Genuine Federalism in the Russian Health Care System: Changing Roles of Government

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Abstract The reforms that have affected the Russian health care system since the breakup of the Soviet Union, principally those in the general administration of the Russian Federation, have suffered from inconsistency and the absence of a strategy. The various reforms have caused a shift from a national health system characterized by highly centralized management and control, typical of the totalitarian uniform state, to a highly decentralized but fragmented multitude of state systems. Each of these systems is relatively centralized at the local level and run by local administrations with limited government infrastructure and experience. The role of government in the emerging system, and in particular the role of the federal government, remains ill defined. As a result, there is a grave risk that the Russian health care system may disintegrate as a national system. This undermines (a) the prevailing universal and fairly equitable access to care, (b) stabilization of the system following a long period of transition, and (c) the long-term reform that is required to bring the Russian health care system up to par with the health care systems in other developed countries. A rapid transition to a genuine federal health system with well-articulated roles for different levels of government, in tandem with implementation of the 1993 Compulsory Health Insurance System, is essential for the stabilization and reform of the Russian health care system.

Since the breakup of the Soviet Union in 1991, there have been considerable shifts in the allocation of legislative and executive powers affecting the Russian health care system. These shifts have influenced the relative roles of the central or national government vis-à-vis local government as well as the relative roles of government vis-à-vis other old and newly established public institutions that form part of the system.

The various changes leading to these shifts, some constituting con-

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Figure 1  The Russian Health Care System, 1991. FMOH = Ministry of Health, RAMS = Russian Academy of Medical Sciences, SCSES = State Committee for Sanitary and Epidemiological Surveillance, SES = Sanitary and Epidemiological Surveillance, NS = Nursing Schools (Intermediate Medical Education), H = Medical Institutes for Higher Education, P = Postgraduate Training.
• Institutions of the Russian Academy of Medical Sciences managed by the federal government and financed through the federal budget (panel D);
• Institutions run by other ministries and financed through the federal budget as well as enterprise incomes (the Parallel Systems [not shown in Figure 1]);
• Institutions such as medical cooperatives and private entities financed by their own income (not shown in Figure 1). \(^2\)

Medical care is provided in the Ministry of Health (MOH) system, the Parallel Systems, and the Russian Academy of Medical Sciences, with the MOH system controlling 90 percent of medical resources (Chernichovsky, Barnum, and Potapchik 1996). \(^3\) The left panel of Figure 1 shows the structure of this system. The federal level includes the FMOH and the Russian Academy of Medical Sciences, clinical institutes, central basin or interregional hospitals and polyclinics, and other federal institutions. The federal level institutions mainly provide highly specialized care. General medical care is provided at the oblast and local levels. The Parallel Systems provide medical care to the employees (and sometimes to their dependents) of various ministries through the enterprises that employ them. These health care institutions are directly attached either to an enterprise or to the ministries that oversee them.

Until 1991, health promotion activities were the responsibility of the FMOH. Since then, the MOH system has retained responsibility for some aspects of health education through various types of campaigns, while the SCSES has been responsible for implementing federal, regional, and local regulations for health improvement and disease prevention programs. It has recommended ways to improve hygienic and anti-epidemic measures to be carried out by state bodies, public organizations, enterprises, officials, and citizens. The SCSES has also promoted sanitary practices and supplied information to the population about health hazards in the environment and about practices that it has identified as detrimental to people’s health. In addition, it has been responsible for quality control in the production of vaccines.

For reasons discussed later, since 1991 the SCSES has also carried out health promotion functions separately, in cooperation with the FMOH.

\(^2\) Until 1993, the number of such institutions was not significant. No reliable information about this group is available to date.

\(^3\) Some health-related activities, such as the rehabilitation of the disabled, were carried out through the Ministry of Social Protection, which has since been abolished.
These functions have included administering preventive medical tests for workers at risk because of exposure to harmful materials, eliminating substances that increase the risk of occupational poisoning, and controlling infectious and noninfectious diseases. The SCSES and the FMOH have also held joint responsibility for health education, specifically in the area of hygiene. Special services and departments—for instance, the army, railways, and internal affairs—carry out sanitary and epidemiological surveillance through their ministries.

Environmental protection is the joint responsibility of the SCSES and the Ministry of Nature.4 The SCSES defines the levels of hazardous substances in the environment while the Ministry of Nature defines and monitors standards regulating rational use and renewal of natural resources. Coordination of activities between these two institutions is defined in regulations signed by both authorities. The SCSES monitors all types of ionizing radiation in inhabited locations, while the Ministry of Nature monitors global radiation. Some functions are carried out cooperatively. For instance, the Ministry of Nature monitors emission levels of domestic or industrial pollution following approval by the SCSES.

Medical education is carried out at the federal level only in institutes or academies funded directly by the FMOH. Contrary to the practice in industrial democracies, these medical institutes are not affiliated with independent research institutions. Continuing education for physicians is mainly provided under the FMOH, but also by institutions in the Parallel Systems. Training of paramedical personnel is carried out at all administrative levels (federal, oblast, and local), mostly within the FMOH system.

Medical research is carried out largely at the federal level in the research institutes of the Russian Academy of Medical Sciences and the FMOH, with the exception of three oblast-level research institutes. For research, the Russian Academy of Medical Sciences is financed directly by the Federal Ministry of Finance, with approval from the Federal Ministry of Science. With respect to clinical activity, however, the academy is financed directly by the FMOH.

Until the late 1980s, management of the health system in the former Soviet Union was completely centralized (Rowland and Telyukov 1991; Telyukov and Caper 1991). The different institutions making up the system were fully integrated vertically: the same authorities handled finance,

4. Global environmental control, which is not part of the immediate protection of the human environment, is not discussed here.
management, and provision of care. Regardless of the level of administration and the source of financing, the system was managed according to strict directives from Moscow concerning the following critical aspects of the system. First, heads of the oblast-level health authorities and main institutions were appointed only after Soviet FMOH confirmation. Second, the FMOH periodically established investment and development needs primarily in terms of hospital beds and "visit capacity of clinics." Third, although the system was financed through oblast (state/province) budgets, mandatory allocation norms linking manpower, supplies, and operating budgets to the number of hospital beds and the "visit capacity of clinics" were enforced by the Soviet Federal Ministry of Finance and the Soviet FMOH (Chernichovsky, Barnum, and Potapchik 1996). The central authorities thereby created a hierarchical and uniform system and approach to care across the Soviet Union.

**The Soviet Record: Successes and Failures**

In spite of persisting regional variations in health, medical, and socio-economic indicators through the end of the Soviet era (Table 1), the centralized Soviet health system made a considerable contribution toward improving the health status of the population through the late 1950s (Tulchinsky and Varavikova 1996). Among other things, it did so by achieving regional equality in access to care over a vast nation. The Soviet allocation mechanism appears to have been effective in responding to variations in demographics (and mortality) and in ironing out geographical differences in income (Chernichovsky, Potapchik, and Tulchinsky 1998). Nevertheless, in comparison with other developed nations, by the end of the 1980s the Soviet system still had a poor record with regard to the health status of the population. Life expectancy was 69.2 years in the Soviet Union compared to 76 years in the industrialized democracies (Goskomstat 1994; World Bank 1993).5

Lifestyles and environmental hazards contributed to this dismal record (Feshbach 1996). But the Soviet health system also contributed to this record, at the very least due to its failure to either cope with or offset the prevailing risk factors. During the 1960s, Russia seems to have missed the epidemiological transition that other industrialized countries experienced, that is, moving away from a public health situation dominated by

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5. It is noteworthy that while Russia has not had the per capita income levels of industrialized democracies, comparatively speaking it has not lacked technological potential or real (numerical) resources in medical care (Chernichovsky, Barnum, and Potapchik 1996).
<table>
<thead>
<tr>
<th>Region</th>
<th>SMR (%) 1989</th>
<th>Personal Income per Capita (Rb)</th>
<th>Local Health Expenditure per Capita (Rb)</th>
<th>Cost of Care Index, 1990</th>
<th>Hospital Beds per 10,000</th>
<th>Doctors per 10,000</th>
<th>Nurses per 10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>98</td>
<td>2,900</td>
<td>116.8</td>
<td>1.08</td>
<td>139.6</td>
<td>43.3</td>
<td>143.6</td>
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<td>Northwest</td>
<td>100</td>
<td>2,730</td>
<td>99.0</td>
<td>1.00</td>
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<td>65.8</td>
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<td>Volgo-Vyatky</td>
<td>97</td>
<td>2,270</td>
<td>84.9</td>
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<td>143.5</td>
<td>38.9</td>
<td>117.8</td>
</tr>
<tr>
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<td>98</td>
<td>2,260</td>
<td>84.2</td>
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<td>Povolzhsky</td>
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<td>96</td>
<td>2,210</td>
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<td>1.00</td>
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<tr>
<td>Western Siberia</td>
<td>107</td>
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<td>105.8</td>
<td>1.03</td>
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<td>1.03</td>
<td>144.5</td>
<td>41.8</td>
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<tr>
<td>Far East</td>
<td>106</td>
<td>3,490</td>
<td>138.3</td>
<td>1.14</td>
<td>147.9</td>
<td>51.1</td>
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</tr>
<tr>
<td>Kaliningradskaya oblast</td>
<td>99</td>
<td>2,530</td>
<td>86.5</td>
<td>1.00</td>
<td>143.2</td>
<td>44.7</td>
<td>136.8</td>
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<tr>
<td>Russia</td>
<td>100</td>
<td>2,520</td>
<td>94.5</td>
<td>1.02</td>
<td>137.5</td>
<td>46.9</td>
<td>122.6</td>
</tr>
</tbody>
</table>

Source: Russian Federal Ministry of Health working tables.
Note: Rb = rubles
communicable diseases to one where noncommunicable diseases were dominant. The Russian health system failed to respond effectively to the emergence of the latter group of diseases as key contributors to ill health at a time when the industrialized democracies were making considerable gains in this regard (Chernichovsky et al. 1998).

"Federalism" in the Former Soviet Union

The reasons that the Soviet medical system failed to realize its potential are complex. It was not government's involvement in the system per se, but rather, the nature and qualities of this involvement that rendered the government ineffective and even detrimental. Considerable central government involvement in the health system has also been common in the West. This involvement has been principally confined, however, to policy making, health care finance, and national regulation. Considerable decentralized decision making and management, principally with regard to the provision of care, have been retained by local governments—especially in federal systems, medical institutions, and the medical professions. A lack of similar decentralized decision-making and management in the Soviet system contributed to the government's failure and, hence, to the system's dismal record.

According to Weaver and Rockman (1993), effective government means (1) setting and maintaining the right priorities, (2) targeting resources effectively, and (3) promoting innovation. Accordingly, for the first aspect, the central or federal government should be charged with setting a national policy framework, including objectives and priorities. For the second, the central government should (1) redistribute resources to meet priorities, including social equity, (2) stabilize the system, avoiding waste either through over- or underproduction, (3) support the production of goods that benefit from economies of scale and uniformity of consumption, and (4) handle externalities, the effects that are beyond the control of local government but that affect its population. The third aspect, promotion of innovation, could be supported by central government mainly through national research and training programs that may entail considerable economies of scale and through the promotion of successful local experiences in the finance, management, and provision of care.

These responsibilities of central government, principally those concerning the last aspect of effective government, should complement, however, the responsibility of local government: overseeing the effective allocation of the majority of health resources. Local government can be
more responsive to local needs and aspirations than central government, on the one hand, and to local costs or constraints of providing services, on the other hand. This responsiveness entails the promotion of innovative approaches that evolve from initiatives in response to local circumstances.\footnote{This particular discussion is largely based on Oates 1972.}

A health care system, particularly one like the current Russian system that provides universal entitlement, presents some additional challenges. First, while finances are mainly public, service provision need not be public. And the government need not even manage the public finances. This may call for an intricate relationship between the government and other public and nonpublic entities. Second, the concepts of “need” and adequacy of service are hard to define and quantify, and consequently can be points of conflict between central and local authorities. Third, in the interest of national economic policy, the national government invariably tries to contain cost of care and discourage expensive care models. Consequently, it has become common for the federal government to promote a set national health policy and national institutions through federal grants. Key elements of such a policy are equitable access, which involves redistribution of resources, and measures to contain cost of care, largely through the regulation of investment in costly technology and through the regulation of private-public mix (Chernichovsky 1995, 1996).

The establishment of effective government, especially in the federal system, is best secured when constitutionally and effectively there are set issues over which different levels of government and other institutions can make final decisions (Riker 1975; Lijphart 1984). This is in spite of the fact that in Western democracies the determination of these issues is usually a constant source of friction between local and central authorities (Peterson 1995).

The poor record of the Soviet system can be cast in this general framework of effective federal government, which is probably the only conceivable form of effective government in a nation as vast and varied as Russia. In spite of the legal stipulations of the Soviet constitution, there was not a genuine functioning federal health care system under the Soviet regime. There were no activities over which a regional government, as a member of the federation, could make final decisions in response to local circumstances. Although regional health care systems under the Soviet regime were financed from their own budgets (the share of local expenditure constituted 97 percent of total health expenditures in 1990), all
allocation and management decisions were based on uniform norms set by the central government in Moscow, as discussed earlier.\footnote{In this particular regard the Soviet system was deceiving by common Western standards as those are summarized by Lijphart (1984: chap. 10, Table 10.2). An examination of public finance sources by those standards might suggest that the Soviet system was highly decentralized, but it was not.}

The situation had several manifestations that led to the Soviet record. The centralized policy making and top-down management system eventually developed resistance to change regardless of circumstances, mainly in service (as opposed to industry) areas like health, which eventually became a low priority under the Soviet regime (Chernichovsky, Gur, and Potapchik 1996). This was reflected in the apparent lack of systematic evaluation of epidemiological data that could contribute to an effective health policy. Or possibly, when data were evaluated, too little knowledge, resources, and incentives were available to respond to the data in an innovative manner. Although planners appeared to respond to variations in overall morbidity and mortality or demographic factors, they did not respond effectively—primarily in the period after the late 1950s—to changes in the composition of morbidity and mortality and risk factors. Those changes required modifications in the orientation of care toward preventive medicine and health promotion in the community similar to those achieved in the West. Instead, allocation of resources eventually followed outdated criteria promoting the construction of hospitals rather than the provision of care in the community. The situation reflected two markers of the centrally planned system: uniformity and disregard of local and changing realities and an extensive approach that emphasized quantity and size rather than quality.

The tight control of the federal government over medical training and research and the absence of any other independent political and scientific forces within the health care system, notably independent professional associations and research and training institutions, contributed to the inflexible and uniform approach to medicine (Chernichovsky, Gur, and Potapchik 1996). This was accentuated by the prevailing view in the Soviet Union that medicine should be regarded as a vocation rather than a science. The resulting scientific isolation contributed to ignorance of advances in Western health technology and approaches.

The Soviet system was in sharp contrast with health care systems in Western federations (e.g. Australia, Canada, Germany) and even in unitary Western nations (e.g., the United Kingdom, Sweden). In all of these nations, regional or local states or authorities oversee their health care
systems, develop their own variants, and entrust professional associations with virtual freedom regarding the merits of the professions. Moreover, in most of those instances, while overseeing the health services, local authorities by and large have not run them.

In conclusion, it should be noted that the Soviet health care system was successful in those areas where the centralized unitary state has clear advantages: redistribution of health care and management of communicable diseases. It failed in those areas where the genuine decentralized federal state is successful: sensitivity to variations in circumstances over time and across locations, and the ability to promote innovation in the system through freedom of professional education and research and managerial initiative.

**Structured Reform and Decentralization**

During the period of perestroika, growing dissatisfaction with the health care system coupled with recognition of the poor health status of the population led to a quest for new ways to organize and manage health care in Russia (Rowland and Telyukov 1991; Telyukov and Caper 1991; Sheiman 1991).

The New Economic Mechanism introduced during the second half of the 1980s stipulated radical changes, intended to decentralize the management of medical care institutions in order to increase both their efficiency and their responsiveness to the population, by diminishing direct government involvement in the management of care. It was implemented in three locations: the city of St. Petersburg and the oblasts of Kemerovskaya and Samarskaya. Territorial medical associations (TMAs) were established as the organs responsible for managing and providing care for particular populations. The concept behind the TMA is similar to that underlying the U.S. health maintenance organization (HMO) and principles of managed care. In fact, the public TMAs were established as budget holders, assuming full responsibility for providing care to an enrolled population. The structure of each TMA was defined by local circumstances. The individual local health authority made the decision to form a TMA, subject to approval by the executive committee of the local council of people’s deputies.

This experiment, even by international standards at the time, was both

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8. **Territorial** here means local. A given administrative territory such as an oblast may have several TMAs. The TMA was confined primarily to the rayon, the lowest unit in the administrative hierarchy.
politically bold and conceptually innovative. In a number of respects it had promising results. Inpatient care declined in favor of care in community polyclinics, and work performance increased (WHO 1989). This led to a shift in the incentive to allocate resources to hospitals and made services in general more accountable to clients. However, people had no choice over the TMA they enrolled with. Moreover, no quality control and accountability mechanisms were established that would mainly have monitored potential underhospitalization resulting from the prevailing incentives.

In 1989 the Council of Ministers of the USSR issued regulations of the New Economic Mechanism in the health system (Ministry of Health 1989a). The regulations stipulated a transition from central, vertical management to decentralized management. They also stated that the local councils of people’s deputies would control most of the resources needed to maintain the local health system, taking into account regional variations in the health status of the population and in health care provision within each region.

Some additional changes took place at the national level. Beginning in 1989, staff norms, which were the main mechanism of central control, were no longer compulsory (Ministry of Health 1989b). As of 1988, the heads of health institutions had the right to set staff levels and salaries independently, within the framework of the existing wage bill. In addition, they could transfer funds from one line item to another, except for expenditures on salaries, food, and pharmaceuticals. From 1991 on, health institution managers could reallocate the entire budget across line items within the framework of the given budget (Council of Ministers 1991). Because federal norms for capital expenditures were last approved in 1987, budget development became the responsibility of the territorial authorities.

While the New Economic Mechanism and the ensuing legislation gave greater autonomy to the local health authorities, especially medical institutions, their principles did not stipulate a change in the governance of the system. Heads of health authorities were still appointed with the approval of the FMHOH, and the overall allocation schemes mentioned earlier remained binding, although appointed managers had more freedom to deal with line items within overall approved budgets. This was particularly true for medical facilities.9

9. At the federal level, several institutions began operating according to the new principles during 1988–1991. Among these were the Interbranch Scientific and Technical Complex for Microsurgery of the Eye, the Bakulev Scientific and Research Institute for Cardiovascular Surgery, and the Burdenko Scientific and Research Institute for Neurosurgery.
The changes stipulated by the New Economic Mechanism and what followed through 1992 were barely implemented, principally because local authorities lacked the required capacity to manage the new responsibilities and budgetary processes. Nevertheless, the various reform efforts initiating decentralization did represent recognition that the system had basic flaws that needed to be addressed in a structured fashion by the government. And although it was initiated by the central government, this was a first necessary step toward genuine federalism.

**Unstructured Decentralization and Fragmentation**

In 1991–92, the orderly decentralization process in the health system was overtaken by broader changes in the general administration and in the budgetary system of the Russian Federation. These led, by default, to changes in the financing and administration of the health system that were not coordinated with further reform in the system. Some of the changes were in the health system itself; others were in the general administration.

In the health system, with the breakup of the Soviet Union, part of the Soviet Academy of Medical Sciences became the Russian Academy of Medical Sciences. Thus, new clinical, educational, and research institutions financed through the federal budget became part of the Russian federal health system. In 1991 the Supreme Soviet of the Russian Soviet Federation of Socialist Republics promulgated a law that separated SCSES from the FMOH (Supreme Soviet 1991a). The SCSES was granted institutional and financial independence. It remained financed through the federal budget, maintained its centralized federal structure, and was required to report directly to the president of the Russian Federation. Moreover, this happened at a time when the FMOH was practically forced to relinquish control over the system to local authorities. The merits of the separation of the SCSES from the FMOH were questionable at the outset, and indeed the decision was reversed in 1996. This separation was significant in that—more than any other major change in the system at the time—it reflected the conservative and outdated public health perceptions of Russian health policy makers. It was perceived that the dismal performance of the system was related to inadequacies in the field of communicable diseases, which was the immediate responsibility of the SCSES.

As for overall changes in the Russian administration, after the emergence of Russia as an independent federation, the law on krai and oblast
councils and on krai and oblast administrative bodies was adopted.\textsuperscript{10} It stipulated that the rights of krais and oblasts are equal to those of the republics of the Russian Federation in the sphere of social and economic development. It further stipulated that they have ultimate responsibility for the management of their property, land, and natural resources (Supreme Soviet 1991b, 1991c, 1991d; Wallich 1992).

According to both this law and the law on local authorities in the Russian Soviet Federation of Socialist Republics, oblast- and local-level administrations are to manage their own medical services. This has meant that these administrations may appoint heads of territorial health authorities and heads of appropriate medical facilities and can develop programs for improving the population’s health and preventing disease without the approval of the FMOH (Supreme Soviet 1991e). Accordingly, below the oblast level, the councils of people’s deputies of the appropriate administrative territorial units are now entitled to develop, approve, and implement their budgets independently.

Thus, as of 1991, local authorities were required to construct their own health budgets and have not needed FMOH or Federal Ministry of Finance approval. The law on the foundation of budget structure and budgetary process has strengthened this right (Supreme Soviet 1991f). For most practical purposes, the various legislative acts removed the federal ministries of health and finance from any jurisdiction over the local medical systems, which have become practically independent.

**The 1993 Amended Health Insurance Legislation**

In 1993, two years after the health care system had been de facto decentralized to local governments, the law on the amendments and additions to the law on health insurance of the citizens in the Russian Federation was adopted. The legislation established the compulsory health insurance system (Supreme Soviet 1993a). The legislation maintains universal and comprehensive entitlement to care based on principles of public finance and aims to offer citizens the right to enroll in any insurance company they wish while healthy, and to choose providers when sick. In addition, citizens have a right to voluntary or optional insurance to supplement their public entitlement. To achieve these ends, the law stipulates

\textsuperscript{10} Krai was in the past an administration with a lower administrative standing than an oblast. By virtue of the 1983 Russian constitution, krais and other state-like administrations were equalized to that of an oblast (state/province).
separation of the functions in the health system: finance, the organization and management of care for consumers (OMCC), and the provision of care. The government has been legally removed from direct management of all these functions.11

As for finance, the amended health insurance legislation (AHIL) established a social health insurance system for health care at both the federal and territorial levels. It created federal and territorial (social) health insurance funds as public nongovernmental finance institutions that manage compulsory insurance revenues from a wage-bill tax of 3.6 percent and the contributions of territorial governments for the unemployed. The federal health insurance fund has been given the function of achieving cross-regional equity objectives with .2 percent (included in the above 3.6 percent) of the wage bill (Supreme Soviet 1993b; Chernichovsky, Barnum, and Potapchik 1996).

The second function, organization and management of care consumption (OMCC), is carried out by “insurers” and—where insurers are not available—by temporary or transitional branches of the Territorial Health Insurance Funds (Chernichovsky and Potapchik 1997). Insurers, and by implication the branches, are reimbursed on a capitation basis under a public contract with Territorial Health Insurance Funds.12 At the same time, the insurers may also offer voluntary insurance covering privately financed services. (It should be noted that Russian insurers are first and foremost contractors for public entitlement.)

The third function, provision of care, is carried out by providers of any type of ownership, contracted by the insurers or branches. That is, OMCC institutions are (1) health maintenance organization–type institutions that directly provide some or all care and that contract with freestanding providers for the care they do not provide, (2) preferred provider organization–type institutions that leave individuals a wider range of choice than that offered under public entitlement, but that require extra direct out-of-pocket or insurance payment, and (3) groups of general practitioners who become budget holders controlling their clients’ entire health budget or the larger part of it.

The 1993 legislation thus transfers the responsibility for allocating the public health budget, organizing and managing care consumption, and

11. For a conceptual discussion about this separation of functions, see Chernichovsky 1995.
12. It is noteworthy that the Russian Territorial Medical Associations under the “New Economic Mechanism” that started in the late 1980s have come close to the organization and management of care consumption concept (see Telyukov 1991; Telyukov and Caper 1991; Sheiman 1991; and Chernichovsky, Potapchik, and Tulchinsky 1998).
(at least by implication) providing curative and rehabilitative care from local governments to nongovernmental entities. This legislation thereby provides the framework for the reform of the health system, complementing the previous reform in the general administration.

For all its potential virtues, however, a basic flaw of the legislation is that it has not assigned clear roles to the local and federal government in the health care system, in conjunction with the new health care system that the legislators envisioned. This is in spite of the fact that about 90 percent of health care finance in Russia is still derived from public sources (1996), that 60 percent of total finance is from general revenues, and that government controls almost all health care facilities.

The AHIL recognizes that the so-called state and municipal systems (SMS) are still financed directly from the budgets of different levels of government.13 These systems incorporate the activities of the SCSES, the Russian Academy of Medical Sciences, and other federal and regional institutions dealing with so-called expensive treatment, public health, health promotion, training and research, and other activities associated with substantial externalities and economies of scale (Supreme Soviet 1993a, 1993c). These parts of the health system have been mostly retained under federal jurisdiction. The 1993 legislation does not, however, assign a clear interaction between the new institutions it stipulates and the government.

This has had political consequences. Not only have governments at all levels had to relinquish resources and management powers to the Territorial Health Insurance Funds, the Federal Health Insurance Fund, and insurers, but also, at the outset, the government had no sense of ownership over legislation. Consequently, the government fought rather than led change. In many ways the 1993 AHIL was implemented in spite of (rather than because of) the government (Chernichovsky and Potapchik 1998a).14

The Perils of Unstructured Government in the Health System

The health system administration that emerged in Russia through mid-1996 is depicted schematically in Figure 2. This system includes five

13. On the organization of the system, see also Chernichovsky and Potapchik 1997.
14. The principles for the 1993 AHIL were laid down by an interministerial committee chaired by deputy Federal Minister of Health Dr. V. Satardubov and assisted by the World Bank. While officially blessed by the government, its work was of more concern to the legislators than to the government. Moreover, the Federal Health Minister, Dr. E. Nichaev, who was appointed soon after the passage of the legislation, opposed it.
uncoordinated administrations. Two of these have been decentralized vertically. Critically, the general role of the government, and the role of federal government in particular, have remained unresolved. In effect the FMOH has ceased to set policy and priorities for the health care system or to regulate it in any effective way. The consequences of the lack of clear governance for the Russian health care system are considerable.

As was previously discussed, policy making in the Russian health system was compromised from the outset. Since 1991, responsibility for national health care policy has been divided among the FMOH, the SCSES, the health institutions of the other ministries (the Parallel Systems), and local authorities. Since 1993, this responsibility, mainly in the area of health care finance, has been further divided to include the new federal and local health insurance funds. To aggravate matters, from the beginning of 1994 through 1995 the FMOH was in charge of the medical industry, whose policies and considerations are quite different from those of the health care system.

The void in policy making and outright lack of any leadership happened at a time when—especially in economically weak areas—local authorities, inexperienced in policy making and planning, and lacking any alternative resource allocation models, looked to Moscow for solutions. The quest for guidance from Moscow is also a result of the prevailing political culture. Consequently, officers in local governments continue, by inertia, to plan and construct budgets in much the same way as before, according to outdated bed- and clinic-capacity–based standards, while responding primarily to changes in levels of local finance.

In spite of the provisions in the 1993 AHIL, as well as those in the Soviet
legacy, the emerging system lacks the means for genuine fiscal federalism, that is, a structured financial relationship between different levels of government and the compulsory health insurance system. This has several implications for equity and for the stability of the health system. Following decentralization of the government, the health care system became increasingly dependent on the state of the local economy. This had an immediate effect on the distribution of health care finance in the system. Although in 1993, per-capita health care expenditures returned to the 1990 level, the disparities among the different regions are growing. The health care system has deviated from the original 1990–91 regional allocation of finances that corresponded closely to an equitable capitation-based formula (Chernichovsky et al. 1998). In the long run, this deterioration in the distribution of finances may lead to a decline in the average health of the population. It will certainly have an impact on the distribution of manpower and the medical infrastructure, which at least in the short term remained intact during the transition period.

This situation also means that the stability of health care system finances, a key for orderly and efficient operations, has been compromised. Local government administrations do not have the fiscal and, above all, the monetary means to stabilize their economies, let alone their health care systems (Chernichovsky and Potapchik 1998a). The lack of fiscal federalism (combined with a lack of clear policy) deprives the system of a major means of executing an effective national health care policy.

The administrative changes in the health care system, especially the split between the FMOH and the SCSES during the transition period through 1996, compounded the existing impediments to health promotion by modification of behavioral and environmental risk factors. Resources for health promotion are sparsely spread, both horizontally among different agencies, specifically the FMOH and the SCSES, and vertically among different levels of the administration. In addition, there is no national policy in this critical area (Tulchinsky and Varavikova 1996).

The efficiency of the national health care system, the area that stands to gain the most from the reform process, remains unattainable under the prevailing circumstances. Essentially, control over the health care system has moved, by and large, to centralized and inexperienced local administrations. And while those coming under financial pressure are probably streamlining their systems and making them more efficient, in general these administrations continue to apply the old-style system. While about 500 insurers operated in Russia as of 1996, their full potential as care managers remains unrealized because almost all provider institutions are
owned and operated by the government, which in many instances transfers finances directly to those institutions, contrary to the 1993 legislation. Provider institutions remain local monopolies vis-à-vis their constituencies, and local administrations are monopsonies—single buyers—vis-à-vis medical staff and other suppliers. In the absence of appropriate regulations that would replace the central government’s direct control of institutions, local government monopolies and monopsonies are likely to lead to inefficient use of resources and may not be responsive to patient needs and preferences as intended by the 1993 AHIL. This is a particular bind of the Russian system; local government, with considerable vested interests in the health care system, has to reform the system, divesting itself of a considerable political and financial power base (Chernichovsky and Potapchik 1998a). That is, as long as local government does not decentralize further down, to the institutions stipulated by the AHIL, the overall situation may not be better than it was under the Soviet regime.15

The lack of a national perspective and appropriate means prevent the promotion and imitation of the results of promising “natural experiments” that most likely occurred in individual locales during the transition. The situation in Russia has an added dimension in this particular aspect of systemic efficiency: to be effective, additional funds in the system need to be coupled with innovation and new approaches to care. Efforts to adopt expensive technology without appropriate training and changed approaches to care would just aggravate the situation, increasing the cost of care without bringing apparent gains. The stipulation in the 1993 AHIL that oblasts meet national minimum levels of entitlement might create a snowball effect if expensive models that obstruct cost-containment efforts, efficiency, and equity are followed. This would be contrary to the interests of the system. At the same time, positive experiences remain unnoticed.

In sum, Russia went overboard, changing from a highly centralized “federal” health system to one that is considerably fragmented and does not operate as a national system. Consequently, it has lost the benefits of the centralized unitary state—maintaining systemic equity and stability and systemwide support—without gaining the benefits of the decentralized state efficiency based on the capacity to innovate and to respond to

15. In this regard the price of federalism (Peterson 1995) in the Russian system is quite different from its price in Western systems. In the latter this price principally entails the resistance of usually able local government to give up powers to central or federal authorities. In Russia it entails the creation of able local authorities by the central government.
local conditions by means of competing forces. The Russian situation is compounded by the lack of a democratic tradition, specifically the lack of effective local government. Namely, in the Russian Federation—unlike in Western federations—the ineffective federal government prevents the buildup of the infrastructure of local governments.

A Framework for Genuine Federalism in Russia

Genuine federalism in the Russian health system could succeed in establishing and maintaining a systemic order out of the currently fragmented system. Such order would on the one hand imply well-defined and effectively complementary roles for local and federal entities, and on the other hand imply these roles for the various institutions comprising the system. This order is necessary to stabilize the system, mainly with regard to the level of finance and its distribution, and to help to continue the reform, principally with regard to infrastructure, organizational frameworks, and incentives that would improve approaches to health and medical care (Chernichovsky and Potapchik 1997, 1998a, 1998b). This reform would also entail building the infrastructure of local government.

Accordingly, the federal government would take responsibility for formulating national health care policy and for effective fiscal federalism, which would mainly enhance stability and equity in the system, and for promoting efficiency through national and regional programs that would in part advance the governing and managing capacity of local government. Local government, for its part, would secure and oversee the orderly operation of services in accordance with local conditions.

In compliance with the stipulation of the 1993 AHIL, the government should reduce to a minimum its involvement in the management of health care monies. This has become the role of the Territorial Health Insurance Funds and the Federal Health Insurance Fund. The legislation also implies that the government should relinquish the ownership and direct management of at least curative and rehabilitative medical services, as well as the management of the role of insurers and freestanding providers. This process of denationalizing health services in Russia may prove to be lengthy, but it must be initiated as soon as possible in an orderly manner (Chernichovsky and Potapchik 1998a).

Russia could base this shift toward genuine federalism, first, on (1) current legislation, appropriately modified, and in particular, on the Foundations of the Legislation of the Russian Federation on the Protec-
tion of Citizens’ Health (hereafter referred to as the foundations law [Supreme Soviet 1993c]); (2) to some extent, the centralized Soviet legacy that demonstrated the feasibility of creating equity across a vast nation comprising many regions; and (3) the experience of other nations, such as Germany, Canada, and Australia, where effective federal systems operate. We focus mainly on the first shift.

The 1996 decree of the president on the structure of federal organs of executive authorities took two major steps to improve the governance of the health system (President’s Office 1996). First, the FMOH would no longer be held responsible for the medical industry. Second, the SCSES would again become an organ operating under the FMOH. These two measures, when fully implemented, have the potential to substantially increase the effectiveness of policy making in the system and to effect a more coherent approach in the handling of health promotion. The orderly transfer of the policy making and overall system management functions of the Parallel Systems to the FMOH and corresponding local entities would also serve these objectives in a federal system.16 The federal government’s policy statement of November 1997 concerning the Russian health care system underscores the issues raised in this discussion (Government of the Russian Federation 1997).

The foundations law signed by the president on 22 July 1993 after the passage of the 1993 AHIL stipulates the principles governing the Russian health care system. Following the Soviet legacy, this legislation includes both an extensive constitutional bill of rights for citizens and patients with regard to their health and a framework for health system administration. Consequently, the foundations law establishes the responsibilities of the different levels of government with respect to the protection of citizens’ health. The law assigns responsibilities to the federal, oblast (state/province), and municipal governments. The oblasts and municipal governments are responsible for their health systems while implementing federal policies, as well as formulating local policies that do not conflict with those of the federal government (see Appendix).

While providing a viable framework for a federal system, the foundations law has several key conceptual shortcomings and in any event needs to become effective in order to avoid the kind of Soviet-type discrepancy between constitutional legislation and its implementation or effectiveness. Both those shortcomings and the potential lack of effectiveness

16. Dismantling of the parallel systems may follow naturally as Russian industry is restructured and sheds “social responsibilities.”
relate to the law’s practical oversight of the 1993 AHIL that preceded it. As previously outlined, stabilization and equity or redistribution are key roles of the federal government and were major achievements of the Soviet system. Despite the fact that stability and equity are in great peril under the current system, the foundations law does not legislate the pertinent functions of government. The law charges only the lower level of government with “ensuring access.” This omission may have been caused by an adherence to the Soviet legacy that took this function for granted. Partly, however, it also follows from the foundation’s failure to come to grips with the 1993 legislation. With regard to financial stability and equalization, the law leaves out the key organ, the Federal Health Insurance Fund, the sole function of which is regional equalization in the system. It also misses the notion of equalizing monies and grants as key levers for rendering effective the provisions of the law regarding the respective roles of different levels of government and the Compulsory Health Insurance System stipulated by the AHIL.

Achievement of systemic effectiveness and efficiency as well as client satisfaction by responding to local circumstance are those aspects of reform in which Russia needs to make the most strides. Moreover, unlike the situation in other developed nations, there is no appropriate legacy of competition in the health care system that can serve these objectives. The foundations law overlook this aspect too by ignoring the AHIL. Indeed, the foundations law charges local administrations with the responsibility of creating an environment for “denationalized” provision of care. Simultaneously, however, in line with the Soviet tradition, the law stipulates that the oblast authorities are responsible for developing a local network of medical facilities and that city and rayon authorities are responsible for determining the nature and scope of medical facility activities. These authorities need indeed to make sure that services are available through the licensing and regulation of insurers and providers. At the same time, it should have been made clear that the primarily independent nongovernment insurers and providers, and not the state, should be charged with the responsibility and accountability for providing at least curative and rehabilitative care.

Moreover, given the political economy of the situation and the prevalence of largely unregulated local state monopolies, the federal government should be given regulatory responsibility for outlining the roles of local government, of the Territorial Health Insurance Funds, and of the freestanding providers. In addition, through a granting system, the federal government should be given the responsibility for supporting the
establishment of and investment in privately owned medical facilities, and for controlling monopolies and monopsonies of whatever kind. These are needed in order to facilitate consumer choice and production efficiency (Chernichovsky and Potapchik 1998a).

To deal with the above, the foundations law needs to be recast to recognize that the Compulsory Health Insurance System stipulated by the 1993 AHIL entails—at least by implication—a new social contract in the Russian health care system, with constitutional rights accorded to new institutions. This social contract specifies that the health system has an exclusive source of public finance—an earmarked payroll tax. In addition, it specifies that public health insurance funds, insurers, and freestanding providers as well as citizens have constitutional rights. Insurers and providers (under the insurers’ contracts) are meant to operate under the auspices of public finance but independently of the state in order to ensure maximum client choice.

**Corporate Federalism**

Indeed, a major challenge facing the Russian health system is the need to establish the structural integration of the government administration and the Compulsory Health Insurance System stipulated by the AHIL. A viable solution to the problem of creating a link between the state and the insurers would be to establish a corporate federation of the health system within each oblast. This “internal federation” within each constituent member of the Russian Federation would include the insurers in each oblast together with the local regional health ministry; the latter would operate as the federal authority within each state or oblast. This would imply that:

- The Territorial Health Insurance Fund would be recognized as the sole agency managing the public monies allocated for the Compulsory Health Insurance System.
- Insurers, whether national or interregional, would operate as regional or oblast “cost/profit centers” subject to regional regulations.
- Insurers would have a final say in how care is organized and managed as stipulated by the 1993 AHIL (contrary to the stipulations of the foundations law).

The oblast government would set policy, propose legislation designed not to conflict with the basic rights of insurers as the representatives of their enrollees, and carry out the various other functions stipulated by
the foundations law. This arrangement would further support the creation of independent insurers and providers that are key to the reform of the Russian health system (Chernichovsky, Gur, and Potapchik 1996; Chernichovsky and Potapchik 1998a). If the foundations law is to incorporate modifications reflecting the modifications just stated, it could provide a viable framework for achieving genuine federalism in the Russian system.

**Federal Levers**

In the absence of mandatory directives, which were a characteristic feature of the Soviet centralist system, there is a need for appropriate incentives, a common characteristic of federalism, to induce subnational and local entities (which have constitutional rights) to follow federal or national policy, regulations, and guidelines. This inducement is essential for better-off regions that may be inclined to go their own way, fearing that they will inevitably be losers in what they may perceive to be a zero-sum game of federal taxes (levies) and subsidies (benefits).

Federalism, if effective, is bound to lead to increased efficiency, improved quality, and even to higher revenues for local health systems. These would result from federal programs that exploit economies of scale, produce positive externalities (exterritorial effects), eliminate the cost of detrimental externalities to individual regions or populations, and bring about outright financial grants. These incentives can attract even affluent regions to play the “federal game.”

The benefits of economies of scale can be realized in federally funded centers of excellence in education, research, and medical treatment, in epidemiological surveillance and investigation, and in national programs for health education, especially those using mass communications and those for emergency relief. In these regards the federal aspect is vital because it may not be efficient or even feasible for most if not all oblast governments to establish or maintain pertinent institutions. To be cost-effective, such institutions require substantial investments in human and nonhuman capital and a large population base.

Major benefits in the form of positive externalities, which are often linked to economies of scale in production, ensue from the federal control of activities that are beyond the reach of local governments, but that can bring substantial health benefits to their local populations.

17. For a fuller discussion of underlying concepts, see Chernichovsky 1996.
These activities include controlling the environment, fortifying food. efficient procuring of pharmaceuticals and vaccines, acquiring technol- ogy, and initiating international cooperation, all of which are currently underdeveloped in Russia. Local health care, moreover, can benefit from access to federally financed schools of medicine, public health and management, specialized laboratories, information systems, highly specialized treatment centers, and centers of research and excellence in general.

As a way to promote efficiency, federal authorities can help extend innovative programs developed in different localities. By the same token, the federal government can act as a political mechanism to divert pressures from a region's population and interest groups. Also, local authorities can use federal authorities as the political scapegoat for restraining health expenditures, especially in affluent regions.

In general, grant funds channeled through the FMOH mainly for investments in the system and through the Federal Health Insurance Funds principally for the operation and promotion of freestanding institutions can be fundamental levers to promote federal policy and to reform the system.

**Conclusion**

The current ambiguous administrative status of the Russian health sys- tem could accommodate and even support the creation of a federal health administration out of the vestiges of the current fragmented system. For as long as no new power bases or vested interests are forged, there would be little or no resistance from local authorities in the regions to yield some powers to federal authorities, and, most important, to relinquish powers by appropriate federal regulations and incentives to new freestanding, competing, and professionally independent institutions.

The transition to federalism in Russia involves four major tasks. The first is to clarify the conceptual distinction between the nature of the "federalism" that existed under the Soviet regime and genuine federalism. This is of importance particularly since there is a tendency to confuse the old centralized system with an administratively decentralized but centrally supported and coordinated system. Moreover, the federal government in Russia needs to help build up the capacity of local government. This task is a particular challenge in view of the Soviet legacy, on the one hand, and the lack of a similar role in Western federations on the other hand. The second task is to design a federal system that can
provide an infrastructure for the distinct health care models now evolving under the 1993 AHIL. The third is to clearly delineate the functions of different levels of government and state authorities in the different potential models. Finally, it will be necessary for the federal government to assess which potential health policy—that is, which administrative as well as financial levers—will most efficiently promote an effective transition to a practicable and successful federalized system.
Appendix

Key Stipulations of the Foundations Law with Regard to the Role of the Government

In general, all levels of government are to

- establish health policy,
- enact and enforce legislation and regulation,
- manage state property used in the health protection area,
- coordinate all activities within the state, municipal, and private systems,
- set the public health budget from the general revenues, and
- defend human rights in the area of citizens' health protection.

The role of the federal government, beyond initiating federal legislation, consists of

- establishing a unified system for reporting and statistics,
- ensuring uniform technological policy with regard to pharmaceutical and medical industries,
- certification and licensing of medicines, drugs, equipment, and technology in general,
- developing uniform criteria and federal programs for training medical professionals as defined by the federal government,
- establishing and enforcing quality standards of medical care,
- establishing licensing procedures for medical and pharmaceutical activities,
- developing and approving basic compulsory social health insurance programs,
- establishing preferential treatment for certain population groups (e.g., the disabled),
- financing and coordinating medical research,
- organizing state sanitary and epidemiological services,
- setting compulsory health insurance contributions, and
- implementing disaster relief.

Key responsibilities of the oblast/state government include:

- implementing public health and disease prevention measures,
- developing a local network of medical facilities,
- overseeing quality control of medical care,
- licensing medical and pharmaceutical activities and organizing and coordinating work to train health care personnel, and
- granting tax privileges to institutions dealing with health protection.

The local (city and rayon) government's role is to:
- determine the nature and scope of medical facility activities,
- organize and promote primary and other types of care,
- ensure access to medical care,
- assure drug provision, and
- create conditions for promoting a private health system.

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