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" regions[2] 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 (*Rostechnologii*).

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 Lukiyanova, 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 time[9] 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 though 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 measured 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 heath 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 *Roszdravnadzor* 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 Chuvas 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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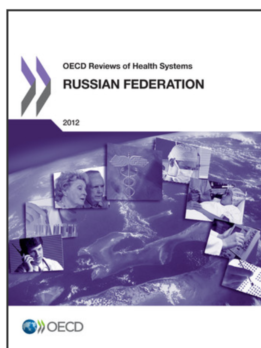

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