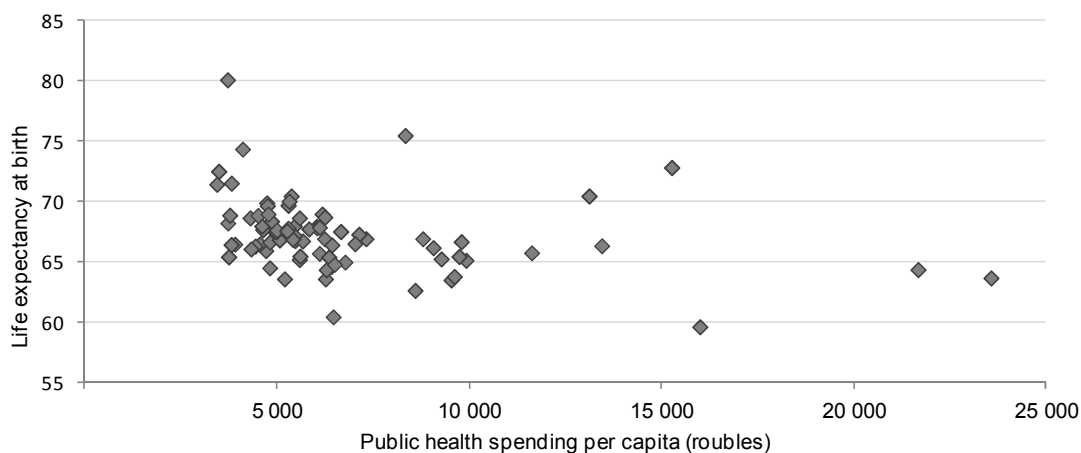


Note: Data on total health expenditure per capita, USD PPP for the Russian Federation is a WHO estimate.

* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data.

Figure 3.16. Life expectancy and public health spending by region, 2008/09



Source: Rosstat (2009), *The Demographic Yearbook of Russia 2009*, Rosstat, Moscow and E. Potapchik (Institute for Health Economics, HSE). Estimations based on federal treasury data and federal MHI fund data.

While the results need to be treated with caution, recent studies (Hauner, 2007; World Bank, 2008b) examine the health outcomes in the Russian Federation using frontier analysis and available information on inputs. Comparisons are made across a range of OECD and non-OECD countries and between regions (municipalities) within the Russian Federation.²⁴ The results in both dimensions suggest that there is substantial room for improving public expenditure efficiency. Comparisons with other countries suggest that the Russian Federation's health outcomes are similar to those achieved by some countries which spend 30 to 40% less. The results on the basis of comparisons across regions/municipalities suggest that current health outcomes could also be produced with about two thirds of the present inputs if the less efficient regions were able to emulate the most efficient ones. Some regions have been more successful than others in achieving results even though the resources at their disposal have sometimes been more modest.²⁵ Indeed, two World Bank demonstration regions (Voronezh and Chuvash Republic) appear to have had considerable success in improving health care supply and health outcomes demonstrating that there is considerable potential for higher performance (Box 3.1).

Box 3.1. Restructuring regional health systems in the Russian Federation: the case of two regions

Reform of the regional health systems is a major challenge for the Russian Federation. From 2003 to 2008 the World Bank gave support to the MHSR Health Reform Implementation Project (HRIP) which restructured the health systems of two pilot regions southeast of Moscow: the Chuvash Republic and Veronezh. The programme was managed by officials from the two regions and backed at the highest political level in both.

Comprehensive plans were prepared in both regions on the basis of detailed assessments of needs, drawing on international experience. The aim of the project was to improve access to the system by shifting from inpatient to outpatient services and from specialist to primary care. Policy and regulatory instruments – prepared by the MHSR – were put in place to guide the actors. About 500 disease management protocols were produced on the basis of available clinical evidence to improve the process of care in health facilities. The health worker remuneration system was restructured and a system of national accounts was set up and integrated into the MOH and the regions to monitor flows of funds and resources.

On the basis of a master plan, the investments were made in the infrastructure focusing on increasing the capacity at the primary care level while gradually substituting hospital care for outpatient services. Primary care networks were strengthened with the construction of new centres and repair of existing facilities and investment in new equipment were also made to ensure better diagnostic and treatment capacity. The scope and scale of primary care services were progressively replaced by unified general practice (GP) physicians supported by nurses and other staff. These units are now responsible for the care of patients within defined geographical catchment areas ranging from 1 700 to 2 500 persons. The units also focus on health promotion and disease prevention emphasising the use of primary care physicians as gatekeepers to specialists and other medical services as well as continuity of care. Elsewhere in the system there was more attention paid to services on an outpatient basis with improved medical equipment and diagnostic material organised on an inter-unit basis to discourage duplication.

The population covered by general practice units increased significantly and both regions are now ranked at the top of the regions as regards the numbers of general practitioners per capita. The gatekeeping role of these first line providers has reduced referrals by a factor of four. Hospital beds were rationalised: the number of hospitals was reduced by half and the number of 24-hour beds reduced by about one fifth while day beds were increased. In Veronezh, day care increased by 79% over the period 2002-07 and 40% of surgeries were on a day-care basis. Hospital admissions also declined, as has length of stay in inpatient care. Emergency services were improved by better communication systems, modernising ambulance fleets and increasing skill levels leading to significant falls in the average response time for emergency calls.

There has now been a major shift in expenditure: Spending on primary health care has risen from 31-42% in 2002 to 43-52% in the Chuvash Republic and Veronezh respectively in 2008, bringing them closer to OECD experience. The number of 24-hour beds has also fallen by roughly a fifth in both regions. However, the length of stay only fell from 13.2 to 12.1 days and remains close to the national average (13.6 days). Day beds have increased and 40% of operations were carried out at ambulatory centres.

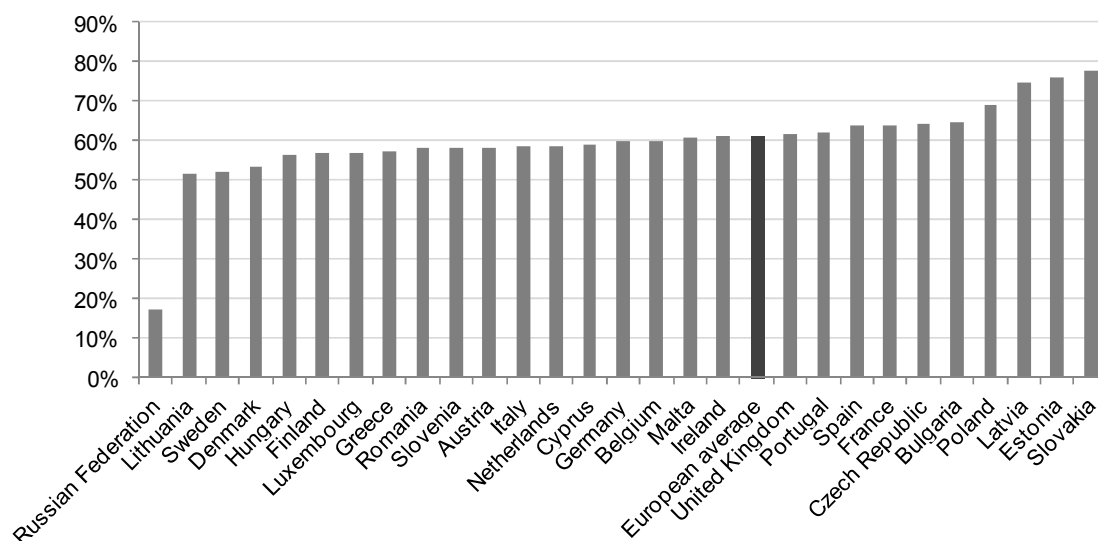
Source: Marquez and Lebedeva (2010), "Restructuring Regional Health Systems in Russia", *The World Bank, Europe & Central Asia Knowledge Brief*, Vol. 32.

Priorities for improving efficiency and achieving better health outcomes

Increased focus on prevention

There is considerable scope for other cost-effective prevention policies which should be easy to introduce. For example, there is ample scope for improving diet to reduce the risk of cardiovascular disease and cancer. In this context, the Finnish experience (in North Karelia) indicates the sizeable potential benefits that can be achieved from changing diet and other risk factors. As regards substance abuse, taxes on tobacco and alcohol have been increasing but – on the basis of available international data – remain below European standards (Figure 3.17).²⁶ There is evidence that low prices of these products encourage higher consumption of tobacco and spirits (Treisman, 2008). Limiting the influence of producer lobbies would help increase policy coherence and lower substance abuse over the longer haul. Traffic deaths could also be reduced through simple measures to reduce vehicle speed via radars, increased fines from traffic violations and simple speed bumps may be cost-effective policies. The wide range of individual policies which touch on prevention and on non-communicable disease possibly (see Chapter 2) suggest the need for greater policy integration across the various programmes.

Figure 3.17. Tobacco taxes in the Russian Federation and EU countries, 2008



Note: Overall minimum excise duty as percentage of TIRSP (excl. VAT). TIRSP is retail selling price, all taxes included.

Source: Danishevsky, K. (2009), *Aktyzy na tabachmyu productsiyu v Evropeiskom Soyuze*, mimeo, and excise duty tables, Part III – Manufactured Tobacco, Ref. 1.026, January 2008, http://ec.europa.eu/taxation_customs/index_en.htm.

But, reducing mortality towards levels found in more developed OECD countries can only occur if Russians citizens can be convinced of the need to reduce the risk of disease and death by changing their health-related behaviour.

Enhancing performance: some selected issues

Shifting from hospital to primary care

There is a widespread consensus that productive efficiency could be improved through a shift from an inpatient care and specialist treatment towards primary care (WHO, 2001; Atun,

2004). Despite a slight downward trend in the number of beds per 100 000 population there would appear to be considerable over-provision in secondary and tertiary beds. This may partly reflect the use of acute hospital beds for long stays by the elderly and the chronically ill (Tompson, 2007) and geography. But current methods of paying hospitals are an additional contributing factor.

The difficulty in shifting to primary care may also reflect problems at the primary care level:

- There are patient concerns over the quality of primary care doctors. According to Federal Service on Surveillance in Health Care and Social Development (*Roszdraznadzor*), 15% of medical personnel have not had any professional training in the past five years and the number is considerably higher for primary care physicians (reported in Sheiman and Shishkin, 2010);
- Primary-care doctors – who are usually salaried – still have every incentive to refer patients to higher levels of care to reduce their own work-load. Thirty percent of primary care patients are referred to specialists in the Russian Federation while the norm is closer to 4-10% in OECD countries (Vishnevskiy *et al.*, 2007).

As noted, the authorities have increased spending within the NPPH for district doctors or primary care specialists to become general practitioners or family doctors (Chapter 2). As a result, 7 570 were re-trained in 2007 and a further 10 000 doctors in 2008. But, with a total of 70 000 primary care (district) doctors working in the country, there is a considerable way to go. Improved care at the primary level will also require changing the methods of paying for primary care providers.

Improving human resource use

Russian nurses may have more limited training relative to the norms in OECD countries and their role in the health system is more restricted than in many OECD countries. Nurses may not be used efficiently as they often perform secretarial tasks rather than medical tasks supporting doctors. As primary care expands relative to inpatient care as the authorities intend, then the scope-of-practice rules for nurses could widen if backed up by better and longer training.

Enhancing the incentives facing providers

As noted, “dual financing” of the GGP weakens the incentives to providers: Sixty percent of public financing of the health care services originates from budgetary sources and the budgeting of providers largely takes place on an input rather than an output basis. The bulk of the remainder comes from the MHI system where, for example, insurers may pay providers on an activity basis. Such arrangements may dilute any incentives to reduce hospital supply: if all funding came via one source (or through one channel) it would be easier to influence behaviour.

In practice, many of the payment methods used by the regional authorities do little to increase the efficiency of provision. For example a number of regions still reimburse providers on the basis of a fee-per-outpatient (polyclinic) visit or pay by bed day in the hospital sector, thereby encouraging over-use of the system and reducing incentives to enhance prevention (Figures 1.8 and 1.9).

Such problems may be attenuated by the recent reforms to the financing of the GGP.²⁷ Although full information is not yet available concerning the new policies, the bulk of the financing of providers of the GGP will be channelled through the MHI as from 2013; competition in insurance and provider markets is being strengthened and the overall thrust of the recent legislative changes appears aimed at increasing significantly the play of market

forces. Private insurers will act as purchasers of health care services for their insurees and competition among providers will be largely based on quality. Money will follow the patient and payment of providers will be fixed nationally, leaving the regional funds the possibility of providing supplements.²⁸ Under the new arrangements, consumers will have free choice of insurer, doctor or care institution (*e.g.* polyclinic or hospital).

Market incentives are intended to encourage improved health care system efficiency. Nonetheless, Tompson (2007) and Smith (2008) argue that introducing and sustaining competition in health care markets is a particularly daunting task and existing experiments in OECD countries do not appear conclusive.

Restructuring of relative wages and salaries of health care professionals

Low wages have demoralised doctors and nurses alike and encouraged informal payments. The National Priority Programme “Health” represented a start in increasing the remuneration of doctors and nurses but the *ad hoc* nature of the reform created its own tensions because wages of specialists were not increased. While some upward adjustment in wages is needed, any increases need to be used to “buy” reforms in the pattern of care provision – *i.e.* increasing the role of ambulatory care. This will also require changing the incentives facing providers to encourage the desired shift in the pattern of care.

Summary

The overall efficiency and effectiveness of the Russian health system needs improvement. While health care is free for a wide range of services, the large share of out-of-pocket spending may be leading individuals with health problems not to contact the health care system or at least to delay it. In addition, unequal financing for health care services across regions means that some regions have lower levels of supply than others.

Surveys suggest that patients are generally dissatisfied with the functioning of the overall health care system. This raises questions as to whether the current configuration of supply is in line with broader population needs and patient demands.

In this context, increased access to the Government Guarantee Package will require higher public financing as a first step. But the discussion of the longer-term sustainability of the system indicates that there are a number of trends – such as population ageing and a declining workforce – that are likely to lead to increasing demands for care and higher unit costs of health care in the future. It is for this reason that the authorities must improve the efficiency and effectiveness of the health care system. In this context, work by other international organisations indicates that there is considerable scope for efficiency gains (World Bank, 2008b).

A final issue concerns system governance and oversight. Given the cross regional diversity in financing and health care provision, information on regional health system performance is highly desirable and can permit benchmarking of performance across regions. The decision of the federal authorities to identify and collect a set of 300 commonly defined indicators (72 relate to health) is a welcome development. It can only be stressed that these data would be even more useful if they were defined and collected in line with international standards, which would permit international as well as inter-regional benchmarking.

Notes

1. Premature mortality refers to mortality before the age of 65. Standardised mortality rates were extracted from the WHO Europe Database “Health for All” for the year 2005 (<http://data.euro.who.int/hfadab/>).
2. In addition, 40% of boys and 7% of girls smoked (MHSD, 2007).
3. While WHO data suggests that “only” ten litres of alcohol-equivalent per capita is consumed each year – a level not far off certain European countries such as France and the United Kingdom, the Russian authorities estimate that it is as high as 18 litres once unregulated home brewing and distilling is taken into account.
4. Russian Longitudinal Monitoring Survey (RMLS) of the Russian population. The RLMS is a household survey jointly operated by the Population Centre of the University of North Carolina and the Institute of Sociology of the Russian Academy of Sciences. The RLMS is a panel with 16 waves covering 1992-2007; there were three data collection rounds in 1993, but there are no data for 1997 and 1999. Since 2000, data are collected annually. The sample is small at around 4 000 households or about 10 000 persons, and it is biased toward the low-income populations (the sample does not cover those who change residential area and new buildings which are often occupied by richer households). The RLMS does not seem to be representative at regional level, not least because of the low response rate and high attrition in major cities. Then again, the questionnaire is quite comprehensive on the income side in terms of wage and non-wage incomes of adults and on expenditure patterns including detailed questions on food consumption in the last seven days and non-food consumption over the last three months (OECD, 2011).
5. Data provided by the Russian authorities.
6. But with a confidence interval of between 23 000 and 71 000 persons.
7. In 2008, Rosstat recorded “only” 4 460 deaths from HIV/AIDS on the basis of death certificates. The wide divergence in estimates may reflect insufficient screening of high-risk sub-populations.
8. Infant mortality rate (IMR) is the number of deaths of children under one year of age in a given year, per 1 000 live births. Some of the international variations may result from differences across countries in the practice of registering premature babies. While most countries have no limits for mortality registration, some countries impose a lower limit on gestational age and/or weight threshold for a death to be counted as a “death after live birth”. This limit is higher for the Russian Federation (28 weeks) than for other countries (see OECD, 2009).
9. The term “marginal” denotes certain vulnerable groups/subpopulations deprived of robust involvement in social, political and economic life of the society (WHO, 2001).

10. Data are based on a survey of death certificates in three Russian regions (Kirov, Smolensk and selected districts in Moscow) at various levels of economic development. Results appear to be in the form of confidence intervals.
11. Compared with the leading OECD country (Japan), the differences for men and women, respectively, are just under 18 and 12 years.
12. In previous periods, the improvements in life expectancy appeared first among the young (15- to 24-year-olds) and then among the older, working-age groups of the population (40- to 64-year-olds). Lower death rates reached the more problematic groups (25- to 39-year-olds) last. The Russian Federation recorded its first pronounced year of life expectancy growth in 2006.
13. Indeed, some studies find little evidence of a link between health and mortality outcomes and access to health care – or the lack of it – in the Russian Federation (Brainerd and Cutler, 2005).
14. Inter-regional differences in financing come from: *i*) different levels of payments to regional MHI funds for the working population due to large variation in the wage bill across regions; *ii*) variation in payments to regional MHI funds from regional budgets for the non-working population – the minimum level of per capita payments was not fixed until 2007 – and, *iii*) different levels of spending on health care from regional and municipal budgets.
15. These enhancements have taken a number of forms: extra free services to the Government Guarantee Package; targeting of certain diseases and vulnerable groups; free drug provision for costly treatments; increased availability and use of high-cost medical technologies; and by restructuring health care provision (for example, by developing GP practices as in Samara, Voronezh and the Chuvash Republic.)
16. Such problems have certainly become less marked as a result of increased spending under the NPPH.
17. CEFIR estimations based on the Russian Longitudinal Monitoring Survey (RLMS).
18. There is some anecdotal evidence that patients are encouraged to undertake additional tests requiring the use of high(er) technical equipment. Since rules on chargeable services are often not clearly defined, this leaves the provider with some liberty in deciding what is free and what is not.
19. Such fines and penalties may also be levied by regional branches of the Russian Federal Consumer Rights Protection and Human Health Care Control Service, the Federal Service on Surveillance in Health Care and Social Development, and the regional branches of Mandatory Medical Health Insurance Funds.
20. For example, insurance companies have hired experts and organised inspections to fulfil this role. One large insurance company (ROSNO) claimed to have undertaken an extensive claim review in 2007 (Svetlichnaya, 2008). In half of the cases studied, there were a variety of regulatory violations but inadequate quality of medical services had occurred in less than 20% of them.
21. However, the size of this effect will depend on a number of factors including the possibility of lengthening lifetimes in good health. A number of studies have argued that health care costs may not increase because, as average lifetimes lengthen, the high costs of care associated with the period immediately before death will be progressively put off into the future.

22. It averaged 1.1 in the period 2000-05 (World Bank, 2005). The recent increase reflects a range of factors. Delayed family formation may be beginning to unwind as in a range of European countries (*e.g.* France). And this appears to have coincided with an increase in the number of women of child-bearing age. However, these effects are likely to be temporary and unlikely to affect the longer-term patterns of fertility. This development may also reflect the government's recent family policy although it is too early to judge its impact. <http://demographymatters.blogspot.com/2010/01/on-russias-brief-population-increase.html>.
23. These projections have been produced by Valary Yelizarov, Head of the Centre for Population, Moscow State University Economics Department.
24. The efficiency of public spending is measured by comparing actual spending with the minimum spending theoretically sufficient to produce the same actual output. Inputs are measured by public spending in specific functional areas, while outputs are represented by indicators of the impact of public spending in these areas. Health outcomes are measured by indicators such as infant mortality, life expectancy, physicians relative to the population. For local governments, public sector performance (PSP) and public sector efficiency (PSE) scores are used.
25. The Russian authorities conducted a comprehensive assessment of the health care systems effectiveness in 2008 and found that 28 regions had ineffective health care systems with poor services and limited resources. The study also found that 32 of the regions enjoyed strong financing and budget surpluses while 15 were able to achieve high levels of medical care at low rates of financing. This suggests that there is scope for bringing poor performing regions up to the level of the best performers.
26. As noted in Chapter 2, both alcohol and tobacco excise taxes are being increased sharply.
27. Information on how this is expected to work in practice was not available at the time of completion of the report (Federal Law No. 326-FZ of 29 Nov. 2010 "On Compulsory Medical Insurance in the Russian Federation").
28. However it remains unclear how the system will adjust for cream skimming across insurers and whether insurers can obtain cost savings and quality improvements for patients.

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Annex A

Complementary tables

Table A.1. Responsibilities of different government levels in the health system

	Regional level	Municipal level
Federal level		
Protection of rights and freedoms in the area of health protection		
Public health		Public health
Development and approval of federal sanitary regulations, norms and hygienic standards; setting up control and supervision of compliance with the sanitary legislation of the Russian Federation. Elaboration of federal policies to protect citizens' health and federal policies for prevention		Organisation, maintenance and development of municipal health care facilities
Management of federal property used in health prevention		Securing the health and wellbeing of the population
Elaboration and implementation of federal programmes on health care development, disease prevention, medical care delivery, public health education and other issues to protect citizens' health;		
Financing	Financing	Financing
Setting federal spending on health care within the federal budget, as well as broader fiscal policy (including tax exemptions, duties and other payments to the budget) which can affect prevention. Finance the set of health care services to be funded by the federal government according to Order 811 on Guaranteed Package.	Development and allocation of the regional budgets Material and technical supplies for the provision of health care owned by the region Finance the set of health care services to be funded by regional governments according to Order 811 on Guaranteed Package	Development of the local budget for health care expenditures Finance the set of health care services to be funded by municipalities according to Order 811 on Guaranteed Package

Table A.1. Responsibilities of different government levels in the health system (*cont.*)

Quality and safety	Quality and safety
Development of a common framework for federal medical education and training programmes, as well as setting the list of specialties in health care	Organisation and coordination of training of health protection personnel
Establishment of standards of quality of medical-care and ensuring compliance	Licensing of medical and pharmaceutical activity within the regions
Defining procedures for the licensing of medical and pharmaceutical activity	
Establishment of procedures for medical expertise	
Health insurance/ population coverage	Health insurance/population coverage
Development and approval of a programme of compulsory health insurance and fixing premiums	Approval of compulsory health insurance programmes at the regional level
Defining benefits for certain population groups receiving medical-social care and pharmaceutical supplies	Provision of additional benefits for certain population groups receiving medical-social care and pharmaceutical supplies
Monitoring of the system	Monitoring of the system
Co-ordination between different levels of government	Co-ordination of activity of state authorities, municipal and private health care systems' subjects in the area of health protection
Establishment of a common federal statistics and accounting system in health protection	

Source: 1993 Act "Fundamentals of the Russian Federation Legislation on Citizens' Health Protection".

Table A.2. Breakdown of spending in the Russian National Priority Project “Health”

Main items of spending under the National Priority Project “Health” (NPPH)

	2006		2007		2008		2009		2010		2011		2012		2013	
	bn roubles	%	bn roubles	%	bn roubles	%	bn roubles	%	bn roubles	%	bn roubles	%	bn roubles	%	bn roubles	%
Total	87.9	100	117.1	100	131.8	100	148.3	100	145.3	100	157	100	165.9	100	165.6	100
<i>of which</i>																
from federal budget	62.1	70.6	95.8	81.8	113.2	85.9	127.7	86.1	126.5	87.1	134.9	85.9	139.5	84.1	100.5	60.7
from Federal MHI Fund and Federal Social Insurance Fund	25.8	29.4	21.3	18.2	18.6	14.1	20.6	13.9	18.8	12.9	18	11.5	19	11.5	23	13.9
from resources of MHI Fund	-	-	-	-	-	-	-	-	-	-	4.1	2.6	7.4	4.5	42.1	25.4
Total	87.9	100	117.1	100	131.8	100	148.3	100	145.3	100	157	100	165.9	100	165.6	100
<i>of which</i>																
Support of healthy life style	-	-	-	-	-	-	0.8	0.5	0.8	0.6	0.8	0.5	0.8	0.5	0.8	0.5
Increased pay for primary care medical staff	15.4	17.5	18.3	15.6	22.6	17.1	23.3	15.7	21.3	14.7	22.1	14.1	22.1	13.3	22.1	13.3
Additional payments for primary care provision	23.9	27.2	4.8	4.1	-	-	-	-	-	-	-	-	-	-	-	-
Increased pay for paramedicals in rural areas and acute care medical staff	5.2	5.9	8.4	7.2	8.1	6.1	9.4	6.3	9.7	6.7	10.3	6.6	10.3	6.2	10.3	6.2
Additional payments for staff in maternity hospitals (“birth certificates”)	-	-	14.5	12.4	16.6	12.6	17	11.5	18.4	12.7	18	11.5	19	11.5	23	13.9
Development of perinatal centres system	-	-	-	-	6.3	4.8	7.2	4.9	5.6	3.9	0.3	0.2	0.8	0.5	0.8	0.5
Development of prenatal diagnostics	-	-	-	-	-	-	-	-	0.1	0.1	0.7	0.4	0.8	0.5	0.9	0.5
Equipment for neonatal screening	0.4	0.5	0.4	0.3	0.4	0.3	0.6	0.4	0.6	0.4	0.7	0.4	0.7	0.4	0.6	0.4
Additional financing of medical care provision for newborn babies with low and extremely low weight	-	-	-	-	-	-	-	-	-	-	2.9	1.8	5	3.0	2	1.2

Table A.2. Breakdown of spending in the Russian National Priority Project “Health” (cont.)

Main items of spending under the National Priority Project “Health” (NPPH)

Diagnostic equipment for polyclinics and other outpatient facilities	14.3	16.3	15.4	13.2	0.1	0.0	-	-	-	-	-	-	-	-	-	-	-
Upgrading emergency vehicle fleet	3.6	4.1	3.9	3.3	0.2	0.2	-	-	-	-	-	-	-	-	-	-	-
Diagnostic equipment and emergency vehicles for hospitals located along main autoroutes	-	-	0.1	0.1	3.2	2.4	2.6	1.8	3.4	2.3	3.2	2.0	5.9	3.6	5.9	3.6	3.6
Diagnostic equipment for cardiovascular diseases	-	-	2.3	2.0	3.6	2.7	3.2	2.2	3.1	2.1	3.4	2.2	5.9	3.6	5.9	3.6	3.6
Diagnostic equipment for oncological diseases	-	-	-	-	-	-	6.8	4.6	5.9	4.1	7.2	4.6	7.1	4.3	6.9	4.2	4.2
Development of blood banking	-	-	-	-	3.3	2.5	4.2	2.8	4.5	3.1	4.2	2.7	5	3.0	5	3.0	3.0
Prevention, diagnosis and treatment of persons infected with HIV-AIDs, hepatitis B and C	2.8	3.2	7.8	6.7	8	6.1	9.3	6.3	13.5	9.3	19.6	12.5	19.7	11.9	19.7	11.9	11.9
Prevention, diagnosis and treatment of persons infected with TB	-	-	-	-	-	-	2.8	1.9	4.1	2.8	5.2	3.3	4.9	3.0	3.1	1.9	1.9
Programme of regular immunization and vaccinations (including flu)	4.5	5.1	3.8	3.2	5.0	3.8	6.5	4.4	5.6	3.9	5.6	3.6	5.6	3.4	6.1	3.7	3.7
Additional prophylactic medical examinations of the working population	3.9	4.4	6.4	5.5	7.8	5.9	6.2	4.2	4.4	3.0	4.1	2.6	4.1	2.5	4	2.4	2.4
Prophylactic medical examinations of children in orphanages	-	-	0.3	0.3	0.8	0.6	0.9	0.6	0.8	0.6	0.9	0.6	0.9	0.5	1.0	0.6	0.6
Prophylactic medical examinations of teenagers	-	-	-	-	-	-	-	-	-	-	0.9	0.6	0.9	0.5	1.0	0.6	0.6
Construction of high-tech medical centres	3.2	3.6	7.1	6.1	9.9	7.5	11.6	7.8	6.9	4.7	3.7	2.4	-	-	-	-	-
Increased volumes of high-tech medical services	9.9	11.3	17.5	14.9	24.2	18.4	30.5	20.6	36.2	24.9	42.2	26.9	43.2	26.0	43.2	26.1	26.1
Development of high-tech medical technologies	-	-	-	-	7.7	5.8	5.1	3.4	-	-	-	-	1	0.6	1	0.6	0.6
Development of system of palliative care for children	-	-	-	-	-	-	-	-	-	-	2.9	1.8	5	3.0	2	1.2	1.2
Pilot Project	-	-	5.4	4.6	3.4	2.6	-	-	-	-	-	-	-	-	-	-	-

Source: Ministry of Health and Social Development of the Russian Federation.

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