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Constraints on Universal Health Care in the Russian Federation

Inequality, Informality and the Failures of Mandatory Health Insurance Reforms

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Contents

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
EU	European Union
FIDH	International Federation for Human Rights
GATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
HIO	Health Insurance Organization
HIV	Human Immunodeficiency Virus
I/NGO	International/Non-governmental Organization
IDU	Intravenous Drug User
IFI	International Financial Institution
IOM	International Organization for Migration
MDR TB	Multi-Drug Resistant Tuberculosis
MHI	Mandatory Health Insurance
NOBUS	National Survey on Public Well-Being and Engagement with Social Programs
NPPH	National Priority Project on Health
OECD	Organisation for Economic Co-operation and Development
RLMS	Russian Longitudinal Monitoring Survey
STD	Sexually Transmitted Disease
TB	Tuberculosis
UNRISD	United Nations Research Institute for Social Development
VHI	Voluntary Health Insurance
WHO	World Health Organization

Abstract

Healthcare in Russia has gone through many transformative stages, from a Soviet-era model of public provision to an emphasis on privatization under economic liberalization during the 1990s. Both have legacies that survive to the present, and now a mix of both public and private healthcare provision operates across Russia. Throughout all these periods, universalism has been enshrined as a guarantee, at least nominally. The extent to which this right has been upheld varies greatly, with some major constraints to universal provision in Russia. Underfinancing presents a persistent obstacle to universal access, and substantial inequalities in healthcare access and quality exist across different regions and income groups, with some vulnerable and marginalized groups left almost entirely excluded. Furthermore, despite efforts to improve quality and provision of healthcare, Russia has a poor record in many health indicators, and its national system is struggling to become more efficient and effective.

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Introduction

The Russian Federation inherited from its Soviet predecessor a universal system of basic health care that was state run and free at point of access. The Soviet state established this system during the 1930s and 1940s as part of rapid modernization and industrialization. For several decades the system produced significant improvements in key health indicators: life expectancy increased, infant mortality declined and infectious diseases were brought under control. It was reasonably effective in implementing broad public health measures and controlling communicable diseases, but could not adapt to treat more complex non-communicable conditions such as cancer and cardiovascular diseases. By the 1980s accumulating problems of bureaucratic rigidity, low levels of medical technology, underfinancing and failed reform efforts were contributing to the deterioration of health conditions among Russia's population. With the collapse of the Soviet Union in 1991 Russia's statist political economy imploded, and its health care system was thrown into crisis.

During the 1990s the health sector was buffeted by Russia's decade-long economic decline and radical efforts to transform health care provision according to a liberal, market-based insurance model. Public expenditures on health declined dramatically. President Yeltsin's poorly designed reforms introducing health care de-statization, privatization and marketization led to political conflict and disorganization that worsened dysfunction. By the late 1990s key health indicators had declined dramatically. Famously, male life expectancy in Russia declined to below 60 years, a level not otherwise seen in peacetime developed economies. Russia began a sustained demographic decline. From 1993 to 2005 the number of deaths exceeded births by 11.2 million, and the population was declining by about 700,000 per year (Putin, 2005). While deficient health care was certainly not the only cause here, it is broadly seen as a contributing factor. Infectious diseases re-emerged and spread, and even childhood immunization programmes collapsed temporarily in parts of the Russian Federation. The worst effects on health indicators had been largely reversed by 2010, and the formal guarantee of universal rights to health care was retained throughout. However, the decade of crisis in the 1990s produced changes in income distribution and health care practices that have persisted as major constraints on universal access. High levels of inequality in Russian society have created an "underclass" of low-income strata, especially rural populations and urban migrant workers, who have little access to medical services. Processes of "spontaneous privatization" and "shadow commercialization" within the health sector have raised barriers to health care, and ubiquitous practices of informal payments persist as obstacles that exclude or restrict access.

During the decade 2000–2010 the Russian health care system recovered substantially in terms of financing, performance, organizational coherence and health outcomes. Rapid growth of Russia's economy from 2000 to 2007 provided resources to restore and increase health expenditures, while the Putin administration broadly revived the state's administrative capacities, including in the health sector. Public expenditure recovered, increasing as the economy grew, though the proportion of the growing gross domestic product (GDP) expended for health care remained modest. In mid-decade the Putin administration, responding to the demographic crisis, made health care a major policy priority. Administration of the health care system was partially recentralized at the federal level, a pro-natalist campaign was launched and the National Priority Project on Health (NPPH) showcased the political elite's concerns. Older reforms, including medical insurance reform, were revived. These efforts produced positive results: by 2009 life expectancy had nearly recovered to its 1990 level, infant, child and maternal

mortality had declined significantly, and rates of infectious diseases had stabilized (see Table 1). Survey evidence showed that the health care system had become more accessible, and that demands for informal payments in exchange for treatment had declined (Potapchik et al. 2011).

Table 1. Life expectancy, infant mortality, under-5 and maternal mortality (selected years, 1990–2009).

	1990	1995	2000	2005	2009
Life expectancy at birth, female (years)	74.3	71.6	72.3	72.4	74.7
Life expectancy at birth, male (years)	63.7	58.1	59.0	58.9	62.8
Infant deaths (per 1,000 live births)	17.4	18.1	15.3	11.0	8.1
Probability of dying before age 5 (per 1,000 live births)	21.3	22.5	19.3	13.9	10.2
Maternal deaths (per 100,000 live births)	47.4	53.3	39.7	25.4	22.0

Source: Popovich et al. (2011: 10) from Federal State Statistical Service 2010.

Serious problems remained, however, and with economic recovery a new population—hundreds of thousands of labour migrants—was added to the mix. The combination of rapid economic growth with Russia's demographic decline produced a strong demand for labour. In response, beginning in 2000, large numbers of migrants came, mainly from Central Asian and other post-Soviet states, and mainly to Russian cities. Post-2000 labour migrants are predominantly non-Slavs who enter Russia legally through a visa-free regime, then remain and work, often without legal registration. Lacking citizenship or residence permits, most are largely excluded from the public health care system, adding another category of constraint on universal health care access in the Russian Federation. The deepest inequalities inhabit this transnational space.

In sum, Russia's health care system has recovered substantially from the crisis conditions of the 1990s, has improved or at least stabilized key health indicators and has retained its constitutional commitment to citizens' universal health care rights. At the same time, the system performs poorly in comparative international terms. Russia's public expenditure on health falls within middle-income country norms, but its effectiveness is low; countries spending 30–40 per cent less get similar health outcomes in terms of mortality (Popovich et al. 2011: 171). Life expectancy, a key indicator of the population's health, remains low especially for men. Infectious diseases have been stabilized, but rates of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) remain comparatively high, and Russia has very high rates of tuberculosis (TB) and multi-drug resistant tuberculosis (MDR TB). Strong patterns of socioeconomic inequality—rich/poor, urban/rural and inter-regional—affect provision, as do continuing pressures for informal payments for services. High-quality private facilities are mainly limited to the elite, groups at high risk for infectious diseases are often beyond the reach of the health care system and Russia's large migrant population has very limited access to care. Overall, Russia's system of health care has become fragmented, with different population strata experiencing highly differentiated levels of access, services and quality of care.

This paper delves into the sources and patterns of constraints on universalism and the strengths and weaknesses of Russia's contemporary health care system. It briefly reviews the achievements, limits and legacies of the Soviet-era system, the persisting negative effects of defunding and botched reforms during the 1990s, and the system's recovery after 2000. The bulk of the paper covers the contemporary period, focusing on institutions, actors and processes; positive trends and developments; sources of constraints on access; and the drivers of fragmentation, causes of inefficiency and the mixed picture in overall health outcomes. The discussion highlights the effects of informality as well as social exclusion of the large population of labour migrants and limited outreach to vulnerable groups. Some attention is given to the role of International/Non-governmental organizations (I/NGOs) in Russia's health care system. The conclusion extracts some policy lessons.

Legacies of the Soviet-Era Health Care System

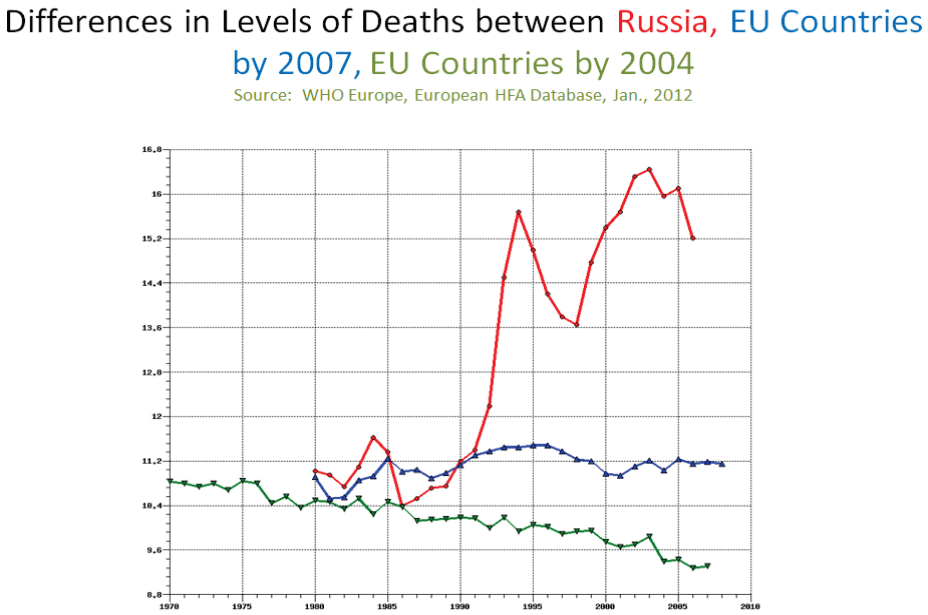
The Soviet state monopolized the health care system's financing, organization, licensing, structure, norms and practice guidelines. Private medical practices were for the most part illegal. The system was centralized and bureaucratically managed, with the All-Union Ministry of Health at the centre and its agencies articulated down to regional and local levels. Pharmaceuticals were produced or imported and distributed exclusively by the state. Like all sectors of the Soviet economy, the health sector was planned on an input-based, extensive model—progress was measured largely by the number of practitioners educated, hospitals and polyclinics built, rural health points established; quantitative indicators mattered much more than qualitative. The well-known examples of rural "hospitals" that lacked running water epitomized the negative effects of this approach, but the larger systemic problems were over-reliance on staffing, specialization, hospitalization and inpatient treatment. World Health Organization (WHO) comparisons of Soviet (and other communist) systems found, for example, excessively high provider–patient ratios and numbers of hospital beds by international standards. The Soviet health care system is commonly characterized as underfinanced, or financed on the "residual principle"; that is, with the funds remaining after the priority areas of industry and defence had received allocations (Cook 2007a). However, in comparison with Latin American and East Asian states at similar levels of development, communist states had extensive and generous systems of public health provision (Haggard and Kaufman 2008).

While access to basic health care was virtually universal, provision of medical services was formally and explicitly stratified. The health care system was legally divided into six distinct subsystems—departmental, elite, capital city, industrial, provincial city and rural. Each sub-system served different population groups at differing levels of financing and standards of care.[1] Corruption and informal payments played a role, but had relatively less influence on access than the system's formal stratification (Davis, 1988). It should be noted that universalism was a product of state mandates: health workers, like all others, were assigned to jobs and localities after completing their education, and the state used these administrative powers to staff rural facilities. The system was quite effective with broad public health measures such as vaccinating and screening. It helped to bring adult life expectancy and infant mortality close to European norms in the 1970s, but this achievement proved temporary. By the 1980s the system had become outdated and increasingly ineffective, unable to modernize to provide the

[1] In the 1980s less than one-half of 1 per cent of the population had access to the elite system, while about half were served in the lowest-quality, rural district system (Davis 1988). Education and social status also played important roles in health care utilization (Rusinova and Brown 2003).

more sophisticated treatment required for complex and chronic conditions such as cancer and cardiovascular disease. The disparity between basic health indicators in Europe and Russia grew during the 1980s, then spiked in the 1990s (see Figure 1). Evidence of popular dissatisfaction also grew. By the late Soviet period the health care system was deficient in comparative international terms, characterized by chronic shortages of pharmaceuticals and advanced diagnostic equipment, utilizing low levels of medical technology in generally poor health facilities (Tragakes and Lessof 2003).

Figure 1. Differences in levels of deaths between Russia, EU countries by 2007 and EU countries by 2004



Source: WHO (2006–2013).

The Soviet health care system left three critical legacies that have continued to shape the present: (i) the new Russian state inherited a large public health care bureaucracy and labour force, networks of administrative organizations and health care personnel who had vested interests in the old system of state administration and input-based planning and financing. These interests would stand as an obstacle to marketizing and efficiency-oriented reforms of health care financing and practice, as would the absence of private providers or financing mechanisms, (ii) the system had entrenched norms and practices of over-staffing and excessive reliance on specialization and hospitalization, and these would prove difficult to change, (iii) the system left a mixed legacy of universalism and inequality.

Given the emphasis of this paper—and of the broader United Nations Research Institute for Social Development (UNRISD project)—on possibilities for universal health care, it is worth considering some of the problems and limitations even when the Soviet system approached universal provision of basic health care, and what lessons they might have for the present.

1. "Universal care" concentrated resources on diagnosis and treatment of disease, rather than on its prevention. Contemporary experts recognize that the extremely high rates of cardiovascular and other chronic diseases in Russia's current population require both better health care and major preventive efforts.

2. "Universalism" in the Soviet context meant coverage of the population by facilities and providers more than quality and effectiveness of care. Experts agree that reforms must focus on quality and effectiveness, and that simply spending more on the existing infrastructure of staffing and institutions is unlikely to help.
3. The Soviet system relied on broad screenings of the population at school and work to diagnose infectious diseases, and often on hospitalization to treat them. The main contemporary infectious diseases (TB, HIV/AIDS) tend to be concentrated among at-risk populations such as intravenous drug users and sex workers, who are often socially excluded or marginalized. Broad screenings are ineffective in covering these populations, while the threat of mandatory hospitalization (still sometimes used for TB) may deter some from seeking care. Targeted forms of outreach and less coercive policies are needed.
4. While basic health care was available to poorer and less educated Soviet citizens, it was of poor quality, rude and ineffective. Ethnographic evidence shows that many people in these strata delayed seeking care and relied on self-treatment as long as possible, though this was obviously not an option for serious health problems (Rusinova and Brown 2003). The lesson here is that health services must be not only available but decent and dignified, or people may avoid seeking care until illnesses become serious and expensive to treat. Experts argue that, in order to fulfil its promise of universalism and effectiveness, Russia's health care system must mitigate the worst financing inequalities, focus on prevention, reach at-risk groups and improve quality (Potapchik et al. 2011; World Bank 2011; UNDP 2010). I will return to these points in the concluding discussion on policy lessons.

The decline and reform of health care in the 1990s

With the Soviet collapse in late 1991, Russia's political economy was thrown into a crisis that featured a decade-long economic decline, hyperinflation and rapid increases in poverty and inequality. Ramifications for the health care system were severe: overall levels of state financing fell by an estimated one-third, by mid-decade state salaries for the majority of health care workers had fallen below the subsistence level, key pharmaceuticals were in deficit and the large inherited stock of health care infrastructure was deteriorating (Gosudarstvennyi komitet po statistike 2001, 2002). At the same time, the official poverty rate grew to 25 per cent of the population (with some estimates higher), and inequality spiked (Cook 2007a). The cumulative effects helped to drive Russia's health indicators to their lowest levels at the end of the 1990s, led by major declines in male life expectancy (see Table 1). The main causes of adult mortality were cardiovascular disease; cancer; and external causes such as accidents and poisonings, often alcohol-related and concentrated among working-aged men, though infectious diseases also played a role. Incidence and deaths from TB more than doubled during the decade (UNDP 2010). Russia's population began a generation-long decline in numbers that was driven mainly by excess middle-aged male mortality; low birth rates also contributed.

President Yeltsin and his domestic and international advisors sought to address the problems of Russia's health care system through a series of liberalizing and marketizing reforms that formed part of their broader policy of economic "shock therapy". During the first half of the 1990s the health care system was decentralized, partially privatized and moved to an insurance model that was supposed to introduce competition and provide choice for patients. New legislation legalized private outpatient practices, pharmaceutical and medical equipment production and distribution were privatized, and formal ("cash register") payments were introduced for some health services (Davis 2001). Organization and financing of health care were also reformed. Most

responsibility for financing and policy was devolved from the federal government to 89 regional health committees. Most significantly, the inherited system of single-payer public budget financing was replaced by a new system of Mandatory Health Insurance (MHI), financed by a mix of payroll taxes for the employed population, and regional and local budget revenues to cover those outside the labour force (including pensioners, children and the disabled). Health Insurance Organizations (HIOs) were created to purchase medical care from providers according to a "competitive contracting" model.

These Yeltsin-era reforms were driven by both fiscal pressures and politics. On the fiscal side, federal budget revenues plummeted with economic contraction during the 1990s, pressuring the government to reduce its responsibilities for social welfare by decentralizing and moving to tax-based financing. The specific design of the reform—introduction of medical insurance, competitive contracting, co-payments and privatization—was driven by politics, that is, the neoliberal pro-market ideology of Yeltsin's presidential administration and the International Financial Institutions (IFI) that advised it. The reforms were premised on the familiar liberal assumptions that competition, choice, decentralized control and individual responsibility would create the proper incentives for efficiency and responsiveness. These reforms were introduced very rapidly and with little preparation or attention to the institutional context in Russia. Together they constituted an abrupt departure from traditional lines of responsibility for health care administration and financing, an "overnight massive de-statization of medical care…extending shock therapy into the health care system" (Twigg, 1998: 586). Within the space of a few years, a decentralized public–private mix, underfunded and poorly regulated, replaced centralized state control, planning and finance (TACIS 1999; OECD 2001). It is important to emphasize here that, despite the reform's liberal ideology and design, the Russian Government at the same time codified its commitment to free universal health care in the 1993 Constitution, Article 41, which remains in force.

The reforms arguably did more harm than good. None worked as anticipated, and much of the old system remained in place. The "competitive contracting" model proved a hopeless failure; necessary financial and legal infrastructure was absent and in any case many localities had only a single, monopolistic source of health care provision, obviating the prospect of competition among facilities. Local and regional governments contributed far too little to the MHI system and opposed HIOs, instead using scarce revenues to continue financing the medical infrastructure and personnel in their regions. The insurance mechanism was seriously underfinanced from the outset (Blam and Kovalev 2006). Statist actors, particularly the Federal Health Ministry and its subordinates, resisted privatization and insurance reforms, which threatened their control of the health care system2 (Cook 2007b). The medical profession itself was split. Activist doctors, including some in the legislature (Duma) played a leading role in health reform, eager to adopt Western models that they expected to perform better than the Soviet model. Many doctors initially expected that reform would produce more stable and adequate sources of financing for the health sector, while others opposed the dispersion of responsibility from the state (Ryan 1992). In sum, Russia's health care system, already in crisis, was for much of the 1990s caught up in political and bureaucratic infighting and contention between reformers and inherited statist actors.

The 1990s reforms did have significant and lasting effects on Russia's health care system:

[2] Senior Russian health economist, interview with Judyth Twigg, Moscow, 21 May 1997 (transcript provided to the author).

1. They shifted a substantial part of the burden for health expenditures to households and regions. Federal budget financing for health care fell from 100 per cent to about 50 per cent during the 1990s, with insurance and household payments making up the difference, a major and lasting shift in the burden of financing (see Table 2). The proportion of household payments for health services and pharmaceuticals increased greatly, to almost 30 per cent of the total. The average share of medical expenditures in household income grew steadily from 1994 to 2004, though it has since declined.
2. The reform created a mixed ("two channel") system of health care financing, one channel coming from wage taxes and the other from general (federal, regional and local) tax contributions. While wage taxes have served as a reliable source of financing, regional and local governments have continued to resist making adequate contributions to the insurance system. The federal government has made several efforts to coordinate these two "streams" of funding, most recently the 2008 "single channel" financing reform. But the problem persists, contributing to chronic underfinancing of the government's "Guaranteed Package" of medical services. Reforms also undermined the Federal Health Ministry's regulatory powers, contributing to the system's disorganization and fragmentation.

Table 2. Main sources of health care financing in the Russian Federation (% of total).

Source of finance	1995	2000	2005	2009
Government revenues	48.4	35.7	36.0	39.4
MHI funds	25.5	24.2	26.0	25.0
Out-of-pocket payments	16.9	30.0	31.3	28.8
Private insurance	1.6	3.2	3.1	3.9
NGOs	2.8	1.7	1.8	1.4
Other private sources	4.8	5.2	1.8	1.5

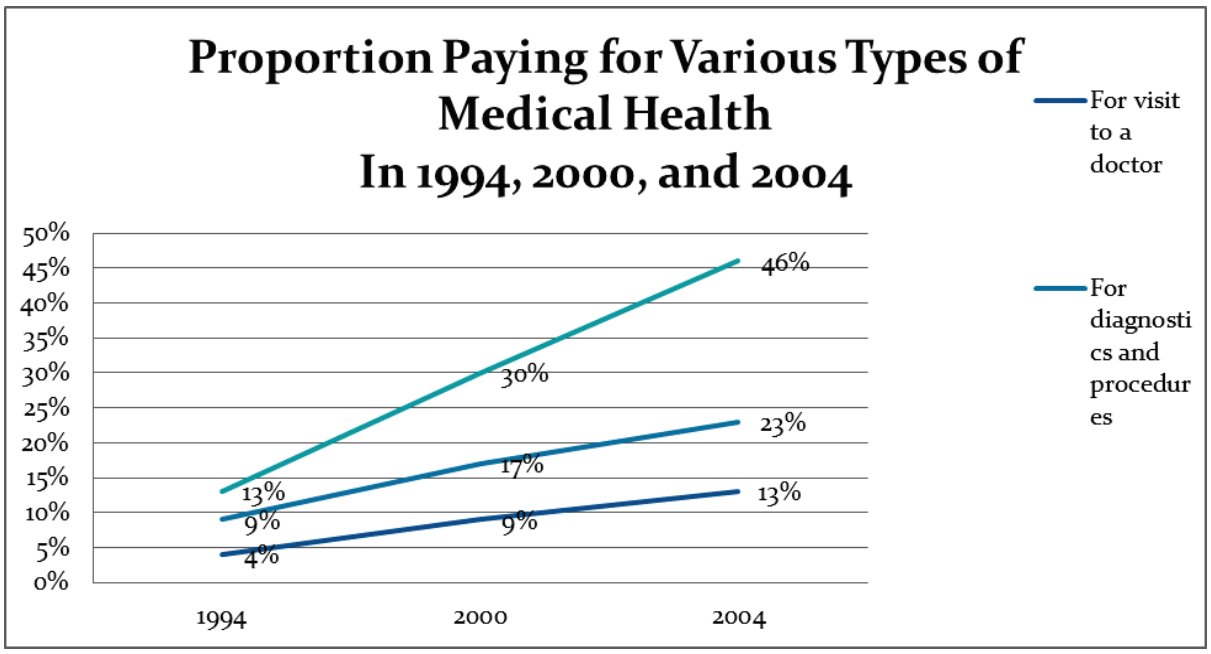
Source: Popovich (2011, 73) based on data from WHO, 2006–2013. MHI, Mandatory Health Insurance; NGO, non-governmental organization.

Spontaneous privatization and shadow commercialization

The economic decline and institutional chaos of the 1990s contributed to another set of effects on health care: practices of "spontaneous privatization" and "shadow commercialization" emerged on a large scale, in part as survival strategies for health care workers. Despite substantial defunding of the health sector, most health infrastructure remained in operation during the 1990s, the number of providers in some categories appears to have grown and the state continued to mandate free provision of most health services. As public expenditures became patently inadequate to support existing infrastructure, personnel and guaranteed services, health professionals turned to informal income-generating strategies that became known in the Russian medical sociological literature as "spontaneous privatization" and "shadow commercialization", a "tendency to spontaneous and unofficial replacement of free services with paid ones" (Feeley et al. 1999; Blam and Kovalev 2003, 2006; Cook 2014). Increasingly health sector administrators, doctors, nurses and others used control over access to facilities and professional skills to impose informal or "shadow" payment requirements for treatment.

By the mid-1990s informal payments had come to play a significant role in access to medical services. People at all income levels were paying out-of-pocket, and while these payments included some legal "cash register" changes, many were informal. The proportion of the population paying for medical services increased steadily from 1994 until the 2008 recession (see Figure 2), with by far the biggest increases for hospitalization and pharmaceuticals (Popovich et al. 2011; Shishkin et al. 2008b). Charges varied according to medical specialties, hospital departments, localities, patients' social and income groups, inpatient and outpatient care, and arbitrarily. The scale of medical professionals' "shadow incomes" remains uncertain, but negotiable "shadow" price lists reportedly existed. Survey evidence from the beginning of the 2000s indicates that surgeons may have supplemented their official incomes by 5–10 times, rank-and-file doctors by 2–3 times, nurses and others by one-fifth to two times. Many providers and some patients considered these payments as fair reimbursement in light of the extremely low official health sector salaries (Shishkin et al. 2003; Blam and Kovalev 2003). Large-scale corruption emerged, particularly in pharmaceuticals, the one part of the health sector that was largely privatized. Collusion between providers and pharmaceutical companies over drug pricing became common (Vacroux 2004, 2005).

Figure 2. Percentages of Russia's population paying for various types of medical care in 1994, 2000 and 2004.



Source: Shishkin, 2008b, p. 148, Fig. 12 (used with permission).

The combination of growing poverty and inequality, underfinancing of the health sector and informal payment requirements had by the late 1990s excluded some sectors of Russian society from access to guaranteed health care. While Russians could visit their local polyclinic, there was great differentiation in the scope and quality of services available for different regions, localities and income groups. Payments had become a de facto requirement for many types of diagnostic tests, medicines and specialist consultations. Substantial numbers of Russians reported abstaining from medical treatment or being unable to complete treatment regimes, particularly to obtain prescribed pharmaceuticals, because of financial constraints. Disparities in the types of services available widened, with the wealthy often accessing high-quality private care in major cities, while poorer and rural strata spent higher proportions of their incomes for

lower-quality services. An Organisation for Economic Co-operation and Development (OECD) report on the Russian health care system pointed to "a growing underclass without access to care" (OECD 2001) in Russia at the end of the 1990s.

2000–2010: Putin, Progress and Persistent Problems

By 2000 Russia's economy had entered a period of strong and steady growth that lasted until the 2008 recession. The rise to power of Vladimir Putin at the same time strengthened state administration, including governance of the health sector. The drivers of Putin-era health policy and reforms, both fiscal and political, stand in sharp contrast to those of the Yeltsin era. While Yeltsin's government was driven to cut costs in a period of sharp economic decline, and moved toward market solutions under Western influence, Putin used a budgetary surplus to turn policy back in a statist direction under the watchword of "sovereign democracy" (Cook 2010). In an economically resurgent Russia the Putin administration focused on population decline and low birth rates, especially their negative implications for economic development and national security. Putin declared health and social policy as "priority tasks" in addressing the demographic crisis. His policies succeeded in greatly improving the performance of Russia's health sector, but also confronted obstacles and persistent problems.

Under Putin, government expenditures in the health sector grew, salaries recovered, the Health Ministry reasserted regulatory control over the system, and new regulations and price controls were imposed on pharmaceuticals. In mid-decade the government turned its focus to demographic decline by launching a NPPH that focused first on pro-natalist improvements in care for pregnant women and newborns and extending life expectancy, then added programmes directed at diseases that had been contributing to high mortality rates, such as TB and cancer. Substantial additional federal budget funds were allocated to these goals. In 2008 officials made raising access and quality of health care for the whole population a major priority (Shishkin 2008a, b). These efforts helped to bring notable improvements in health outcomes and indicators that are shown in Table 1. The government also launched a series of reforms that were designed to deal with problems inherited from the 1990s. Policy relied on both carrots and sticks in the effort to reduce informal payments by, on the one hand, increasing official salaries and formalizing additional "cash register" payments; and, on the other, initiating a campaign against complicit doctors by the police and procuracy (Tompson 2007; Shishkin et al. 2008a). The health insurance reform was revived in the hope of introducing competition, cost controls and consumer choice into the system. In 2008 a pilot programme of "single channel financing", designed to end the confusion and competition between regional health committees and health insurance funds, was launched in 19 regions. Efforts were also made to move away from input-based financing of the health sector, to introduce output-based and qualitative measures of effectiveness and to differentiate medical professionals' salaries according to performance. Salary scales were adjusted to reward primary care practitioners and to discourage the system's entrenched over-specialization. The need to narrow the range of medical services in the "Guaranteed Package" was recognized, and proposals to introduce means-tested medical assistance for the poor were discussed.

By the end of the decade these reforms, in combination with rising incomes and declining poverty, had produced positive results. Key indicators of life expectancy, particularly child and maternal mortality, had improved, and rates of major infectious diseases had stabilized.

Health care became more accessible, and informal payments became less pervasive, though health sector wages stayed near the bottom of the urban wage scale (Potapchik et al. 2011). However, insurance reforms again largely failed (Popovich et al. 2011). Practices and structures inherited from the Soviet period, including input-based financing, over-specialization and over-reliance on hospitalization, proved remarkably persistent. The "Guaranteed Package" continued to promise more health care than the government could or would fund. And, while state funding for the health sector grew with the economy, "welfare effort"—the proportion of GDP expended in the public health sector— remained nearly stable at a modest 4 per cent of GDP. The 2008 "single channel" financing reforms had varying success. According to the authoritative European Health Observatory's 2011assessment of Russia's health system:

> The scope and depth of health reform has varied widely across the Russian Federation depending on the commitment of regional and local authorities, but there is much evidence that it is possible to effectively restructure regional health systems…successful reforms require holistic and well-sequenced approaches. …Partial reforms produce imbalances (Popovitch et. al. 2011: 146).

Russia's Contemporary Health Care System: Institutions, Actors, Processes

At present, health care for Russia's population is provided by four categories of institutions: public, "parallel", private and I/NGO. The system remains overwhelmingly public, with polyclinics, hospitals and research centres falling variously under federal, regional or municipal control. The number of institutions in the public sector has contracted sharply since 2000, with 40 per cent of inpatient and 28 per cent of outpatient facilities closed, including most small rural hospitals (uchastkovye) and other obsolete and marginal facilities from the Soviet period (Popovich et al. 2011). Change in the numbers of health personnel, by contrast, has varied across categories with the overall number per 10,000 population standing near its 1990 level. While the oversupply of specialists has been somewhat mitigated by wage incentives for paediatric and family care practitioners, the provider–patient ratio in Russia remains high by international standards. In sum, post-Soviet governments have had limited success in reforming the massive health sector infrastructure and labour force they inherited.

There also remains a "parallel" system of health care provision that is run and financed by some governmental ministries, including the presidential administration and ministries of defence, interior, economy and others. The parallel system includes polyclinics, hospitals and sanatoria, budgeted and administered separately from the Ministry of Health and Social Development. It is estimated at about 15 per cent of outpatient and 6 per cent of inpatient facilities. This system provides privileged access to ministry personnel and their families, to those in voluntary insurance schemes (see below) and sometimes also to the public through paid access. The "parallel" system is an apparent holdover of the top tiers of the old Soviet nomenklatura system (Popovich et al. 2011; Tompson 2007). "Nomenklatura" is a term that refers to the top ranks of the Soviet political, economic, security and administrative elite. Literally, "nomenklatura" is the list of positions that are of sufficient importance to require that appointment be approved by a Communist Party committee.

Russia's formal private health sector remains small and is concentrated in urban areas and in certain specialties such as dental clinics. As of 2010 the whole of the Russian Federation had only 124 private hospitals, 120 of them in major cities (federation-wide

there are more than 6,500 hospitals) (Popovich et al. 2011: 38). A small voluntary health insurance (VHI) system operates in large Russian cities, covering less than 5 per cent of the population, purchased mainly by employers and providing access to privileged facilities (Potapchik et al. 2011). The clientele of such private and privileged facilities are mostly wealthy Russians and foreign expats; anecdotally, care in these facilities has been compared favourably to that available in Britain, France and Boston, Massachusetts (maternity care in the last case). Some Russians also access cross-border care, or engage in health tourism. Upper-income urbanites travel abroad, mainly to Israel, Germany and Finland, but also to other destinations, for various types of care at their own expense3 (Tikkanen 2005; Budiansky 2012). Numerous foreign governments promote such tourism through trade shows in Moscow and, in the case of Finland, newspaper advertising. Little information is available on the scale of such medical or health tourism.

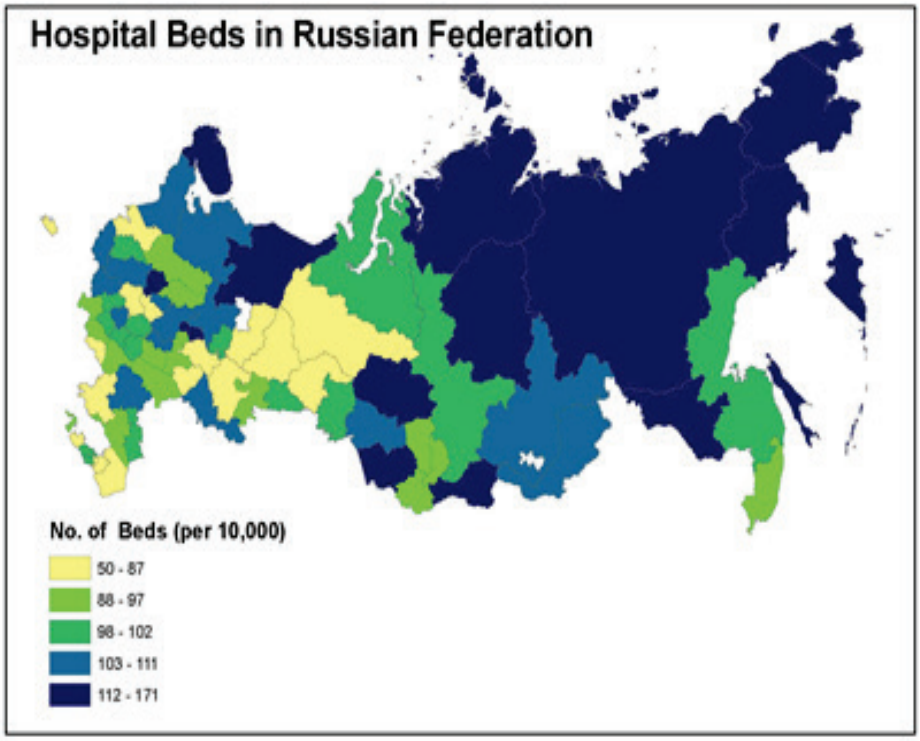
Finally there is a small I/NGO sector in health that plays some role in direct provision of care and health policy advocacy. Its main work and influence has been in the area of infectious diseases, especially HIV/AIDS. In some Russian regions, in collaboration with regional governments and international organizations including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GATM), NGOs have played a significant role in providing outreach, medications, harm-reduction programmes and support for affected groups (Lussier and McCullaugh 2009; Pape 2015). A few I/NGOs, including WHO and the International Organization for Migration (IOM), also do outreach and advocacy for migrant workers' health care. These organizations play a constructive role, particularly working with those affected by HIV/AIDS for years while the government did little, then helping to shape its response when, in 2005, Putin's administration began to devote major policy attention and financing.

Financing and administration

As explained above, Russia's health care system is financed by a mix of general budget revenues (about 40 per cent), health insurance funds (25 per cent), out-of-pocket payments (almost 30 per cent), and VHI. NGOs and other private payments make up the residual 1–2 per cent (Starodubov et al. 2007; Popovich et al. 2011). Per capita expenditures have increased substantially in real rubles because of growth in GDP (see Figure 3), but the level of "welfare effort" in health, a key measure of public commitment, has remained fairly stable at about 4 per cent of GDP. This is moderate given Russia's level of development, and well below OECD and European Union (EU) averages. According to official sources, private health expenditure accounts for another 2–3 per cent of GDP, bringing total health expenditure to above 6 per cent. However, these figures are disputed, particularly the public–private ratio, and in any case the proportion of private expenditure is high in comparative terms. Higher private expenditure tends to be associated with poorer public health outcomes, and is another of the likely factors contributing to the Russian health system's poor efficiency and performance relative to expenditures.

[3] Research on the scope of cross-border care and health tourism remains very limited, and estimates of the numbers involved vary widely, though most sources report that this is a growing phenomenon. In fact a trade conference devoted to promotion of Russians' health tourism has been held annually in Moscow, with sponsors from a number of European, Asian and Middle Eastern states.

Figure 3. Distribution of hospital beds by region, 2009.



Note: This figure was created by the author in ArcGIS using data from Zdravookhranenie v Rossii: Statisticheskii sbornik: ofitsial'noe izdanie (Federal'naia sluzhba gosudarstvennoi statistiki 2009).

The "Guaranteed Package" of health care

Russian citizens have a constitutional right to free health care; the scope of that care is specified annually in a legislative bill defining the "Guaranteed Package", which includes a comprehensive range of benefits. Every citizen is assigned to a polyclinic based on place of legal residence, and in theory can access all covered care without charge at point of service. Pharmaceuticals prescribed to outpatients, dentistry, optometry and some other services are excluded and subject to formal charges for most of the population (exceptions are made for veterans and a few other categories). However, budget allocations for health have never been sufficient to fully fund these guarantees. The gap between the "Guaranteed Package" and actual resources has led to persistent deficits at all levels of public financing, with estimates varying widely, from 11 per cent to 40 per cent of the total (Blam and Kovalev 2003). This chronic pattern of underfinancing contributes to pervasive informal payments in Russia's health sector and to limits or exclusion from access to care.

Obstacles to Universal Access and Drivers of Fragmentation in Russia's Health Sector

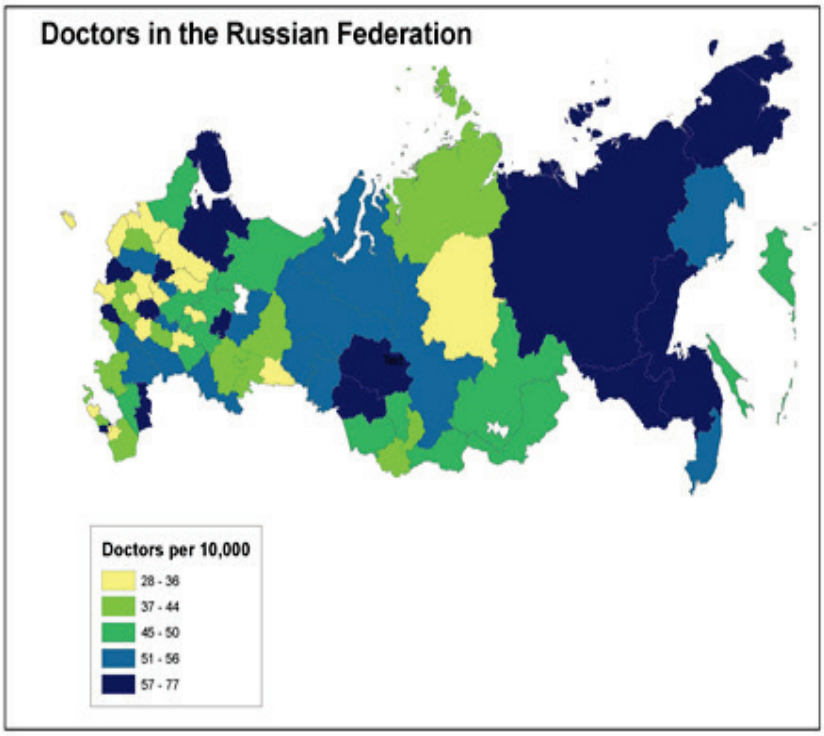
Inequality[4]

Three distinct dimensions of inequality affect access to health care in Russia: household-level, regional-level and rural–urban differences within regions. At the household level, Russia's economic recovery and growth from 2000 to 2008 brought rising incomes and declining poverty, but high levels of inequality persisted and grew. According to Tom Remington's authoritative study, in the Russian Federation, "Inequality rose with poverty in the 1990s, and then rose still faster in the 2000s as poverty declined" (Remington 2011: 38-39). High levels of inequality helped to produce large disparities in the levels and types of health care accessed by patients. Evidence from the Russian Longitudinal Monitoring Survey (RMLS) shows that use of paid facilities has increased steadily among the top income quintile, to more than 20 per cent in Moscow and St Petersburg (Popovich et al. 2011). Disparities in use of private services between the wealthiest quintile and all others have grown since 1998. Private outpatient facilities take in one-third of total household health expenditure while serving less than 4 per cent of patients federation-wide. Russians in the top income quintile seek medical help almost 40 per cent more often than those in the bottom quintile, and spend twice as much in absolute terms but ten times less as share of income than the bottom quintile (Blam and Kovalev 2003, 2006). The vast majority of patients and payments go to the public sector, including both "cash register" and out-of-pocket payments, and the overall burden of expenditure is income-regressive; that is, the proportion of expenditure on health care is much higher in poorer households.

There is also stark differentiation in fiscal capacity, per capita expenditure and health outcomes across Russia's regions (now consolidated from 89 to 83 regions). Russia's post-2000 economic growth has depended strongly on exports of natural resources, especially regionally concentrated oil and gas, leading to sharp polarization of regions by level of economic development and per capita GDP. The cross-regional distribution of health financing became more unequal during economic recovery. In 2011 the reported difference in real per capita expenditures between the highest and lowest-spending regions was 9–10-fold (Shishkin 2006; World Bank 2011). The distribution of medical personnel and facilities is also very uneven across Russia (see Figure 4). Comparative regional studies indicate that residents of poorer, less-developed regions spend higher shares of their income on health care than those living in wealthier regions. Residents of poorer regions pay because no free specialists or diagnostic equipment are available, while those residents of wealthier regions typically pay to get higher-quality care. Finally, health outcomes differ starkly across regions; there is, for example, a 3–4-fold difference across regions in the key indicator of infant mortality.

[4] This section draws on the results of numerous national surveys, including the Russian Longitudinal Monitoring Survey (RLMS), 1994–2000; the National Survey on Public Well-Being and Engagement with Social Programs (NOBUS) in 2003; and the Consumer Sentiment Index Survey carried out in March 2006, as well as regional surveys reported in Aarva et al. 2009; Blam and Kovalev 2006; Satarov 2001; and other sources.

Figure 4. Distribution of doctors by region, 2009.



Note: This figure was created by the author in ArcGIS using data from Zdravookhranenie v Rossii: Statisticheskii sbornik: ofitsial'noe izdanie (Federal'naia sluzhba gosudarstvennoi statistiki 2009).

Within regions, urban–rural differences also matter. Rural populations have less access to health services, and poorer overall health, than do urban populations. Federation-wide the average number of doctors is almost 50 per 10,000 population in urban areas, and a little over 12 per 10,000 in rural areas. A four-region study concluded that the consequences of commercialization were more severe in the poorer provinces than in wealthier cities and regions (Blam and Kovalev 2006). As the European Health Observatory assessment summed up the situation, "the poorest segments of the population receive the least medical care" (Popovich et al. 2011: 167). In all contexts, men's health is worse than women's: there is a 12-year gender gap in life expectancy, while for the working-age population male mortality is 3 times higher than female.

Informality and out-of-pocket payments

Private out-of-pocket spending on health care, both formal or "cash register" and informal, remained fairly steady from 2000 to 2006, at 35–40 per cent of total health care spending, then fell with the 2008 recession (Popovich et al. 2011). The largest share of household payments went to pharmaceuticals, with 80 per cent of patients paying part of the cost for drugs. Informal cost-sharing remained pervasive in the hospital sector, with 80 per cent of patients paying part of the cost. Unrecorded and unregulated work and monetary exchanges, as well as reliance on personal and social networks to access and provide services, remain pervasive in health care.

It is notable that the practice of informal payments persisted through the period of economic growth and increasing state expenditure on the health sector. According to the well-known health sector expert S. Shishkin, "Despite the growth of state financing of

health care and of state-guaranteed free services, informal payments seem to have increased. Forty-five percent of doctors surveyed said that "envelope" payments had increased in the past five years, forty-two percent that such payments had remained stable" (Shishkin et al. 2008a: 231). While the proportional contribution of informal payments to doctors' incomes appears to have declined, there is evidence that the practice has taken on systematic, market-like features, responding to relative wages, degree of expertise and quality of equipment. Payments depend on types of institutions and qualifications of doctors; they are higher in regional and urban hospitals, lower in district (raion) hospitals and small cities. Informal payments were found to be lower in polyclinics, and lower for those categories of doctors who received large wage increases under the NPPH, or who have opportunities to earn in private practices. Paediatricians are least likely to take such payments. There is some evidence of charges being adjusted according to patients' means, but payments influence access and quality. Most respondents said that they received some free services, but the survey concluded that patients who do not pay when asked or who received hints risked not being admitted to a hospital or being admitted to a very crowded ward; not receiving current medications, but cheaper ones; having older technology used; having a less-qualified surgeon; not receiving adequate attention from doctors and nurses; and more (Shishkin, 2008a: 242-243).

While basic care in polyclinics remained broadly accessible in Russia, part of the population reported exclusion or abstention from at least some types of medical treatment because of inability to pay. Data from 1997 show that abstention from various types of care increased as income decile fell, excluding 18–50 per cent of those in the lowest income decile from various types of care. The 2003 National Survey on Public Well-Being and Engagement with Social Programs (NOBUS) found that 10–20 per cent of patients could not get access to care or complete treatment regimes because of cost, often the cost of pharmaceuticals (World Bank 2005; Manning and Tikhonova 2009).
One meaningful measure of limits is access to the government's "Guaranteed Package" of care, which is supposed to be covered by Mandatory Medical Insurance. The Package specifies free-of-charge services to include consultation with a GP or specialist, and two or three diagnostic procedures. In practice, access to this combination of services usually requires payment. A survey of outpatient facilities in three Russian cities, for example, found that only 20–30 per cent of non-paying patients received all guaranteed services, while the majority of paying patients did. Catastrophic medical expenditures—that is, spending of more than 30 per cent of household income on medical care—affected more than 8 per cent of households in the mid-2000s, including 5 per cent of the top income quintile and 10 per cent of the bottom quintile. As one group of researchers summarized the situation, "Steady growth of private expenditures on medical services has been associated with inequality of access among income groups. Spontaneous commercialization has promoted de facto segregation of citizens on the basis of income, place of residence, and work" (Blam and Kovalev 2006: 407).

Research shows recent improvement in indictors of health care inequality and exclusion at both household and regional levels. By 2009, national survey evidence found declines in the percentage of households whose members abstained from necessary medical help and purchase of necessary medicines because of inability to pay. Informal payments continued, but they became somewhat less pervasive for outpatient (though not for inpatient) care, and less coercive, often taking the form of voluntary "gratitude" payments rather than required payments in advance of treatment (Potapchik et al. 2011). Inter-budgetary transfers from the federal level to regions have somewhat diminished regional differences in per capita social expenditures (World Bank 2011). Huge

increases in expenditures for HIV/AIDS (see below) have made free antiretroviral (ARV) therapy available to many of those affected by the disease.

Social exclusion: Unregistered migrants

The discussion in this paper so far applies to health care for Russian citizens, legal residents and those registered to work and covered by the MHI system. Two additional groups that inhabit the Russian Federation are often subject to "social exclusion". The first is the large and shifting population of migrant workers. Migrants congregate mostly in Russia's "global cities", large metropolises that draw both concentrations of educated Russian elites in areas such as finance and business, and also an underclass of service, retail and construction workers, irregular and often temporary. Russia now has the second largest labour migrant population in the world, after the United States. Often, poor sending countries have come to rely on migrants' remittances for substantial parts of their GDPs (as much as one-half of GDP in the case of the most remittance-dependent country, Tajikistan). Thus, migrants now constitute an institutionalized part of the political economies of both Russia's highly-stratified "global cities" and the Eurasian periphery, and represent a new dimension of inequality (Abdurazakova 2010; Hertzer et al. 2009; Buckley 2008; Heleniak 2008; Yudina 2005).

Though pejorative stereotypes in Russian media and elsewhere often present migrants as health threats with high rates of infectious diseases, research finds that those arriving generally exhibit the "healthy migrant effect". This reflects a tendency for migrants to be healthier overall than the receiving society because of their youth, positive health selectivity and better health behaviours (in respect of drinking, smoking, diet) than the native Russian population (Buckley et al. 2011). A number of factors militate against migrants remaining healthy, and substantial numbers do need medical care while in Russia. These factors include the conditions in which migrants work and live, their displacement from home communities and families, lack of knowledge about infectious diseases, conditions of detention and xenophobic violence. Accident rates are high in employment areas where many migrants work. Russia's Federal Labor Inspectorate reports that the majority of workplace accidents, and nearly 40 per cent of deaths, occur in construction, where few even skilled workers were found to be familiar with safety regulations (Olimova 2010). As long as workers are informal, employers bear virtually no responsibility for health and safety conditions. Poor, crowded and sometimes unheated living quarters contribute to infectious diseases, particularly respiratory illnesses. Many migrants live on construction sites, or in non-residential buildings and barracks or other marginal housing provided by employers. Isolated from their families, some may engage in risky sexual and other behaviours. Several studies have shown that levels of information about transmission, prevention, diagnosis and treatment of common infectious illnesses (that is, TB and HIV/AIDS) among migrants are low (Weine et al. 2008; Gilpin et al. 2012). In addition, unregistered migrants are often subject to arrest and sometimes deportation; in either case they may be held in Russian prison facilities where levels of TB and MDR TB are high. The Russian Federation is committed, under international agreements, to provide emergency medical care to all in its territory. My research in Moscow during spring 2012 confirmed that public facilities do provide emergency care to migrants who lack legal status, but little else. According to one survey response, "Doctors provide emergency assistance, then look for a residence permit. When there are accidents, we collect money among ourselves and send the injured person home" (FIDH 2011 p. 16). Legally, it is required that anyone diagnosed with TB be treated in Russia, but migrants have to pay for treatment, so in practice many continue to work or return home for treatment. In sum, migrants have to pay for all but emergency care, and even access to paid care (finding facilities that will

accept them) can be difficult. Treatments are expensive relative to wages, leading many to wait out illnesses, self-treat or return home ill. Fear of being reported and deported or imprisoned also deters access.

The near-exclusion of many labour migrants from health care in Russia has several implications for public health in the Russian Federation and for migrants' health. Their unregistered status pushes some migrants into a grey economy where fake medical certificates and other documents may be purchased, and the potential here for undermining public health and monitoring measures, especially for infectious diseases such as TB, is obvious. Though there is no clear evidence that migrants suffer more health problems than their compatriots who remain at home, some do become ill. Of surveyed migrants who have returning to Tajikistan, for example, 11 per cent consistently cited "worsening of health" as their reason for returning, and medical care in Moscow as too expensive and difficult without citizenship (Hemmings 2010: 17; ILO 2010: 18). Doctors in Dushanbe, Tajikistan, report illnesses related to hypothermia and a rise in TB and HIV/AIDS among returnees (FIDH 2011-12: 16). The Bishkek, Kyrgyzstan, office of the IOM reports that half of all migrants from that Central Asian state return from Russia in worse health than when they left (Grenfell 2011: 33). Finally, excluding a large, vulnerable labour-active urban population from care, particularly for infectious diseases, militates against the success of public health goals and campaigns in Russian society.

Stigmatized groups

Finally, there is the issue of stigmatized groups, including sex workers, intravenous drug users (IDUs), and those living with HIV/AIDS: all populations that are vulnerable to health problems, including infectious diseases. During the 1990s and early 2000s the numbers of people in these categories grew rapidly while they were largely excluded, or self-excluded, from public health services. The Russian Federation has become a major destination for drugs (mainly heroin) from Afghanistan, and experts agree that the country has a serious problem with intravenous drug use, especially among young people (Kramer 2011). The Russian medical communities' approach to IDUs, held over from the Soviet period, is largely punitive. It requires official registration and sometimes involuntary detoxification, and generally rejects methadone therapy, rehabilitation and harm-reduction measures such as needle exchanges. IDUs became a significant source for the spread of HIV/AIDS in the mid-1990s, with Russia experiencing one of the highest rates of increase in the world by the early 2000s (though absolute numbers of cases remain moderate by international standards and regional incidence varies greatly).

Until 2005 the federal government paid little attention to HIV/AIDS despite its rapid spread in Russia and the urgings of international organizations to prioritize its treatment and prevention (Twigg 2007; Lussier and McCullaugh 2009). That neglect had a disproportionate impact on young Russians; HIV/AIDS has a prevalence rate of over 1 per cent among those aged 18–24 years (Twigg 2007). From 2005 policy shifted dramatically. The government has devoted much more policy attention and resources to HIV/AIDS, with massive increases in expenditure.5 It has mounted impressive efforts, establishing a network of regional AIDS centres that provide ARVs and other services. However, the groups most at risk—IDUs, sex workers, gay men—continue to be stigmatized. Efforts to humanize treatment of IDUs have been resisted and reversed, and

[5] See Twigg 2007 for explanations of this shift as well as data on the scale of expenditures and programmes.

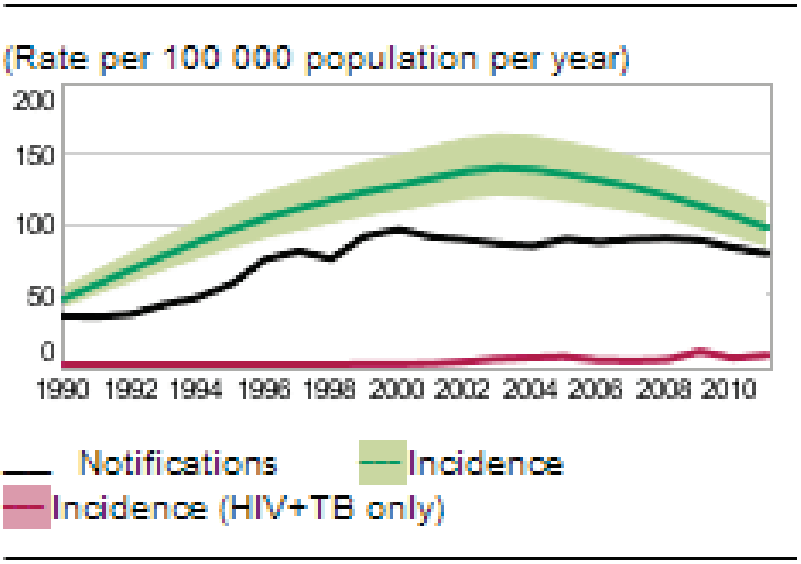
the overall conservative, patriarchal and explicitly anti-homosexual ideology of the Putin administration reinforces exclusion.

In the face of the federal government's neglect, I/NGOs and some regional health authorities have played the major role in dealing with these health problems, treating, counselling and educating around issues of drug use and HIV/AIDS. Studies in several regions show that NGOs, in some cases with international funding and sometimes in cooperation with regional governments, have provided ARVs, counselling and guidance to people living with HIV and AIDS; needle-exchange programmes for IDUs; condoms and counselling for sex workers; and broader education programmes directed to youth and the general population. ARVs have been provided directly to local NGOs by the GFATM, bypassing the federal government, and sometimes distributed with the help of regional health authorities (Lussier and McCullaugh 2009; Pape 2014 in Pape 2015). While this picture is drawn from research only in several regions that may not be representative, it shows that lower-level governments, civil society organizations and international partners have mobilized to fill this "gap" left by the state. At the same time, these actors have limited capacity and reach; they cannot provide comprehensive or coordinated public health approaches and campaigns that would be adequate to deal effectively with such major public health problems federation-wide.

Assessing Russia's Health System: Performance and Outcomes

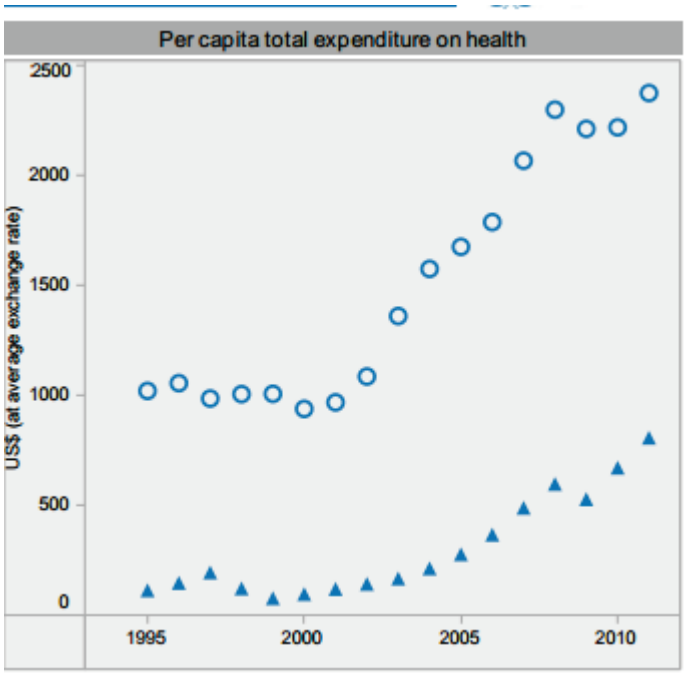
After declining sharply during the 1990s, the health status of Russia's population has improved greatly since 2000. It is, of course, difficult to separate the impact of health policies and programmes from broader improvements in living conditions over the same period in accounting for health gains. However, indicators that are considered sensitive to health interventions, such as infant, under-5 and maternal mortality, have seen the greatest improvements, and compare well relative to other states with similar levels of development and health expenditure (World Bank 2011) (see Table 1 and Figure 5). Increased financing and other modernizing measures have contributed to improvements across all Russian regions. Standard vaccinations cover 97–98 per cent of the population. There have been impressive gains in control of communicable diseases; 75 per cent of those newly diagnosed with TB are now getting WHO-recommended treatment, up from 44 per cent in 2004, while TB mortality has declined by 25 per cent (Popovich et al. 2011; UNDP 2010 (see Figure 6). The broad effects on increased life expectancy are also shown in Table 1.

Figure 5. Tuberculosis in the Russian Federation, 1990–2010.



Source: (WHO 2006–2013)

Figure 6. Total per capita expenditure on health, 1995–2010



Note: circles = average for WHO European region; triangles = Russian Federation. Source: WHO, 2006–2013.

In recent years the Russian Government has also begun to address broader behavioural factors that affect the population's health, including smoking, alcohol consumption, diet and exercise. The National Health Concept to the Year 2020 sets out ambitious targets and concrete measures, including promotion of "health lifestyles" as well as improvements in health system performance. In 2010 the Russian Government adopted a National Anti-Tobacco Policy Concept, based on ratification of the WHO 2008 Framework Convention on Tobacco Control. Recent policy initiatives stress the priority of preventive measures in public health protection. "Healthy Lifestyle" programmes are

directed particularly to young people, and include at least some information about STDs and HIV/AIDS prevention (though most schools still do not provide instruction in these areas). The goals set by the National Health Concept—to increase the population to 145 million, life expectancy to 75 years, and decrease mortality to 10 deaths per thousand—are overly ambitious, and the effectiveness of "Healthy Lifestyle" programmes still uncertain, but the prioritization of preventive measures over curative health care represents a promising initiative (Popovich et al. 2011). At the same time, in comparative international terms, health outcomes are not as good as they should be given Russia's level of development and health expenditure. While overall expenditure on health care is relatively low for the European region, with which it is often compared, it is in the expected range for middle-income countries. However physical inputs in Russia are high relative to human development outcomes (Popovich et al. 2011). As noted in the introduction, countries spending 30–40 per cent less on health care have mortality levels similar to Russia's. Rates of infectious diseases have stabilized but remain comparatively high, especially TB and MDR TB; in 2010 Russia was still among the 22 countries most affected by TB and among the 10 most affected by MDR TB (UNDP 2010). The health system remains relatively ineffective at treating non-communicable diseases. Middle-aged male mortality remains exceptionally high. Women live longer but have comparatively poor health in their senior years. Levels of adult morbidity and disability are comparatively high. Much of the population reports low satisfaction with their health care in surveys. How can the efficiency and effectiveness of the system be improved?

Policy Recommendations

Most recommendations for efficiency improvements in Russia's health care system focus on technical aspects of reform, proposing changes in organizing, management and financing. Many such recommendations have been mentioned above: shifting resources from inpatient to outpatient, and specialized to primary care; moving from input- to output-based financing mechanisms; introducing incentives to reduce volume of care and over-specialization; and designing and implementing an effective single channel financing system. These recommendations make sense, and experiments based on them in some Russian regions have produced positive results (World Bank 2011). Efforts in these directions should continue, but by themselves, they seem likely to produce limited results. Another major recommendation made by analysts is for the Russian Government to focus much more on preventive measures, including education, as well as tax increases and regulatory policies that limit access to tobacco and hard liquor. The latter would, in turn, reduce both road traffic (and other) accidents. To date there have been some initiatives toward education and stronger regulatory policies in these areas. Such policies have been effective in Europe, particularly in the Nordic states which in the past also experienced high rates of alcohol use.

My assessment suggests that inequalities in distribution and access to health services also contribute to the Russian system's poor performance and inefficiency. These inequalities—inter-regional, urban–rural, income-based, and social inclusion/exclusion—are described above. Inter-regional differences in expenditure per capita and health outcomes in Russia remain stark even with federal compensation funds. Rural areas remain underserved, leading to more reliance on hospitalization by their populations. Those in the poorest quintile most often abstain from necessary care or (more commonly) from purchase of prescribed medications because of inability to pay. A World Bank study found that informal payments were linked with worse health outcomes, probably because of obstacles to access (World Bank 2011). Access to health

services is poor for marginalized social groups and unregistered labour migrants, both at risk from infectious diseases.

There is some evidence that equalizing trends in expenditure improves efficiency and performance. For example, regional gaps have narrowed significantly in indicators that have been the focus of federal financing and policy—that is, maternal and infant care—indicating the effectiveness of equalizing expenditure (UNDP 2010). Other equality-enhancing reforms that extend insurance coverage to outpatient prescription drugs provide coverage at least for primary care and infectious diseases to all residents. They also provide de-stigmatized outreach and harm-reduction programmes for marginal groups, and seem likely to improve the system's efficiency in reducing disease and mortality. Extending basic care for treatment for infectious diseases to migrants, and ultimately expanding the system of work permits so that all can register, would limit exclusion and arguably increase the effectiveness of public health measures in Russian cities. Overall, public health expenditure is low relative to private expenditure, a pattern generally associated with poorer public health outcomes. While "throwing money at the problem" may not help, as analysts argue, a structure of expenditure that is more public, less out-of-pocket and more equal seems likely to improve performance, efficiency and the health of the Russian population.

Conclusion

Russia's health care system has a number of strengths: it aspires to universalism, providing a constitutionally guaranteed right to health care for all citizens. Public policy is designed to include all citizens in the MHI system. The government is seriously committed to control of infectious diseases through public health measures, and has brought down rates substantially from the 1990s. Access to free emergency medical care appears to be universal. The system has prioritized the needs of newborns, mothers and young children. Since 2005 the government has directed much more funding and attention to HIV/AIDS, and has permitted regional and non-governmental actors to introduce harm-reduction and education efforts. The recent initiation of "healthy lifestyle" programmes represents a progressive move toward a preventive rather than a curative approach to health care. The very significant overall improvements in key health indicators since the 1990s, though partly a product of economic recovery and income growth, should be recognized and appreciated. It is striking that health care expenditures and performance have improved markedly, even as governance has moved in an increasingly authoritarian direction, providing an exception to much of the recent comparative literature that finds a correlation between democracy and health across many states.

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