

## *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.<sup>1</sup> 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<sup>2,3</sup> (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.<sup>4</sup>

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).

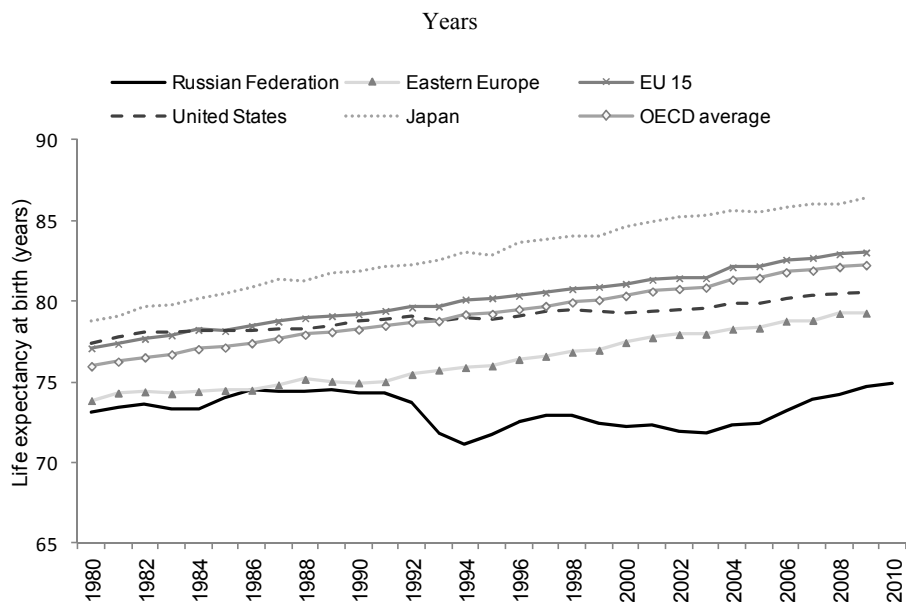
Table 1.1. Inter-regional differences in selected dimensions: highest and lowest regions ranked by GDP level, circa 2008

Russian Federation as of 1 January, 2009

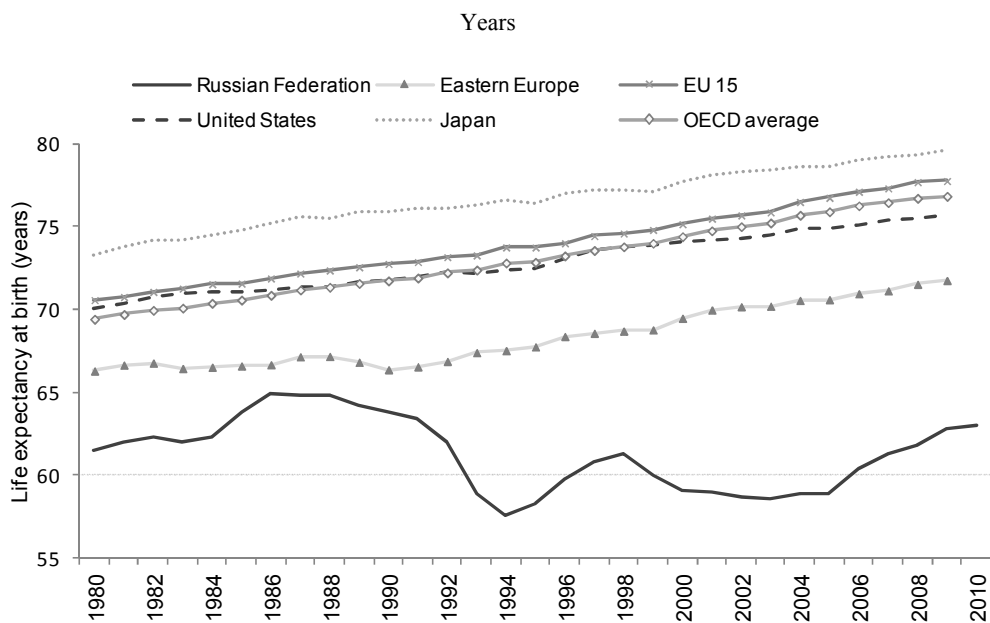
Regions	Population density (persons per sq. km)	Population (in thousands persons)	Share of rural population in total population (%)	Share of population higher educated per 1000 persons (15+) in 2002	GDP per capita (roubles)	Regional structure of value added (% of extracting industries)	Share of the population under subsistence level (%)
<b>Russian Federation</b>	<b>8.3</b>	<b>141 915</b>	<b>26.9</b>	<b>160</b>	<b>241 767</b>	<b>9.9</b>	<b>13.1</b>
<b>1 Central Federal District</b>	<b>57.1</b>	<b>37 118</b>	<b>19.2</b>	<b>197</b>	<b>348 107</b>	<b>0.9</b>	
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
<b>2 North West Federal District</b>	<b>8.0</b>	<b>13 437</b>	<b>17.6</b>	<b>179</b>	<b>252 220</b>	<b>6.9</b>	
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
<b>3 South Federal District</b>	<b>38.7</b>	<b>22 968</b>	<b>43.2</b>	<b>144</b>	<b>120 028</b>	<b>1.8</b>	
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
<b>4 Privolzhsky (Volga) Federal District</b>	<b>29.1</b>	<b>3 011</b>	<b>29.7</b>	<b>138</b>	<b>177 124</b>	<b>12.5</b>	
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
<b>5 Urals Federal District</b>	<b>6.7</b>	<b>12 280</b>	<b>20.3</b>	<b>137</b>	<b>396 763</b>	<b>35.1</b>	
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
<b>6 Siberian Federal District</b>	<b>3.8</b>	<b>19 561</b>	<b>29.2</b>	<b>140</b>	<b>178 596</b>	<b>9.2</b>	
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
<b>7 Far East Federal District</b>	<b>1.0</b>	<b>6 440</b>	<b>25.7</b>	<b>154</b>	<b>239 109</b>	<b>20.6</b>	
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.

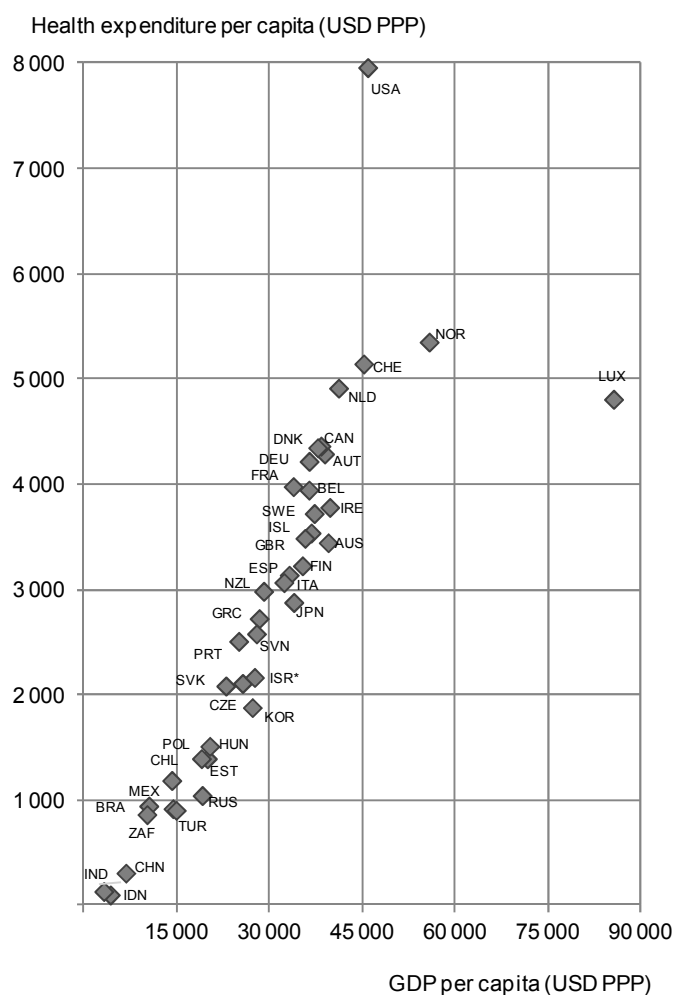
*Source:* OECD Health Data 2011 and Rosstat, MHS estimates for 2010.

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**

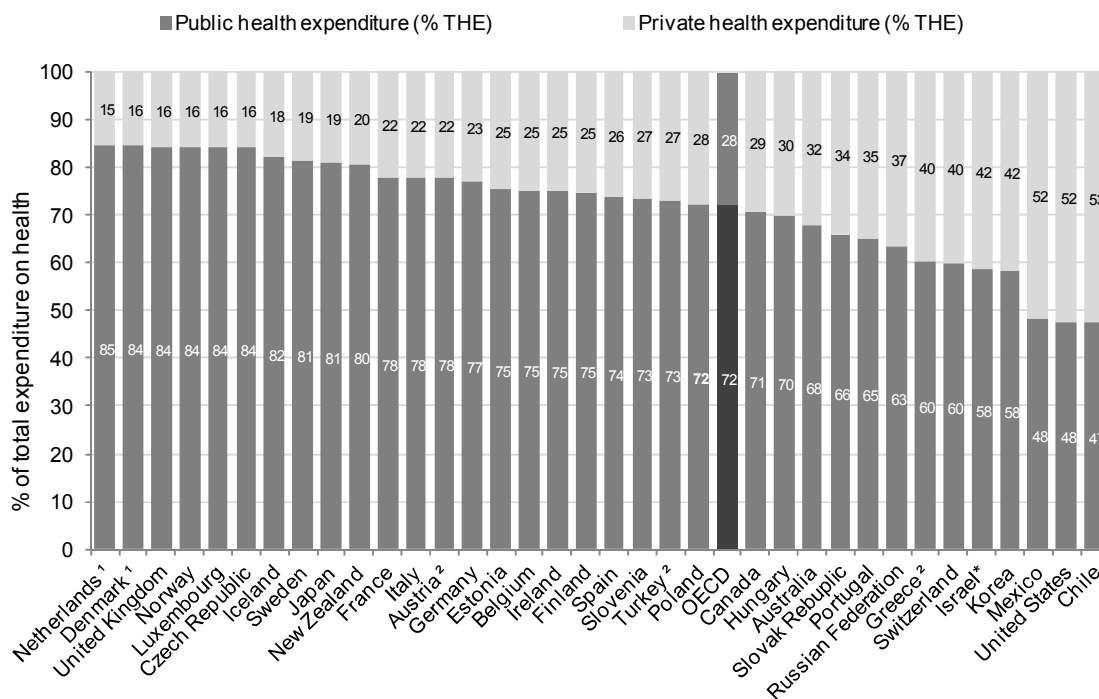


\* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

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**



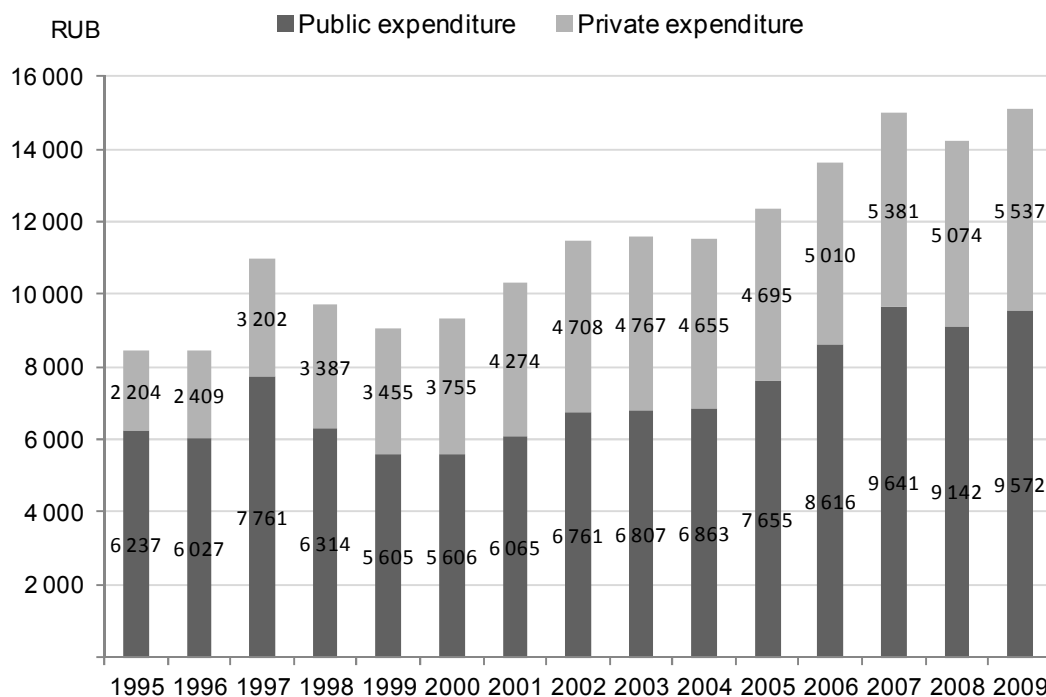
1. 2007; 2. 2006.

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.<sup>5</sup> 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

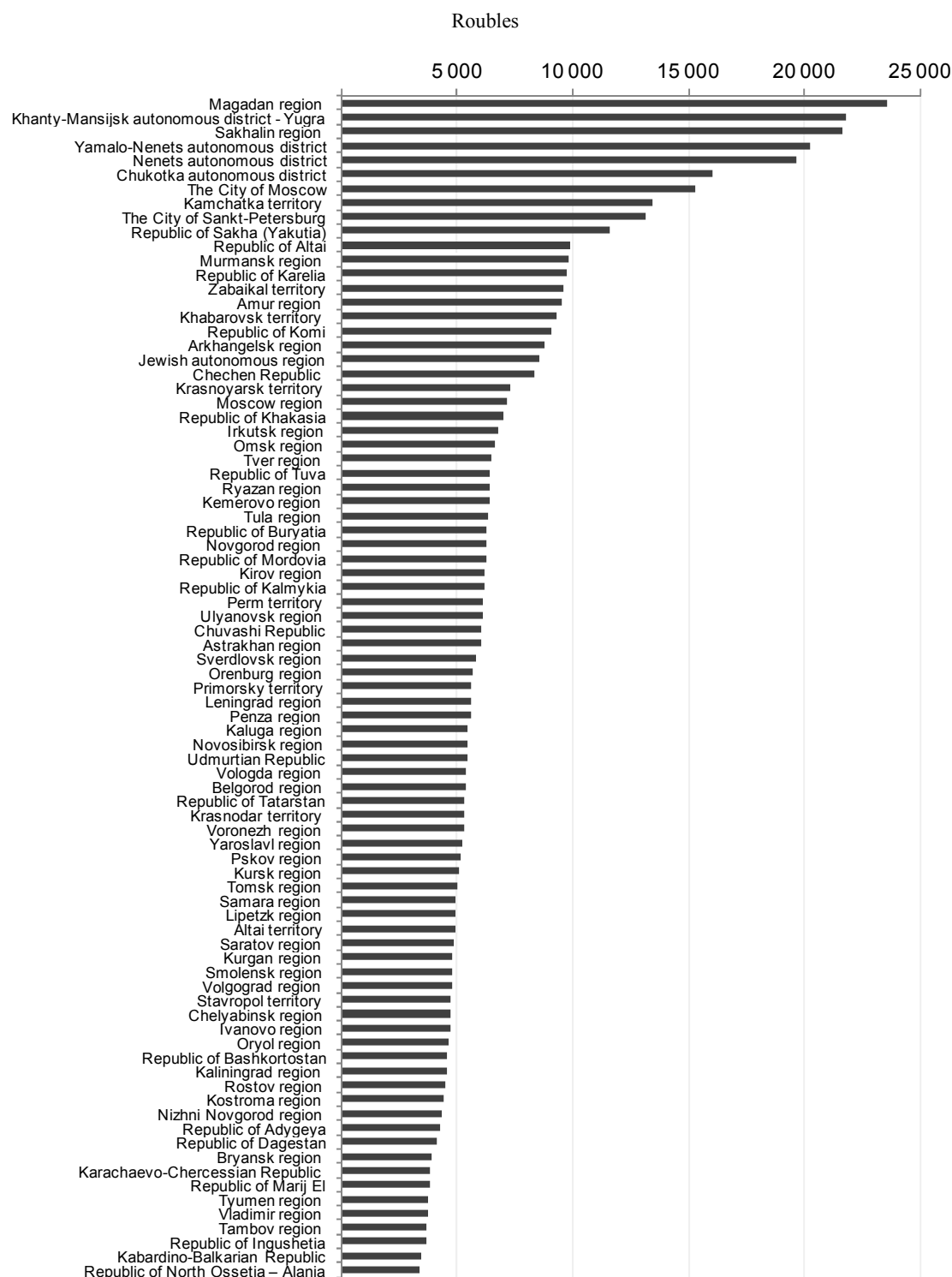
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total expenditure as a share of GDP (%)	5.6	5.8	7.3	6.8	5.7	5.4	5.7	6.0	5.6	5.2	5.2	5.3	5.4	4.8	5.6
Public expenditure as a share of GDP (%)	4.0	4.0	5.0	4.3	3.6	3.2	3.3	3.5	3.3	3.1	3.2	3.4	3.5	3.1	3.6
Private expenditure as a 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	-3.6	-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	-25.6	-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, 1997<sup>6</sup>).

#### 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).<sup>7</sup> 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.<sup>8</sup> 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 MHSB;
- 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.

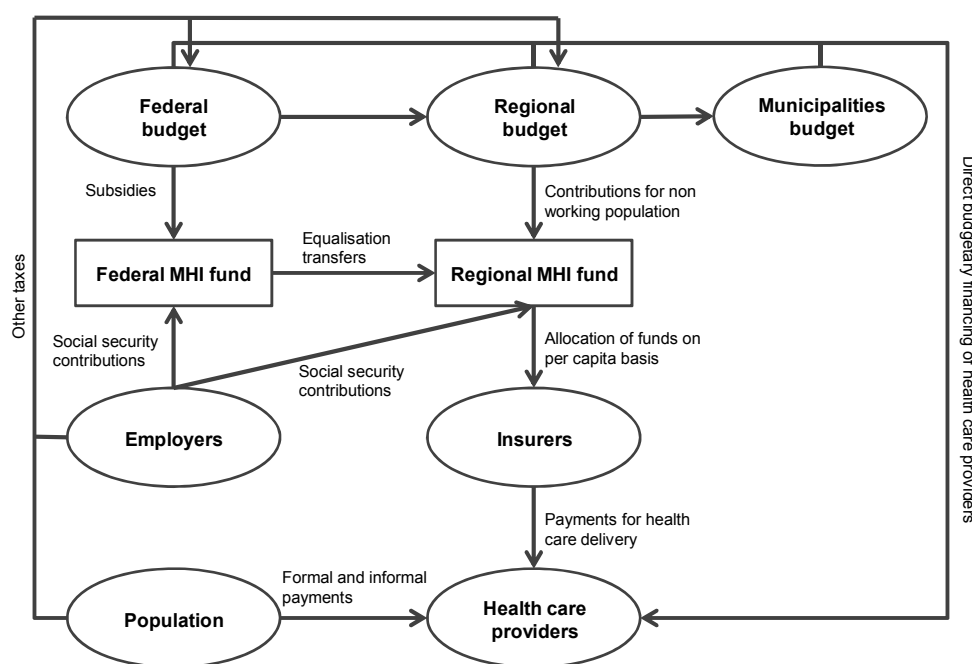
*Source:* Government Order No. 118, issued 2, October, 2009, [www.minzdravsoc.ru/docs/mzsr/letters/163](http://www.minzdravsoc.ru/docs/mzsr/letters/163).

## 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.<sup>9</sup>

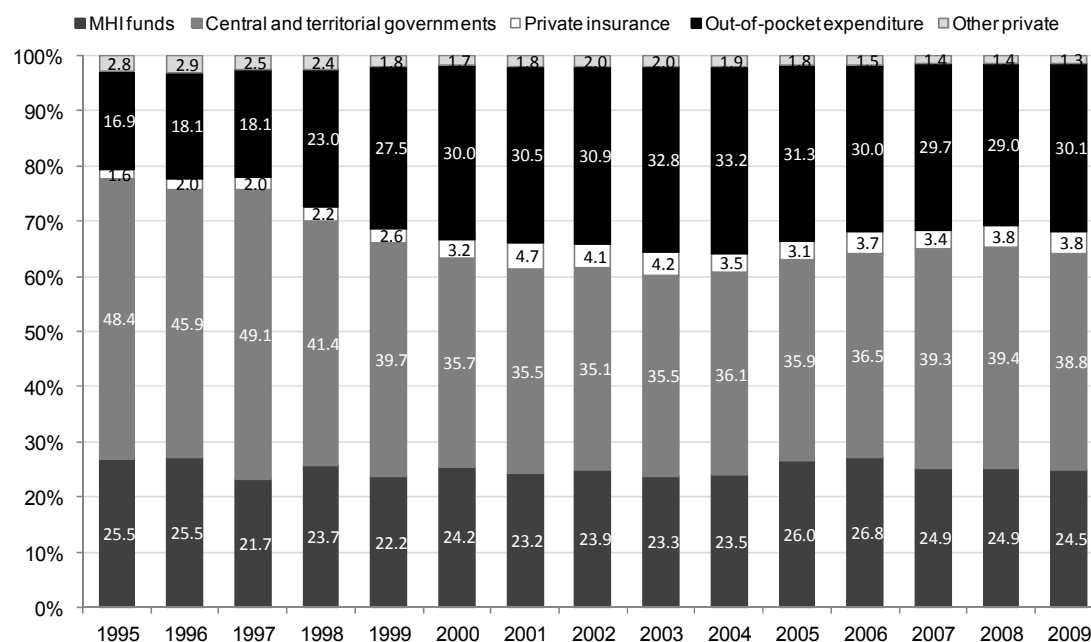
The federal authorities finance the separate health care facilities run by the Ministry of Defence and other ministries, federal-level tertiary hospitals, training, research and public health activities although financing of these entities will be integrated into the Mandatory Health Insurance system 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%.<sup>10</sup>

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.<sup>11</sup> 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 committee<sup>12</sup> 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.<sup>13</sup>

### ***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.<sup>14</sup> 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.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup>

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”.<sup>18</sup> 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<sup>19,20</sup> 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).<sup>21</sup> Official salaries are typically below the average wage<sup>22</sup> 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.<sup>23</sup> 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.<sup>24</sup> 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.<sup>25</sup> 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

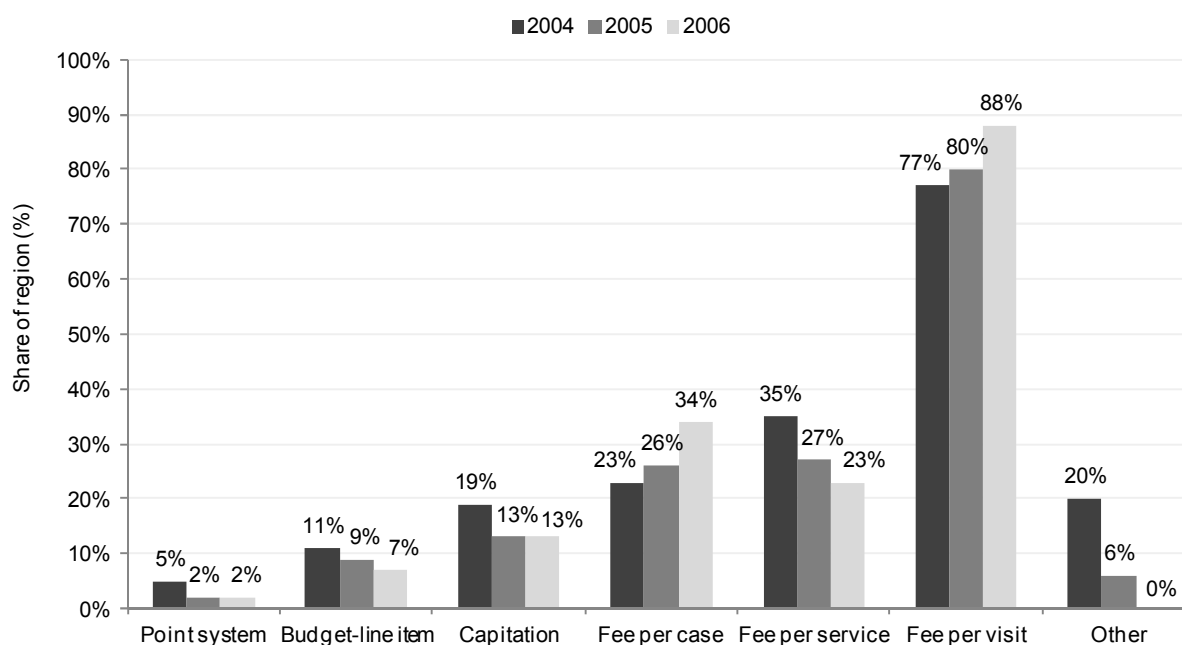
a lack of awareness of incentive problems, but a lack of administrative capacity: regions often tend to adhere to forms of payment that are easier to monitor and administer rather than seeking to experiment with payment aimed at enhancing performance (Tompson, 2007).

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*

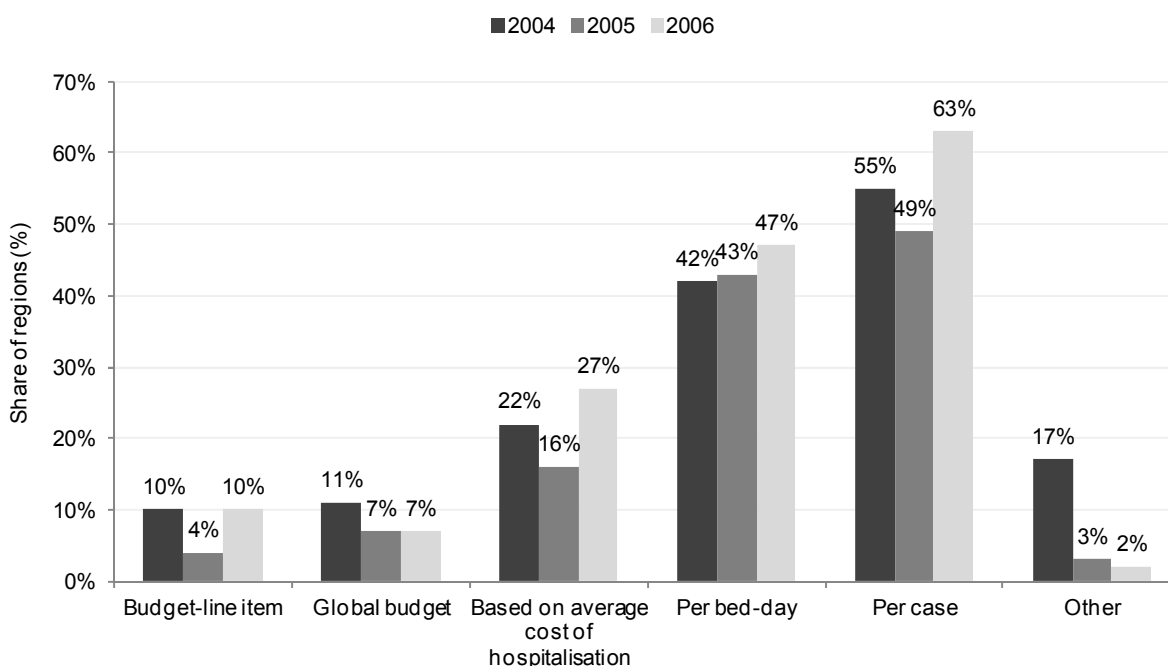
To help resolve problems of insufficient financing of public providers in 1996, the federal government allowed provider institutions to charge patients for certain types of medical care. This was to provide greater flexibility in setting the salaries of medical staff (*e.g.* bonuses) and to allow investment 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](http://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](http://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/](http://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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