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Universal Health Coverage in Russia:  
Extending Coverage for the Poor in the  
Post-Soviet Era

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## Abbreviations

CT	Computerized Tomography
CVDs	Cardiovascular Diseases
DP	District Physicians
DRGs	Diagnostic Related Groups
ECA	Europe and Central Asia region
GDP	Gross Domestic Product
GP	General Practitioner
HSE	National Research University High School of Economics Moscow
LCU	Local Currency Unit
MOH	Ministry of Health
NCDs	Non-Communicable Diseases
OOP	Out-of-Pocket
PHC	Primary Health Care
PPP	Purchasing Power Parity
PSG	Program of State Guarantees for Medical Care
SHI	Social Health Insurance
UHC	Universal Health Coverage
WHO	World Health Organization



## Preface to the second round of the Universal Health Coverage Study Series

All over the world countries are implementing pro-poor reforms to advance universal health coverage. The widespread trend to expand coverage resulted in the inclusion of the “achieving universal health coverage by 2030” target in the Sustainable Development Agenda. Progress is monitored through indicators measuring gains in financial risk protection and in access to quality essential health-care services.

The Universal Health Coverage (UHC) Studies Series was launched in 2013 with the objective of sharing knowledge regarding pro-poor reforms advancing UHC in developing countries. The series is aimed at policy-makers and UHC reform implementers in low- and middle-income countries. The Series recognizes that there are many policy paths to achieve UHC and therefore does not endorse a specific path or model.

The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions- used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to provide a detailed understanding of how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding population coverage while ensuring that the poor and vulnerable are not left behind;
- **Strategic Purchasing:** expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers;
- **Raising revenues** to finance health care in fiscally sustainable ways;
- **Improving the availability and quality of health-care providers;** and,
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions.

By 2017, the Series had published 24 country case studies and conducted a systematic literature review on the impact of UHC reforms. In 2018 the Series will publish an additional 15 case studies, A book analyzing and comparing the initial 24 country case studies is also available: *Going Universal: How 24 Developing Countries are Implementing UHC Reforms from the Bottom Up*. Links to the Series and the book are included below.

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Universal Health Coverage Study Series

Links:

<http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>

<http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up>

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## Executive Summary

**Over the past two decades Russia experienced a significant increase in state-financed entitlements for health care through the Program of State Guarantees for Medical Care (PSG).** The PSG, which is underpinned by the Constitution was an important element of the social contract implemented by the State on the back of rapid economic growth during the 2000s. The PSG is a universal program with uniform benefits paid for through a single national pool. The PSG was accompanied by significant supply side investments to develop a multi-level service delivery system, substantially increase tertiary care provision, strengthen the diagnostic capacity of medical facilities and reduce geographic variations in funding and services.

**This case study examines what the increase in state financed entitlements for health meant for coverage of the poor in Russia, using the health sector in Russia in the early 1990s as the starting point.** The economic and political transformations of the early 1990s resulted in a significant deterioration in health outcomes and financial protection. Although health outcomes have improved, they continue to lag behind that of comparator countries.

**The quantitative evidence presented in this paper suggests that Russia made important gains financial protection and access to care for the poor.** Much of the improvement in financial protection occurred during the late 1990s and early 2000s when rates of catastrophic spending and impoverishment due to out-of-pocket (OOP) payments declined dramatically. Since then, progress has moderated. Financial protection indicators worsened slightly following the recent economic crisis, while inpatient use became more pro-poor, especially for the elderly, but outpatient use more pro-rich. Despite modest improvements, they are significant when compared to the situation in the early 1990s.

**Large PSG related investments and reforms during the 2000s supported the achievement of health gains and moderated the reversal of trends during the fiscal crisis.** Fiscal redistribution has been used to increase resource allocation to less well-off areas. Increased public spending on hospital care helped improve access to inpatient care for the poor, particularly the elderly. Increased investment in diagnostic equipment at outpatient care facilities is associated with increased access to tests and services, albeit only in major cities. A push to reallocate spending towards primary care increased access to both physicians and services in rural areas. Limited PSG coverage for outpatient drug purchases means that OOP drug payments remain one of the biggest threats to financial risk protection.

**To further deepen and expand coverage for the poor, there is a critical need to narrow the divergence between PSG's de jure and actual coverage.** In principle, the PSG provides a uniform benefits package that all Russians are entitled to under the Constitution. In practice, underfunding and a lack of clarity over the benefits package lead to implicit health care rationing through inadequate access to good quality health care services and affordable drugs and supplies. Additional fiscal space for health is needed and health policy must make more effective use of available resources. Expanding coverage for outpatient drugs and strengthening primary care are immediate priorities.

## 1. Introduction

**Russia's health sector performance since the early 1990s reflects the economic, political and social transformations that took place during the last three decades.** The first phase of this transformation adversely affected outcomes, access to health care and financial protection. Subsequent economic growth, poverty reduction and political commitments to improve coverage have led to gradual improvements, but with a time lag.

**The economic, social and political transitions experienced in Russia during the 1990s had deleterious effects on all social sectors, including health.** The dissolution of the Soviet Union, radical change in the political system, and the move from central planning to a market economy hindered sustained economic growth and political stability. In the 1990s, the country faced profound economic disruptions, **climaxing in the 1998 crisis**, and political weakness, as it struggled to define a new global and regional position, a national identity, and an effective economic model. The health system was directly affected by this transition, with coverage and financial protection deteriorating sharply.

**In the 2000s, the economy grew rapidly supporting an improvement in social indicators.** Today, Russia is an upper-middle income country with an emerging middle class, unique in its economic and political model, its size, and its institutions. Despite a current challenging macroeconomic environment, the Government seeks to deepen and strengthen the socio-economic gains achieved.

**Russia's growth model in the 2000s included a solid social contract.** The state played a significant social role in guaranteeing citizen welfare. Russian citizens benefited from a rich and comprehensive set of entitlements and benefits, among them free health (focus of this case study) and education for all, a generous pension system, and heavily subsidized utilities, goods, and services (World Bank, 2016).

**The growth model supported poverty reduction and improved shared prosperity.** Poverty rates plunged from about 30 percent of the population in 2000 to approximately 11 percent in 2014 based on the national poverty line.<sup>1</sup> However, recent national poverty rate data suggest that these trends have reversed: after reaching a record low of 10.7 percent in 2012, the poverty rate edged up to 10.8 percent in 2013 and to 13.5 percent in 2016 (national poverty line). Russia ranked among the top performers in the Europe and Central Asia (ECA) region in terms of income and consumption growth of the bottom 40 percent of the population. Consumption for the bottom 40 percent increased by 5.9 percent annually between 2007 and 2012—surpassing consumption growth of the total population (5.3 percent) and of the top 60 percent (5.2 percent). However, consumption fell 1.9 percent during the 2010–2015 crisis years (World Bank, 2016) for the bottom 40 percent.

### Health Sector Implications of the Transition

**Russia's economic and political transitions of the early 1990s triggered one of the biggest collapse in health outcome collapses ever seen outside war or pandemic situations.** Government health care

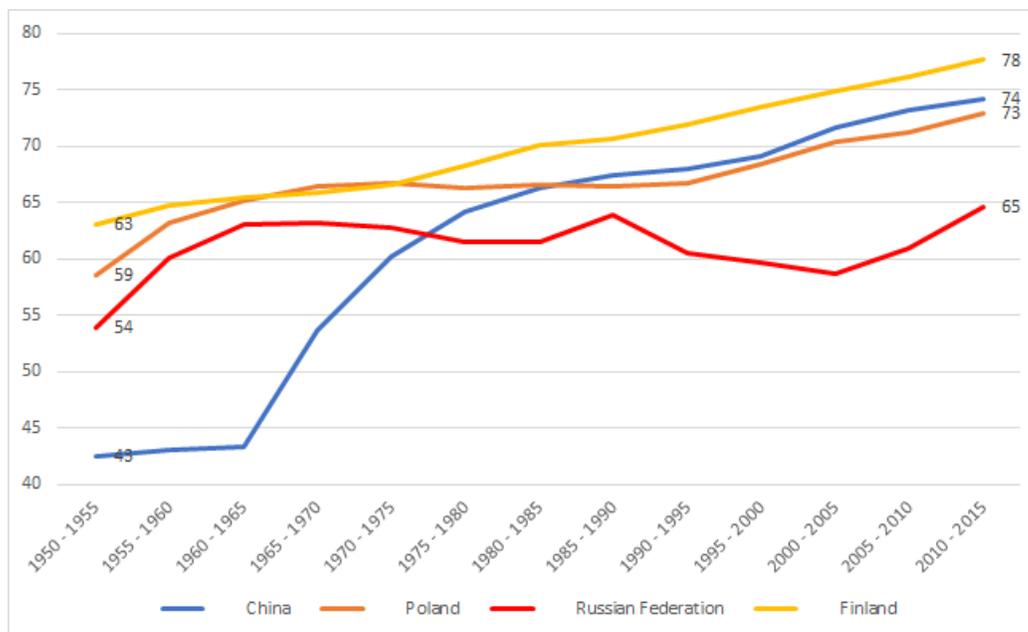
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<sup>1</sup> Using the international US\$5 a day poverty line (real 2005 Purchasing Power Parity values), poverty fell even more, reaching a low of 7.3 percent in 2012.

expenditures declined by one-third in the 1990s. Many secondary and rural facilities that were tied to old Soviet enterprises were closed and service discontinued, increasing utilization of costly hospital services. Health facilities were forced to charge fees while households incurred large OOP expenditures or had to forego care. Public spending only reached above pre-transition levels in real terms in 2006 with the infusion of resources from the 2006-2007 National Priority Health Program (World Bank, 2008).

**As a result, Russia’s health outcomes consistently lagged behind those of other comparator countries and relative to Russia’s income levels.** Life expectancy at birth was 71.4 years in 2015—far below that of lower per capita income BRICs (Brazil, Russia, India and China), Brazil (74) and China (76). Male life expectancy only increased by ten years in Russia since the early 1950s compared to 32 years in China, 21 in Brazil and 15 and 14 years respectively in regional comparators Finland and Poland (see Figure 1). Non-communicable diseases (NCDs), in particular cardiovascular diseases and cancer, as well as external causes are the main contributors to premature mortality and disability in the Russian Federation exacerbated by population ageing.

**Figure 1: Male Life Expectancy at Birth, 1950-1955 to 2010-2015**



*Source: United Nations Population Division (2015).*

**Recent health outcome improvements, albeit modest compared to other countries, reflect both a rise in population income and welfare as well as increased access to health services.** Life expectancy has improved largely due to a reduction in NCD-related deaths. Mortality from cardiovascular diseases (CVDs) has decreased by 30 percent and disability from CVDs by a quarter over the period 2010 to 2015. These outcomes are the result of efforts to combat the main risk factors, such as the introduction of new tobacco control legislation and improvements in access to care for patients with stroke and acute coronary syndrome. An overall income rise and sustained poverty reduction have also played a role. There have also

been marked improvements in key population health indicators such as infant mortality, maternal mortality, and tuberculosis mortality.

**The sustained increase in state-financed health care entitlements was a key element of Russia’s social contract and the focus of this UNICO case study.** Russia’s flagship Universal Health Coverage program is the PSG. The PSG adopts a universal approach to expand coverage, which therefore does not rely on explicit targeting. Given the focus of the UNICO series on health care programs for the poor, this case study will examine how and to what extent the universal PSG approach improved financial protection and access to services for the poor. In order to do this and evaluate the extent of implicit rationing, the case study exploits multi-year household survey data covering the period 1994 to 2014), and other smaller surveys carried out by national researchers including the HSE and other available evidence.

**The increase in state-financed health care entitlements through the Program of State Guarantees for Medical Care during the 2000s was a key element of the social contract.** The PSG is financed through a combination of employer contributions and federal and regional government subsidies. The right to free health care is guaranteed by the country’s Constitution, which states that services are free at the point of service. Health care is provided through a combination of public (majority) and private medical organizations. Regional Social Health Insurance Funds (SHI Funds) allocate revenue to medical insurance organizations (health insurers) that purchase care from providers. The benefits package is comprehensive with minimal explicit forms of rationing, although there is considerable implicit rationing.

## 2. Institutional Architecture of the PSG

**The PSG is underpinned by the Constitution,** which states that “all citizens of Russia are entitled to free care provided in state and municipal medical facilities and paid from the budget or health insurance”.

**The PSG is a universal program with uniform benefits paid for through a single national pool.** Employers make SHI contributions on behalf of their employees. Regional governments make SHI contributions on behalf of the non-working population. The size of the contribution is the same for all categories of the non-working population, including unemployed, disabled, veterans, etc. The benefit package is the same for all groups of population – working and non-working, poor and rich, more or less vulnerable. There are no separate institutional health programs for the poor. However, some elements of the PSG, such as the recent initiative to increase doctors in rural areas were introduced specifically to increase utilization among the poor. In principle, the PSG benefits package is the same across all regions. In practice, as discussed in Section 6, variations in per capita spending across regions mean that the availability and quality of PSG benefits varies by regions as well.

**The PSG is the responsibility of the Ministry of Health (MOH) and regional health authorities<sup>2</sup>, which are also responsible for service delivery planning and organization.** The Federal and regional SHI funds manage the SHI part of the Program. There are 85 regional SHI Funds, one for each administrative region

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<sup>2</sup> In some regions – MOH.

(oblast) with the population ranging from half a million to 11 million. A region consists of municipalities, some of which have local branches of Regional SHI Funds. Initially, it was envisaged that the funds would be completely independent of the MOH and regional health authorities. However, the need to consolidate planning and funding left the MOH in control of SHI funds, and in charge of issuing SHI regulations and surveying the Federal SHI Fund. Similar subordination exists at the regional level.

**The federally determined PSG is the basis for the regional state guarantee programs.** This is in order to: (i) specify entitlements in terms of diseases, types of care, conditions and patterns of provision (see section 7); and, (ii) make the PSG the basis of planning health financing nationwide. To do this, utilization targets (“normatives”) (e.g. the number of visits or bed-days per capita) and unit cost rates are used. Targets are used for care planning and projections but not for limiting use, for example for the number of patient visits or bed-days. There are some care management tools, with health insurers controlling the appropriateness of hospital admissions, length of stay and processing insurance claim checks, as well as quality of care and protection of the rights of the insured, i.e. complaint response.

**The Social Health Insurance Law has significantly increased the influence of the federal government over the regional health systems.** First, the SHI Law has given the federal government ultimate responsibility over ensuring universal coverage and its associated health financing needs. Second, most SHI contributions are centralized in the Federal SHI Fund thereby equalizing regional SHI per capita funding. Third, the Federal Fund and the MOH set and monitor performance targets for the regional systems. Finally, the Federal Fund manages the entire SHI system, including the approval of regional SHI leaders.

**Though centralization has enhanced health care coverage through the equalization of health funding, it has reduced regional governments responsiveness to local needs.** There are many examples of the excessive vertical administrative control over regional service delivery and resource allocation. Regional SHI Funds have to report to regional governments (horizontal link) and the Federal Fund (vertical link), which complicates management and limits their responsiveness to local needs.

### 3. Health Care Financing

**Total health spending was 7.1 percent of Gross Domestic Product (GDP) in 2014, with 62.6 percent from government sources (budget and social health insurance funds), and 37.4 percent from OOP sources (Table 1).** Total health spending is higher than the average for upper-middle income countries (5.5 percent) but lower than the European Union average (10 percent) (World Bank, 2016).

**Public health spending remains relatively low and OOP spending high.** In 2014, public health spending in Russia was 3.5 percent of GDP, significantly lower than the EU-15 average of 8 percent. The government’s share of total health spending and the health sector’s share of total government spending are both lower than that in most of Central and Eastern European countries (e.g Croatia, Slovenia, Baltic countries), while higher than that in most of former Soviet Union members, e.g. in Armenia and Georgia (**Error! Reference source not found.**).

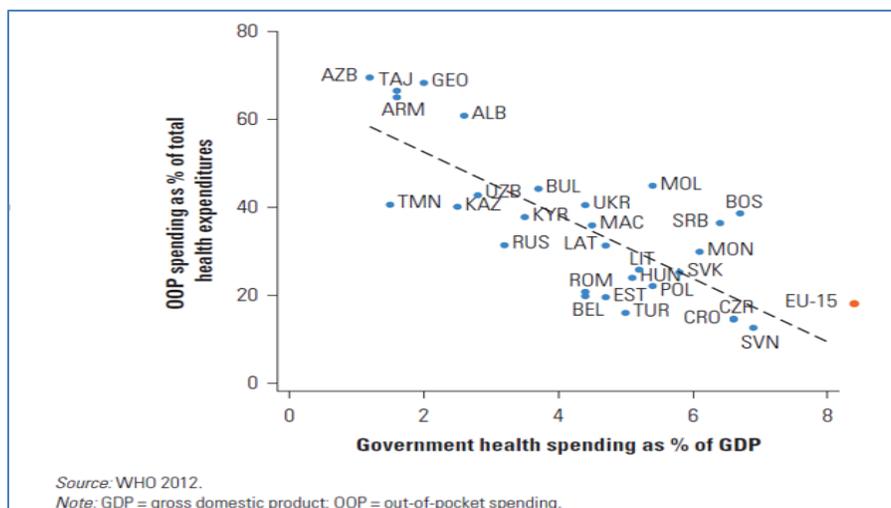
The share of OOP spending as a percent of total health expenditures, often a crude indicator of the degree of financial barriers to access faced by the population, has remained high (Figure 2). The MOH estimates OOP spending at 37.4 percent of total health spending, including voluntary health insurance (Table 2), and the WHO database at approximately 45 percent. Both estimates are substantially higher than the average for Europe, 19 percent (OECD, 2016, p.125).

**Table 1. Health Financing Indicators, Russian Federation and Selected ECA Countries, 2014**

Country/ Region	Total health expenditure per capita (current US\$)	Total health expenditure as a share of GDP (%)	Government share of total health expenditure (%)	Out-of-pocket share of total health expenditure (%)	Health share of total government expenditure (%)
Russian Federation	893	5.9	62.6	37.4	9.5
Armenia	162	4.5	43.0	53.5	7.0
Croatia	1,050	7.8	81.9	11.2	14.0
Estonia	1,248	6.4	78.8	20.7	13.5
Georgia	946	8.6	28.2	66.0	8.9*
Latvia	921	5.9	63.2	35.1	9.8
Lithuania	1,063	6.6	67.9	31.3	13.4
Slovenia	2,161	9.2	71.7	12.1	12.8

Source: World Development Indicators.

**Figure 2: Government and Out-Of-Pocket Expenditures on Health in Russia and Comparator Countries 2012**



General revenues from both federal and regional governments as well as social health insurance contributions by employers together account for about two-thirds of total health spending (Table 2). Russia has a social health insurance model with significant general revenue funding. Employees do not make SHI contributions. Regional governments make SHI contributions on behalf of all the non-working population, regardless of whether they are poor or not, or are engaged in the formal or informal sector. The 2010 Law on Social Health Insurance (SHI Law) sets the minimum contribution rate for each one of the

65 regions.<sup>3</sup> In addition to making SHI contributions, federal and regional governments directly allocate funding to the health sector from general revenues. The size of such allocations is dependent on budget priorities determined at the federal and regional levels as discussed below.

**Table 2: Health Funding by Source in Russia in 2014**

Financing sources	Percentage of total health expenditure
<i>Total (public+private+external) (a)=(b)+(h)+(n)</i>	<i>100% in 2014 (4185 bln. roubles)</i>
<i>Public (b)=(c)+(d)+(e)+(f)+(g)+(h)</i>	62,6 (2620 bln. roubles)
Central (federal) government revenues (c)	13,6
State/provincial (regional) government revenues (d)	15,4
Local/municipal government revenues (e)	0,8
Social security contributions (f)	32,8
Other (h)	-
<i>Private (i)=(j)+(k)+(l)+(m)</i>	37,4 (1565 bln. roubles)
Private voluntary health insurance (j)	2,0
Households out-of-pocket (k)	35,0
Domestic NGOs (l)	0,1
Other (m)*	0,3
<i>Rest of the World (n)=(o)+(p)+(q)</i>	-
Bilateral/multilateral development assistance for health (o)	-
International NGOs (p)	-
Other (q)	-

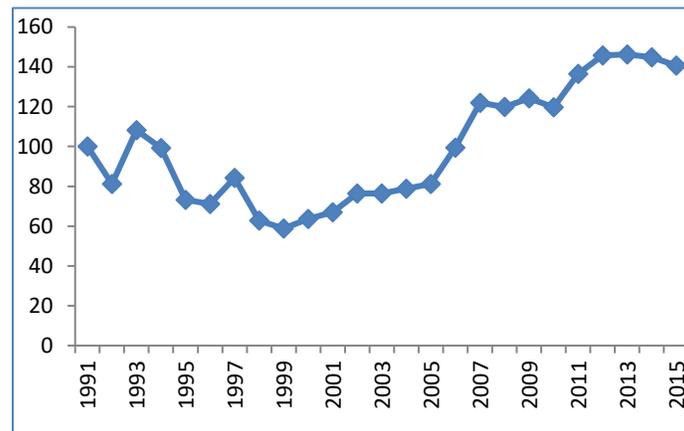
*\*Private organizations' medical benefits for employees (contributions to SHI are not included)*

*Source: Flek 2015, p.114*

**Public health spending fell during the 1990s, rose in nominal terms during the oil boom and associated economic growth of the 2000s but has stalled since 2013** (Figure 3). The increase in fiscal space available for health in the 2000s improved the affordability of pharmaceuticals for vulnerable groups, and supported investments in new medical equipment and the implementation of disease-specific vertical programs (Popovich et al 2011). Spending cuts since 2013 resulted in the rationalization of service supply through reductions in beds and medical personnel and the merging of urban polyclinics and hospitals. Both these trends are discussed in the next section.

<sup>3</sup> A region is a major administrative unit in Russia with population ranging from 1 to 12 million inhabitants. It consists of municipalities with local governments as the administrative bodies.

**Figure 3: Public Health Expenditure Index in Constant Prices in Russia, 1991–2015**



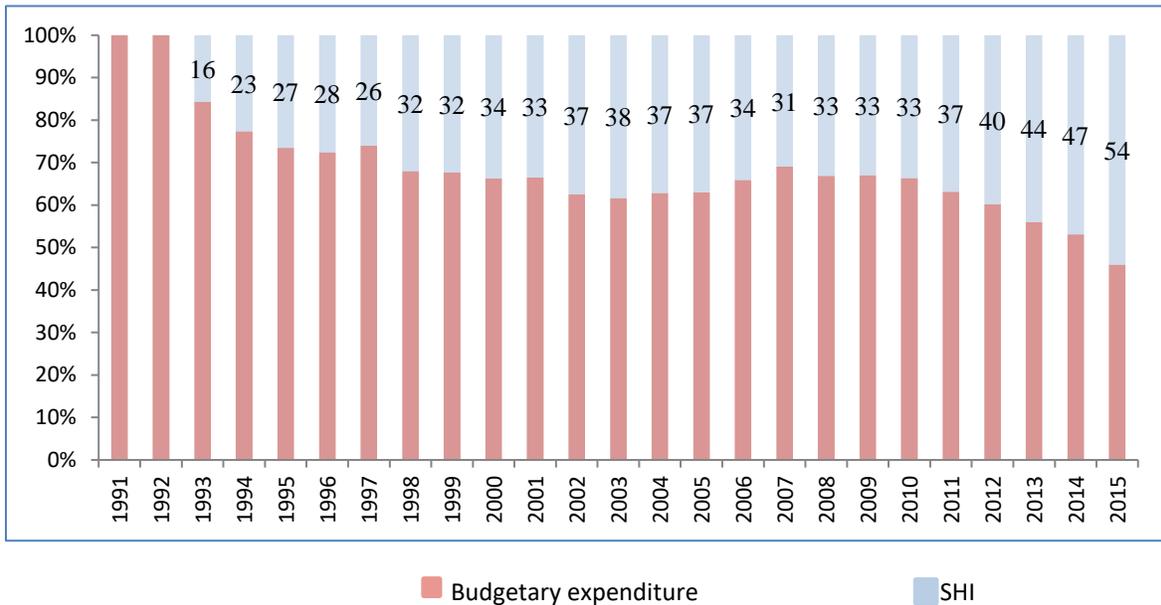
Source: Shishkin et al, 2016.

**The rise and fall in health spending was underpinned by key macroeconomic trends.** In the early 1990s, the dissolution of the Soviet Union, radical change in the political system, and a move from central planning to a market economy was associated with a sharp contraction of the Russian economy. The economic downturn of the 1990s was relatively short-lived, with a recovery underway in the 2000s.<sup>4</sup> Between 2000 and 2013, GDP rose 5.2 percent on average annually, above the 4.5 percent regional mean for ECA. The trend was interrupted only by the 2008–09 crisis, when GDP declined by approximately 7.8 percent, but thereafter resumed quickly. GDP per capita nearly doubled between 2000 and 2012 (from US\$8,613 to US\$15,177 in purchasing power parity, PPP, 2005 terms). For much of the 2000s, buoyant oil revenues accounting for about 25 percent of total revenue boosted public spending and allowed for a steady increase in public employment, wages, pensions, and transfers. Total general government spending as a share of GDP rose from 32.8 to 38.2 percent from 2000 to 2013. However, growth decelerated since 2012 due to binding structural constraints (high wages and consumption-driven growth with limited investment spending) and external worsening conditions (a fall in oil prices and economic sanctions). These factors resulted in lower government revenues and decreasing public health spending.

**The increase in fiscal space for health was due to increased outlays from federal and regional government revenues.** During 2000–2014, the share of SHI contributions (paid for by employers and regional government revenues) and federal government revenues in total public spending on health increased substantially relative to local government revenues (almost zero in 2014) (Annex Table 1 and Annex Table 2). The structure of public health expenditure is increasingly based on SHI allocations. The government has initiated the process of shifting to a “one-channel” model that pools budgetary and SHI revenue in SHI Funds. SHI expenditure as a percent of total public health expenditure increased from 34 percent in 2000 to 54 percent in 2014 (Figure 4).

<sup>4</sup> World Bank, 2016. Russia SCD report

**Figure 4: Share of SHI Expenditure in Russia, 1991-2015, %**



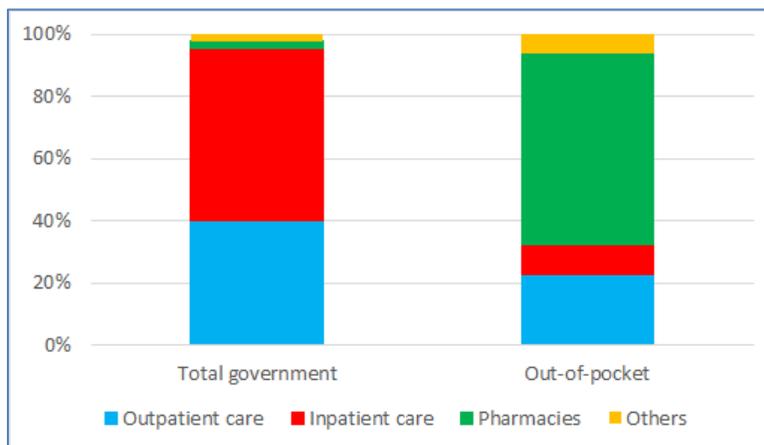
Source: Shishkin et al, 2016

**Russia has a complex system of intergovernmental fiscal transfers with the Federal SHI Fund responsible for the equalization of allocations.** SHI contributions are pooled in the Federal SHI Fund and then allocated to the 85 Regional SHI Funds through a subsidy mechanism (“subventions”) that equalizes health funding across regions. The richer regions contribute proportionately more than they receive. They can also contribute directly to their SHI Funds in addition to the centrally specified size of contribution, thereby resulting in more generous SHI programs in terms of per capita expenditure. In addition to the SHI contribution, there are direct transfers from the Federal to regional budgets – both general and earmarked for health. These allocations take into account the fiscal capacity of the region. The bulk of the intergovernmental transfers are within the SHI system, however. The Federal SHI Fund revenue is the major source of equalization. Its subsidies to regions amount to 94% of intergovernmental transfers for health. The regional equalization policy was initiated in 2011. This has led to a substantial decrease in the variation of per capita health funding across regions. The ratio of the revenue of the richest and the poorest regional SHI Funds dropped to 1.9 in 2015 from 4.2 in 2010 (Shishkin et al, 2016).

**The majority of public funding goes towards the PSG, which consists of two components: the basic SHI program and the package of benefits funded directly from budgetary sources.** The budgetary component is allocated for public health, infectious diseases, mental health, AIDS, a portion of tertiary care (most of it is funded by SHI), outpatient drugs for a relatively small group of beneficiaries (around 10 percent of the population) and other relatively minor items. PSG absorbs around 70 percent of public health expenditure and is the main health coverage program (HCP) for the purposes of this UNICO Case Study. In addition, there are nation-wide general and disease-specific programs funded mostly from the federal budget with some regional budget input. National health programs are supplemented through regional program funding. Both national and regional health programs cover the bulk of investment expenditure.

**OOP spending is dominated by outpatient drugs, which are not adequately covered by the PSG.** Only 10 percent of the Russian population has some outpatient drug coverage, with the rest paying OOP. The public sector’s share of total drug expenditure is 11 percent in Russia, compared to 48 percent in the EU. It is lower than that in most of post-Soviet countries (except for Moldova) – 31 percent in Belarus, 34 percent in Lithuania and 63 percent in Czech Republic (WHO database, 2015). Figure 5 shows the breakdown of total government and OOP spending by type of provider.

**Figure 5: Breakdown of Health Spending by Source and Provider, 2014**



Notes: Total government includes SHI and budgetary allocations. The breakdown of total OOP spending by outpatient and inpatient care is the authors’ estimates as it is not available from the original source.

Source: Flek O. *Russian Health Finance based on health accounting system. Moscow, 2015, pp.27, 28, 37-39.*

**Health insurers are the purchasers of health care in principle.** The health insurers – 67 in total - receive funding from Regional SHI Funds based on an age/sex-adjusted capitation formula, contract providers, reimburse the contracted providers for the services provided and are responsible for the health care quality control. There are 3-6 insurers in each region, each one with its own enrollees. The system was designed to be a “regulated competition model”, but in practice competition between insurers is quite limited. The health insurers compete mostly on customer services rather than price and product (insurance plans). Consumer choice is not supplemented by “price signals” like premiums or co-payment. In each region, the Commission on the State Guarantees of Free Care plans and negotiates care for the entire region and specific providers.<sup>5</sup> This Commission acts as the actual purchaser of care with little direct input from health insurers. Contracts with providers formalize the Commission’s decisions. In short, the health insurers’ role as purchasers is quite limited.

<sup>5</sup>Consists of representatives of the Regional SHI Fund, regional and local health authorities, medical associations and health insurers.

**Providers are paid on a capitation basis for outpatient care and case-based payment for inpatient care.** Case-based payment is based on Diagnostic Related Groups (DRGs)<sup>6</sup>. DRGs were initially introduced for 320 clinically related groups and have been rolled out nationally over the past five years.

**The public sector is the main provider of health services.** Private sector services are growing but primarily provide outpatient services. A limited number of private providers participate in the PSG through contracts with health insurers. Private facilities account for 19.9 percent of all SHI contracts, and about 10 percent of all outpatient care paid for by SHI. The private sector's role in secondary and tertiary care is even smaller (Annex Table 3).

## 4. Supply and Delivery of Health Care

**Public health was historically the cornerstone of primary care efforts in Russia.** Regular check-ups and screening activities for the working population and teenagers have been growing under a nation-wide program of “dispanserization” (screenings and check-ups), and child immunization programs. Treatment and control of tuberculosis, child acute respiratory infections and diabetes are examples of services provided in primary care settings. These programs as well as separate environmental health and communicable disease surveillance programs are fully financed by government revenues with no cost-sharing by users.

**Primary health care is provided in multi-specialty polyclinics in urban areas and smaller settings in rural areas.** District physicians serve children and adults separately, with many primary care functions being delegated to specialists working with district physicians, because the cadre of general practitioners has not been sufficiently developed. Secondary and tertiary care is provided in a hierarchy of hospitals at the federal, regional and local level.

**The traditional role of district physicians<sup>7</sup> (DP) as gatekeepers is on the decline.** In many regions of the country, especially Moscow city, patients can visit a DP or see specialists without a referral. DPs are typically not aware of their patients' hospital admissions and ambulance calls as coordination between primary health care (PHC) physicians, outpatient specialists and hospitals is low. Chronic disease management is weak as a consequence (Sheiman, Shevski, 2014). The role of the DP has been undermined due to shortages as well as perceived lack of quality. The number of patients per DP ranges from 2300 to 3300 across

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<sup>6</sup> DRGs classify patient cases according to the following variables: principal and secondary diagnoses, patient age and sex, the presence of co-morbidities and complications and the procedures performed. Cases classified as belonging to a particular DRG are characterized by a homogenous resource consumption pattern and, at the same time, DRGs are clinically meaningful. Thus, cases within the same DRG are economically and medically similar.

<sup>7</sup> District physicians (DPs) and general practitioners (GPs) are quite distinct in the Russian context. There are two types of DPs – district therapists serve adults; district pediatricians serve children. The major difference between DPs and GPs is that the former has a much narrower clinical area and deal with the simpler internal medicine cases, while GPs provide more comprehensive care that includes some clinical specialist areas. According to federal “normatives”, GPs are responsible for 1200 people (some of them children), while district therapists – 1700 adults, and district pediatricians - 800 children. Russia is slowly developing a cadre of GPs.

regions, which is 70-100 percent higher than the target (“normative” level) established by the MOH (Shishkin et al, 2016). As a result, waiting times to see the DP are long in some regions, while visit times are short and the scope of services offered is limited. Also, patients’ satisfaction with DP services is low. According to the Roszdravnadzor (an agency reporting to the Ministry of Health), only 14 percent of respondents were satisfied with their DPs (Sheiman, Shevski, 2014). The latest survey of the Levada Center (the biggest sociological organization in Russia) revealed similar mistrust: 44 percent of respondents are dissatisfied with the short visit-times at polyclinics; 63 percent dissatisfied with the inadequate qualification of polyclinics physicians and their shortage (Levada Center, 2016). Similar estimates made for European countries (including some post-Soviet countries) indicate that 80-90 percent of respondents are satisfied with their general practitioner (GPs) (Wilson et al, 2015).

**Government programs have sought to strengthen rural primary care in recent years, but have yet to make a significant impact.** Physicians receive a lump sum compensation for housing costs as an incentive to relocate to rural areas. Although initially successful, the impact of the program has waned: the number of participants in the program fell from 7,693 physicians in 2012 to 3,313 in 2014. Despite a shortage of rural physicians, medical facilities have received new medical equipment and the “feldsher-midwife units” (staffed with paramedics) re-vitalized. Furthermore, the rural population now has better access to specialty care provided in “inter-territorial” health centers, medical facilities that serve the population of a group of sub-regional areas. The distance that patients need to travel to seek acute medical care has been shortened as a result.

**The Ministry of Health has also initiated a set of activities to strengthen primary care in remote areas.** New information systems have shown that there are 82,000 locations where the number of households is less than 100. New communication devices are being provided for these areas, households requiring access to services identified and mobile medical teams formed to carry out regular check-ups and respond quickly to urgent health needs (MOH, 2016).

**However, primary care remains the weakest aspect of health service delivery resulting in an over-reliance on hospitals.** Under-provision of primary care generates demand for specialty care and exacerbates an already high reliance on hospitals. The perception that high quality health care can only be received in inpatient care settings is deeply rooted in the population. Although the number of bed-days per capita has declined due to government efforts to shift care from inpatient to outpatient care, this indicator remains 70-75 percent higher than for other EU countries.

**Tertiary care is more centralized than primary and secondary care and highly rationed.** The MOH issues “quota” admissions for tertiary care (“high technology care”) and allocates them to regions. Regional health authorities in turn allocate them to medical facilities. Sometimes the quotas are allocated directly to providers. Each application for tertiary care is assessed on a case-by-case basis. The number of quotas and the actual utilization of tertiary care increased substantially in 2008-2013 - due to substantial additional funding during this period.

**Most health personnel are public sector employees working in public facilities.** The salary of physicians has increased, but in 2015 it was only 41 percent higher than the average salary in Russia (compared to

200-500 percent in Western Europe and the USA), while the salary of medical nurses is 21 percent lower than the average salary in Russia (Rosstat, 2016; OECD, 2015). This limits the motivation of health providers.

## Interactions with the Rest of the System

**Medical facilities owned by ministries other than the Ministry of Health and state corporations represent a parallel health system, although relatively small.** Legally, regional health authorities are responsible for service provision in all regional medical facilities. The parallel health system exists independently with limited links to regional health authorities. Managers of territorial medical facilities report to the regional health authorities, while managers of health facilities in the parallel system report to their ministries and corporations. This complicates service delivery planning in the region and causes duplication. The enrollees of these systems do not lose access to the territorial health facilities (at the places of their residence) with the resulting double funding.

**Another area of interaction is the private health system.** Private medical facilities provide services mostly for OOP payment. As mentioned above, they have limited involvement in the PSG. There are many administrative barriers, including: i) low SHI tariffs, which are not adequate to cover the investment cost of private providers; ii) a legislative requirement not allowing the generation of profits from surplus revenues; iii) commitments by regional governments to increase the salaries of public facility employees.

## Economic Boom and Austerity: what it meant for the Supply of and Access to Health Services

**The boom years of 2000-2013 were associated with several important reforms to improve the accessibility and affordability of health services.** The most significant increase in public expenditures occurred after 2006 when a large-scale National Priority Health Project was launched. This project focused on improving PHC and disease prevention, improving the accessibility of tertiary care and improving maternal and child health services. Over 250 polyclinics were built and more than 3000 repaired, and 1400 feldsher-midwife units built (2000-2015). Resources were allocated to re-equip outpatient facilities so as to accelerate the shift of patients from inpatient to outpatient settings (MOH, 2016). Physicians were encouraged to work in rural areas with lump-sum housing costs compensation, which resulted in the number of rural physicians increasing by almost 25 percent from 2011 to 2016 (MOH, 2017).

**In 2008-2009, there was an added focus on reducing cardiovascular and cancer mortality, road traffic accident mortality and tuberculosis mortality.** At this time, a previous focus on developing PHC and disease prevention was replaced by a greater emphasis on high-tech services. Fourteen new tertiary level federal medical centers specializing on cardio-vascular surgery, neurosurgery and trauma care were constructed improving access to high-tech services. Outpatient and emergency service facilities were re-equipped with modern diagnostic medical equipment. The number of PHC physicians and nurses increased noticeably, which improved the accessibility of high-quality outpatient care in big cities and decreased waiting time for diagnostic procedures and ambulance response (Popovich et al, 2011). Another important investment initiative, the Health Care Modernization Program was implemented in 2011-2012 and focused

on modernizing health care infrastructure nationally at the regional level. Substantial new investments were made in equipment, medical supplies, major repair works, and building new child care facilities.

**The economic downturn and 2014-2016 budget cuts resulted in cost containment and attempts to more effectively use existing resources and maintain care guarantees.** Currently, there are no plans to reconsider citizens' entitlements to free care, as enshrined in the Russian constitution. Cost containment, which was always included in official documents as a key policy strategy has been strengthened through higher policy targets and additional activities. The most important regulatory document is the Federal Government's roadmap titled "Changes in the Social Sector to Enhance Efficiency" (December 28, 2012) and subsequent MOH regulations. Based on these, each region has developed a roadmap for increasing efficiency in the health sector through to 2018. The cost containment measures are described below.

**The government initiated a range of activities to promote healthy lifestyles.** Primary care providers are increasingly involved in smoking and alcohol abuse cessation campaigns, as well as in encouraging healthy diets. There is some evidence of progress with MOH estimates of declines in alcohol sale from 10.7 liters per capita in 2011 to 8.7 in 2015. The share of smokers also declined from 35 percent of the adult population in 2014 to 31 percent in 2016 (Shishkin et al, 2017).

**Hospital services have been rationalized through reductions in beds and medical personnel.** The number of public hospitals decreased by 9.3 percent, bed supply by 4.5 percent, the number of physicians by one percent, and nurses by 2.8 percent between 2013 and 2014 (Shishkin et al, 2016). Each region developed a road map to undertake further rationalization of services. For example, Moscow city reduced the number of hospital beds by 20 percent over the last 3 years. Patients are increasingly being moved to outpatient settings and day care centers.

**To meet the growing demand for outpatient care, polyclinics have been merged to create bigger entities.** Initially, polyclinics were not ready to accept new patients due to shortages in physicians and their lack of qualifications to treat more complicated cases. Merging the polyclinics made it possible to spread scarce resources, particularly expensive equipment and specialists among a large group of enrollees, use them more intensively and save on administration costs. Since 2012, 452 city polyclinics in Moscow were consolidated into 46 outpatient centers for adult health care, each with a catchment area of 250,000-300,000 enrollees. This reduced waiting time for patients, but increased travel time to services and further reduced the gatekeeping role of DPs.

**Efforts were also made to improve the remuneration of physicians and nurses, which have been largely successful.** A Presidential decree in 2012 set an ambitious goal of increasing the average salary of physicians to 200 percent of the average national salary irrespective of region by 2018, and that of nurses and medical aids by 100 percent. Federal subsidies were provided to regions to help them achieve these targets and roadmaps developed with specific annual targets. The annual targets were met every year except in 2016, due to a difficult fiscal situation. This policy continues to be a political priority.

**The Russian population, in particular the poor, have not responded well to the public spending cuts.** In the 2016 Levada Center Survey (2016), 50 percent of respondents reported no changes in access to care,

15 percent an improvement and 35 percent a deterioration. Among the poor, only 11 percent reported an improvement.

**Trends in the incidence of OOP payment in public facilities reflect overall economic trends and the dynamics of public health spending.** According to the annual surveys of private health expenditure, in 2001 52.8 percent of patients in hospitals paid formally and informally for drugs. This share declined to 18.3 percent by 2012, but then went up to 22.1 percent in 2014. The share of patients who paid for physician visits was 8.5 percent in 2001 and 14.7 percent from 2012 until presently (Shishkin et al, 2016). Per capita OOP spending is strongly positively correlated with per capita income and living in relatively “rich” cities, including Moscow and St. Petersburg, with most of the OOP increase during 2005–2012 concentrated in these cities (Shishkin, Potapchik and Selezneva 2014).

## 5. Identification, Targeting and Beneficiary Enrolment

**Three-quarters of the population reported benefiting from some form of social protection through a myriad of federally mandated and regionally organized programs, though none of them specifically target the poor.** The majority of the programs are not means tested. Most social assistance is allocated based on personal or household characteristics not related to income, such as subsidies for maternity, numerous children or disabilities. According to the surveys, only one-quarter of all beneficiaries belong to the bottom 20 percent of income, and they receive only one quarter of all resources allocated to social assistance (World Bank, 2016).

**There are no registries to identify the poor.** The Ministry of Social Support administers a Targeting Registry for the disabled. For health care, each health insurer has its own Registry that is consolidated into a national one. The registry (federal and regional) of outpatient drug beneficiaries, identifies invalids, disabled, veterans and groups of population with some diseases covered by drug benefits. However, neither targets the poor.

**To enroll in SHI, the individual must receive a SHI card (“policy”) of his/her enrollment, as well as the enrollment of their children.** It is issued free of charge by a health insurer selected by the individual. Eligibility is guaranteed by the Constitution as described in the previous section. Failure to produce the SHI card does not result in the denial of services in case of an emergency.

**Primary care providers are required to enroll patients and may keep track of their health status, but are not required to take into account the socioeconomic status of their enrollees.** To enroll with a primary health care provider, the individual must visit the primary health center and enroll with a district physician who serves a certain catchment area. If the individual is dissatisfied with the service of the DP or the entire center, s/he can enroll with another center and choose a DP once a year. DPs are expected to identify and enroll the most vulnerable groups, but not necessarily the poor. In this way, DPs develop a register of patients in the catchment area that can be used to keep track of the health (e.g. chronically ill) status of patients.

**The central government sets enrollment requirements.** Federal and Regional SHI Funds check enrollment data and enter it into a universal SHI database. There is an electronic record of SHI transactions, which is monitored regionally and centrally. There is also a mechanism for cross-checking beneficiary databases with other databases for the purpose of determining if individuals are eligible for enrolment or for a subsidy. This is particularly relevant for the regions where PHC is paid on a capitation basis. The number of enrollees is compared with the number of residents in the catchment area – from the general regional database.

**Health insurers have individual data on each enrollee along with data on utilization and costs.** They are responsible for claim verification, which includes identifying inappropriate hospital admissions, any under-provision of services, as well as other sources of inefficiency in care provision. According to the SHI Law, insurers can retain 10 percent of savings (insurers' revenue less actual health care payment) and therefore have incentives to register patients and monitor their utilization of care.

## 6. Management of Public Funds under the PSG

**The PSG has been associated with efforts to strengthen the planning of service delivery and finance, as well as to improve incentives for providers.** Direct administration of medical facilities and item-based funding have given way to changes in the way in which providers are contracted and paid. The most important changes are as follows.

*(1) The PSG has been associated with a shift from resource-based to utilization-based planning of service delivery.* The main mechanism is to set up utilization targets that encourage a shift of care from inpatient to outpatient facilities, greater use of day care centers, shorter hospital length of stay, more tough requirements for admission, etc. In the first PSG issued in 1998 the plan was to decrease the number of bed-days from 3.6 to 2.8 bed-days per capita over 5-7 years. This target has now been reached. The targets serve as the benchmark for planning utilization and finance for individual providers. These and further planning developments save resources for the UHC. Nevertheless, as noted above, Russia still has a much higher inpatient care utilization rate than other EU countries.

*(2) New provider payment methods have been introduced – capitation for outpatient care and DRG-method for inpatient care.* The focus on prospective payment methods is designed to ensure predictability of utilization and finance, and thereby to increase the sustainability of the PSG. Capitation methods (including the fundholding scheme) are designed to encourage disease prevention, decrease unnecessary patients visits, strengthen integration between inpatient and outpatient care, as well as minimize financial risks of PHC providers (Sheiman, 2016). The use of DRG-based payment methods has made inpatient care more intensive and decreased the share of less complex cases that could be treated in outpatient settings. These methods require further development to contribute to cost control and make patients entitlements effective.

*(3) The PSG presumes a shift to performance-based salaries over time.* The concept of an “effective contract” with health workers was introduced in 2012. This dismantled all former administrative barriers

to improving health work performance – without any limits on the level of salary. Health authorities and managers have developed a set of performance indicators for health workers and contracted them based on performance against these indicators. The effective contract is regarded as a tool to encourage the best medical workers and fire those that do not match the performance targets.

*(4) The PSG has improved the portability of health insurance and allowed “money to follow patients” irrespective of their place of residence and the status of providers. Local providers now serve patients from other areas, military and police medical facilities accept civil patients and provide free care. With all the limitations mentioned above, this development has strengthened medical benefit implementation and encouraged patient choice.*

*(5) The financial management of medical facilities under social health insurance is more flexible. The requirements of item-by-item resource allocation are not so strict as in the framework of the usual budgetary funding. Health managers have more discretion regarding financial decisions, although the heritage of the past command-and-control system still remains (Shishkin, 2016).*

## 7. Management of the Benefit Package under the PSG

**The PSG sets the following parameters with regard to how the benefits package is defined (Government, 2015):**

1. List of diseases: almost all diseases in International Classification of Diseases are included; treatment is free of charge.
2. Types of services: primary care, specialist outpatient care, day care centers services, ambulance care, rehabilitation care, palliative care, specialist inpatient care; treatment is free of charge.
3. List of high technology care: includes only elective care. Tertiary care is explicitly rationed.
4. Waiting time limits: primary care provided by district physicians – within 24 hours; consultations by outpatient specialists – not more than 14 days; instrumental diagnostics and lab tests – 14 days; computer tomography and MRT – 30 days; ambulance care – 20 minutes after registration of a call; high technology care (tertiary care) – 30 days.
5. Drugs: list of outpatient drug beneficiaries and list of essential drugs are specified.
6. Utilization targets for each type of care (see above sections).
7. Funding per capita and unit cost target (normative) for each type of care.
8. Criteria of health care quality: 25 criteria for the individual types of care.

Items (6)-(8) are included for planning purposes and for the evaluation of the PSG. They broaden the prospective for state commitments beyond the area of benefits package specification.

**The coverage of medical services in the PSG is quite comprehensive.** Most of services are provided free of charge, in principle. Only minor services are not included, e.g. check-ups for driving license, some diagnostic tests. Services provided without prior referrals are subject to OOP payments.

**The coverage of drugs is much less comprehensive.** The major outpatient drug program covers 13.7 million people – invalids, disabled, veterans, etc. They are entitled to free outpatient drugs in accordance with the

list of essential drugs. Beneficiaries can choose the actual drug provision or a fixed amount of money (benefits in kind vs. benefits in cash). Only 3.7 million beneficiaries have chosen the drug option because of the fear of drug unavailability in the pharmacies (2.5 percent of population). Another federal program covers the cost of outpatient drugs used for treatment of 24 rare and quickly progressing chronic diseases.

**Although the PSG benefits package is uniform across the whole population in principle, in practice there is quite a lot of variation across regions in terms of how much is actually spent on the PSG package available to beneficiaries.** Richer regions increase coverage of outpatient drugs by increasing the number of beneficiaries covered by the drug programs, or by expanding the list of reimbursable drugs. Since the overall cost of the program is higher in richer regions, these regions can also accommodate higher tariffs for medical services and thus reduce the amount of cost sharing that takes place. In short, although the PSG benefits package is comprehensive and universal by definition, in practice there is a lot of explicit and implicit rationing that takes place. Richer regions are able to spend more and thus have less of both forms of rationing.

**The scope of the benefit package has changed little since the first PSG was issued in 1998.** The major changes introduced were: i) a longer list and higher utilization targets for tertiary care, ii) some extension of outpatient drug coverage and new beneficiaries, iii) inclusion of rehabilitation and palliative care, iv) specification of the waiting time limits. Utilization targets (per capita) have different vectors: upward for tertiary care, services in day care centers, rehabilitation and palliative care; downward for inpatient care; stable for PHC and ambulance care (Flek, 2015). These targets determine the process of service restructuring and must be followed by the regions.

**The main problem with the package of medical benefits in Russia is that it is not specified clearly enough.** The commitments of the government are aggregate in nature in that medical benefits are determined in terms of diseases and types of care across aggregates of medical interventions. Tariffs are also set mostly for these aggregates. The specific diagnostic tests, drugs, implants and curative procedures that are to be provided are not always clear.

**Recent efforts to specify benefits more precisely include the development of clinical standards, patterns of medical care and clinical guidelines for each disease.** The standard is a list of drugs and services, as well as the frequency of their use, for example, computerized tomography (CT) as a diagnostic device is needed for a certain percentage of cases. The pattern of medical care sets requirements for procurement and staffing for each specialty. The clinical guidelines are supposed to establish algorithms of service provision. The latter is seen as the major clinical benchmark for providers. Currently, there are 1200 clinical guidelines covering 90 percent of most common diseases (MOH, 2016).

**The choice of what to include/exclude from the package is made by the top physicians in every clinical area with the involvement of medical associations.** The decision-making process is not explicit. Neither are there regulations to define how a choice is made nor any efforts to compare clinical and/cost-effectiveness of different interventions. Therefore, the choice of specific reimbursable drugs, implants, medical services, as well as the list of tertiary care is not substantiated by clinical and/or economic analysis.

**Clinical standards, patterns and guidelines have not added much to the expected benefits specification.** First, they don't cover some common diseases. Second, they are highly disputed by various groups of medical profession. Third and most important, they are not linked to available financial resources and therefore often unrealistic. This is particularly true for the patterns of medical care. They establish expected requirements to resources per case. For example, a physician of a certain specialty is supposed to have 10-15 cases (hospital beds) rather than the current 20-25 cases, which is unrealistic with the human resources availability. Standards often propose high frequency expensive clinical tests and interventions, which are impossible to provide in regions with low financial capacity.

**These initiatives have established a growing understanding of the need for better management of the benefits package.** A recent amendment to the drug procurement Law introduces the concept of the "complex analysis" of clinical and economic characteristics of reimbursable drugs. Also, a special unit has been set up in the MOH for the clinical and economic evaluation of medical benefits. The initial data generated relates to the evaluation of drugs and not medical services.

## 8. Taking Stock: PSG's Impact on Progress towards UHC

**This section takes a closer look at what Russia's universal approach to expanding coverage has meant for the poor.** As economic growth and revenues improved during the 2000s, Russia embarked on a significant expansion of health care coverage through the implementation of the PSG. After 2013, the economic crisis resulted in expenditure cuts and some rationalization of health services. Nevertheless, even before these expenditure cuts, the benefits package was not fully financed leading to some implicit service rationing. This section describes the impact the PSG had on Russia's progress towards UHC, particularly in the context of a tightening fiscal situation.

**The PSG is a universal program with a single national pool and a uniform benefits package that all citizens of Russia are entitled to under the Constitution.** Neither SHI enrollment nor access to services is linked to the socioeconomic status of the beneficiaries. Employers pay contributions on behalf of their employees and the government pays contributions on behalf of the non-working population regardless of their socioeconomic status. The benefits package is quite comprehensive, particularly with regard to medical services, with all regions expected to make them available to beneficiaries. There has never been any explicit targeting of services, although there has been an element of geographic targeting: fiscal redistribution was used to improve resource allocation to less well-off regions and rural areas. The political commitment to universal coverage was maintained through the recent economic crises.

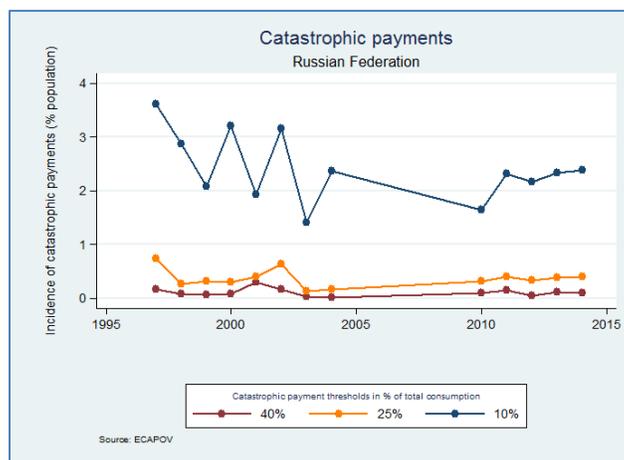
**In practice, a combination of underfunding in health care (Section 2), the lack of clarity over the benefits package (Section 7) and an inadequate focus on the poor (Section 5) has given rise to inequity and implicit rationing of health care.** Major forms of implicit rationing in Russia include: inadequate access to good quality primary care services and effective coordination of care; limited availability and affordability of drugs and supplies; and the opportunistic behavior of physicians, who typically offer the most effective drugs and services only for OOP payment.

This section first presents the quantitative evidence on equity and financial protection from 2000 to 2015 before examining some qualitative evidence on how the poor are affected by implicit rationing in the health sector.

## Quantitative Evidence regarding Financial Protection and Equity

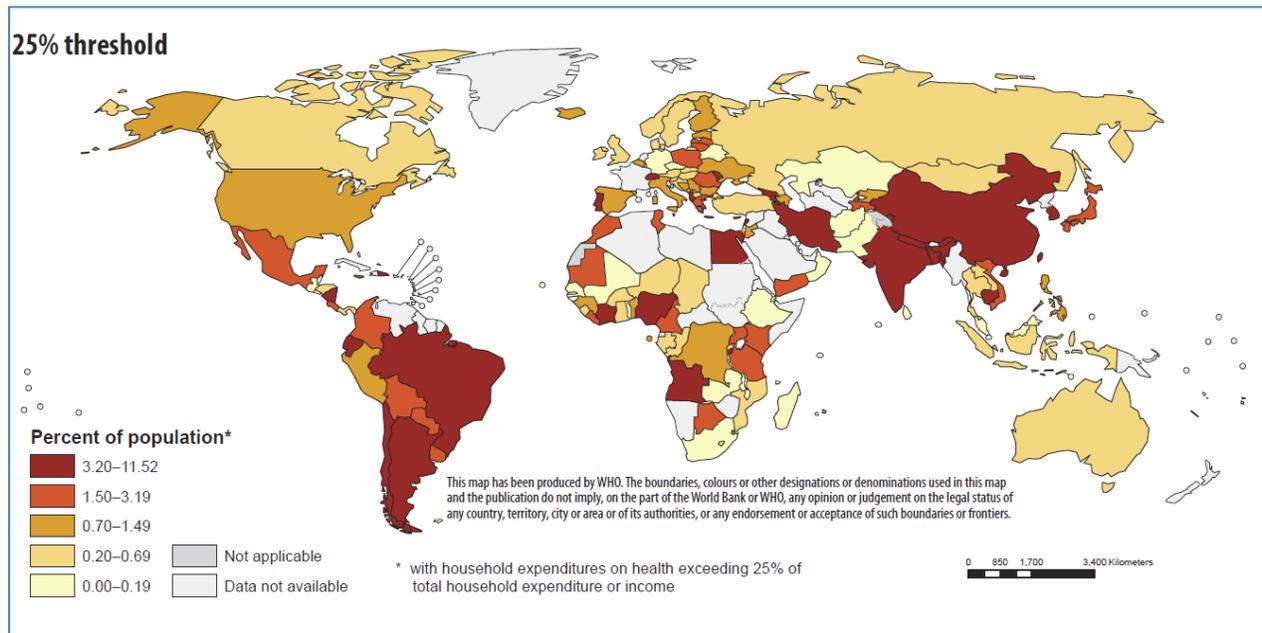
**Financial protection improved significantly as the PSG was rolled out: rates of catastrophic OOP spending declined quite dramatically in the late 1990s, then more gradually and rose only slightly following expenditure cuts.** Data reveals that Russians were significantly less likely to forego care because of financial barriers to access in 2011 compared to 2000 (Shishkin, Potapchik and Selezneva 2014). In 1997, four percent of all households spent more than 10 percent of their total household spending on health payments (Figure 6). This share declined to 1.8 percent by 2010, but rose again to 2.4 percent in 2014 following reductions in public health spending. The recent UHC Global Monitoring Report shows that catastrophic incidence in Russia is comparable to that of many OECD countries at the 10 and 25 percent thresholds (WHO and World Bank, 2017). Figure 7 shows catastrophic incidence at the 25 percent threshold across the world for the most recent year available. Russian data reveal that catastrophic spending was concentrated amongst richer households, and increasingly so during the 2000s (Annex 2, Table A2.1). The percentage of households pushed below the poverty line as a result of OOP payments has been declining as well, though there was a slight increase in 2014. Annex 2 contains a more detailed description of this analysis and results.

**Figure 6: Catastrophic Health Payments as a Percent of Total Consumption**



Source: World Bank analysis of Household Budget Surveys for Russia for 1997-2004 and 2010-2012.

**Figure 7: Global Incidence of Catastrophic Health Spending**



Notes: WHO and World Bank estimates are based on standard definitions and methods to ensure cross-country comparability, which may not correspond to the methods used at regional and/or national level to monitor catastrophic spending on health. Global estimates are based on data availability for global monitoring which may not necessarily align with availability of data at national or regional levels.

Source: Global database on financial protection assembled by WHO and the World Bank (WHO and the World Bank, 2017).

**Underlying these improvements were large reductions in OOP spending on inpatient care, particularly by the poor and those living outside of Moscow and St. Petersburg.** Per capita OOP expenditures on inpatient care declined by 1.6 times from 2000 to 2012, and the share of patients purchasing drugs OOP for inpatient care declined from 52.8 percent to 18.3 percent. Notably, the ratio of per capita inpatient OOPs of the richest quintile to the poorest quintile doubled during the same period, indicating that those expenditures are now more concentrated among the rich (Shishkin, Potapchik and Selezneva 2014), consistent with the above finding that catastrophic spending is concentrated among richer population groups. With the exception of those living in Moscow and St. Petersburg, per capita inpatient OOP spending declined for all others reflecting the increase in free, albeit often low quality inpatient care services and drugs.

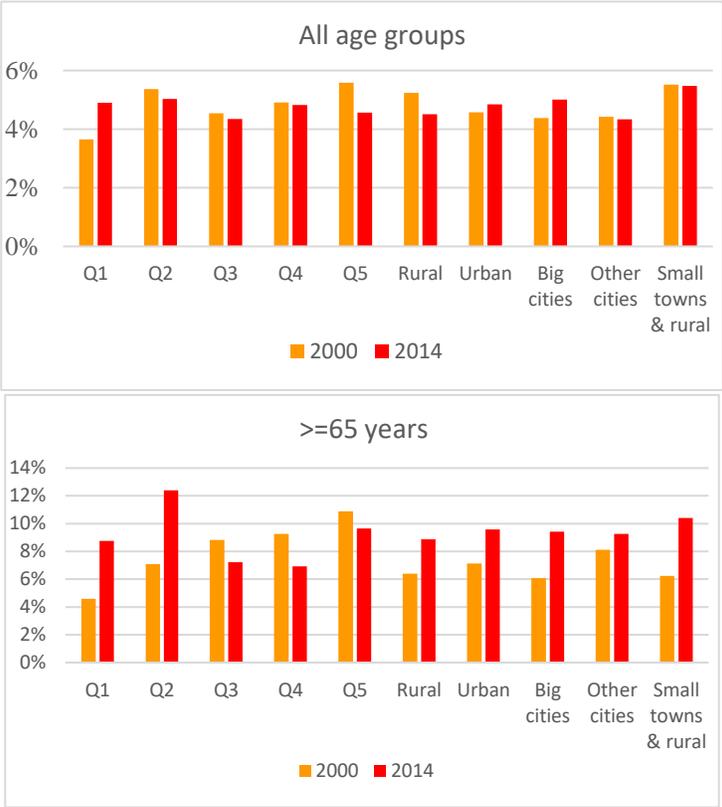
**Large increases in OOP spending on outpatient drugs and services, particularly for the poor weakened financial protection.** As shown earlier in Figure 5, expenditures at pharmacies dominates OOP spending. OOP spending on outpatient drugs, which are not included in the state guaranteed benefits package increased three-fold during 2000-2012 after adjusting for prices, while the share of patients who paid for outpatient care increased from 4 percent (1994) to 9 percent (2000) and 15 percent (2012) (Shishkin, Potapchik and Selezneva 2014). Outpatient drugs accounted for 61.4 percent of total OOP spending, while

outpatient and inpatient drugs accounted for 32.3 percent and 6.3 percent respectively. The rate of growth in outpatient OOP spending was higher for the poor than for the rich.

**Spending on diagnostic tests and services declined only for those living in big cities.** The share of those who paid for tests and medical procedures during outpatient care increased from 8.8 percent in 1994 to 27.4 percent in 2006 and declined thereafter. This decline was a direct consequence of improved public investment to increase the supply of modern diagnostic equipment in outpatient care facilities. However, the fact that per capita OOP spending on diagnostic services declined by 30 percent for those in big cities but increased for everyone else indicates that the residents of large cities may have been the primary beneficiaries of all of the increased diagnostic equipment investments.

**Given these trends in financial protection, it is no surprise that the use of inpatient care became more pro-poor and outpatient care more pro-rich** (Figure 8 and Figure 9) **particularly for those aged 65 years and over.** Inpatient utilization rates increased from 3.6 percent to 4.9 percent for the poorest quintile, but declined from 5.6 percent to 4.6 percent for the richest. Inpatient utilization rates for the poorest quintile increased from 4.6 percent to 8.8 percent for those over 65. Greater use of inpatient care services by the elderly may reflect increased financial barriers to accessing outpatient care. As shown in Figure 9, there has been little change in the distribution of use of outpatient services. For those aged 65 and over, outpatient use has become more pro-rich. The data also suggest that recent utilization rate increases are more pronounced in the big cities.

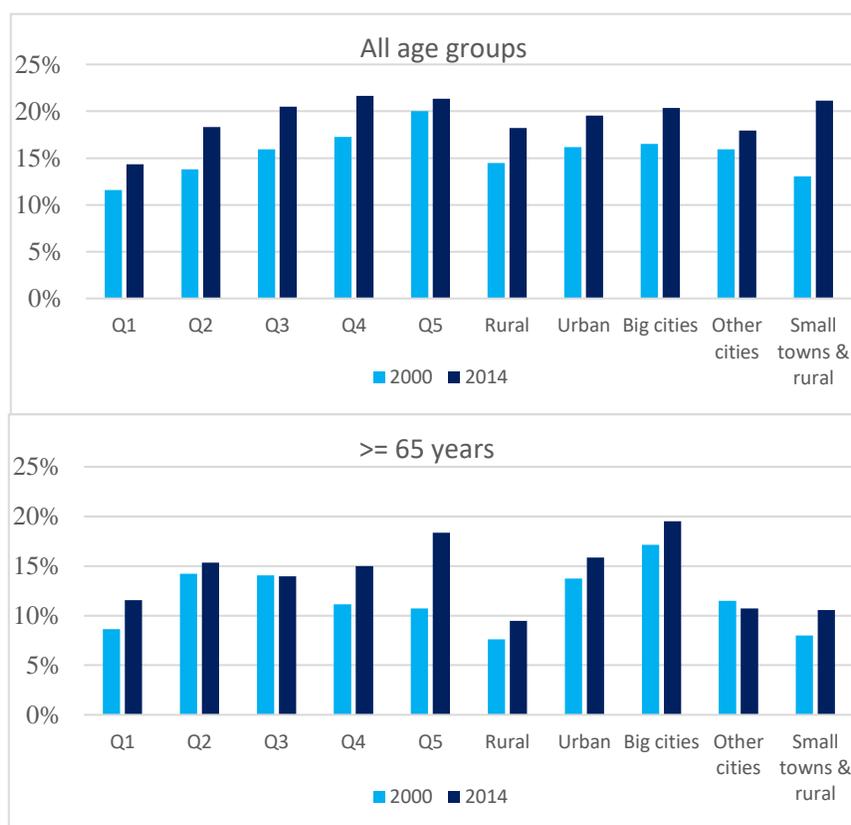
**Figure 8: Utilization Rate of Inpatient Care Services during the Past Three Months by Socioeconomic Status, Area of Residence and Age, 2000-2014**



Source: World Bank analysis of Russia Living Standards Measurement Surveys for 2000 and 2014.

Notes: (1) Q1 to Q5 refer to consumption based quintiles calculated using household consumption reported in the survey with Q1 being the poorest and Q4 the richest. (2) Big cities have a population of over 500,000 and Other Cities have a population of 50,000 – 500,000

**Figure 9: Probability of Having Seen a Doctor During the Past Three Months, by Socioeconomic Status, Area of Residence and Age, 2000-2014**



Source: World Bank analysis of Russia Living Standards Measurement Surveys for 2000 and 2014.

Notes: The outcome variable is the probability of having seen a doctor in the past three months without being sick.

This was the only outpatient care variable for which comparable multi-year data was available.

Q1 to Q5 refer to consumption-based quintiles calculated using household consumption reported in the survey with Q1 being the poorest and Q4 the richest.

Big cities have a population of over 500,000 and other cities have a population of 50,000 – 500,000

## Qualitative Evidence on the Impact of Implicit Rationing

**Primary care providers - DPs and GPs - are in short supply (Section 3) and do not play a major role in the coordination of care.** DPs refer roughly one-third of their first contact patients to specialists (Sheiman, Shevski, 2014), compared to 8-15 percent or lower in the EU. An internet survey of 171 DPs and GPs in 14 regions of Russia conducted in mid-2016 by the Higher School of Economics (HSE, 2016) collected data on actual practice of primary care providers in Russia. It followed a set of indicators included in the European Primary Care Activity Monitor in 31 European countries (Kringos et al, 2015) and provided the following evidence on the extent of under-provision in primary care:

- DPs do not provide adequate follow-up care to patients after hospital discharges. The survey indicated that 63 percent of DPs are unaware of their patients' hospital admissions. The lack of continuity of care is particularly a problem in the case of strokes, myocardial infarctions, and major trauma. Similarly, most DPs are unaware of their patients' ambulance calls, which is an indirect

indication of poor chronic case management. A patient with a stroke is supposed to have rehabilitative care (a PSG provision) after discharge, but in many cases, this is not the case.

- There is little interaction between primary care providers and outpatient specialists in the management of chronic diseases. Only 27 percent of respondents reported having regular discussions of chronic cases with specialists, 30 percent never, and 43 percent - rarely. Primary care providers choose how they refer patients to specialists, communicate with them and provide feedback from specialists.

**Chronic disease management is rationed.** Patients with chronic diseases are entitled to “dispensary surveillance”, or case management by the joint effort of district physicians and specialists. But the scope of these services is limited. According to a group of leading cardio-surgeons, chronic disease management covers only 10 percent of myocardial infarction cases, 23 percent of instable cardiac angina cases, and 43.6 percent with ischemic heart disease. The target outcomes of chronic disease management are not specified (Bokeria et al, 2015, p. 70).

**The PSG specifies waiting time limits for elective inpatient care, but there is no requirement for hospitals to make waiting time information for specific interventions publicly available.** Also, there are no explicit waiting list management procedures. This extends the scope for implicit rationing: elective medical interventions may be postponed until a patient seeks the same care with private payment (sometimes in the same hospital).

**Since the PSG does not specify exactly which diagnostic and curative care services beneficiaries are eligible for, providers have discretion over providing or denying tests and procedures depending on budget availability.** For example, an X-ray may be provided instead of a CT scan for a complex case of back pain even though the CT scan may be the more clinically appropriate option. Instead, the CT exam may be offered subject to private payment. According to the HSE survey (2015), 62 percent of patients who paid for diagnostic services in 2014 did so because they could not get these services free of charge, 15 percent did so because access to the service was difficult or impossible without paying.

**The most common form of implicit rationing is to shift the cost of the service to the user.** A media report found that payments are almost always required for several tests even though, in principle, they are provided free of charge under the PSG. These tests include thyroid function tests (thyrotrophic hormone, T3, T4), a series of massages or remedial gymnastics prescribed by specialists (especially for children), additional physiotherapy (for example: electrophoresis is free but not high-frequency therapy, ultraviolet irradiation, or similar), and Magnetic Resonance Imaging (MRI) or CT (which have waiting times of close to 1-2 months instead of 3-4 days). Users also often have to purchase additional supplies for the surgical trauma treatment and bone or muscular diseases (for instance, surgical hardware or endoprosthesis), intraocular lens prior to cataract surgery, pay for the initial care visit to a dermatologist, anesthesia (for example: in dentistry), and tooth removal (Moskovski Komsomolets, September 19, p 6).

**In a large country with a highly-dispersed population, it is inevitable that the population in remote areas faces barriers to access.** The Levada center survey showed that in mid-2016, 40 percent of rural residents had not seen a doctor over the previous two years, while the national average was 32 percent, and 19 percent for Moscow. Among rural residents, 40 percent cite long waiting times as a major cause of under-

provision, 35 percent low physician qualifications and 35 percent poor medical facility equipment. Urban area residents cite poor physician qualifications as the major access obstacle (Levada Center, 2016, pp. 12,15). Also, there is a substantial gap in the physicians/population ratio in rural and urban areas (Rosstat, 2016).

**On a more positive note, informal payments, which are often associated with implicit rationing have declined in recent years.** The 2012 HSE survey showed that of those who paid any OOP payments, 66.2 percent paid informally for inpatient care and 28.1 percent paid informally for outpatient care. The average share of informal payments was around 30 percent of total OOP. Patients pay for access to care in the best medical facilities, treatment by the best physicians, amenities and sometimes for drugs and supplies that are unavailable or scarce in medical facilities. “Gratitude payments” are also common, particularly for maternity cases and major surgery. However, economic development resulted in a legalization of a certain portion of informal payments, both over time and across regions. There has been a reduction in their frequency and their value as a share of total OOP (Shishkin, Potapchik and Selezneva 2014, p.8).

### Drug Coverage

**Users bear the bulk of the drug costs because of weak PSG drug coverage.** This is particularly true for the elderly, although some are beneficiaries of the drug program. According to the Russia Longitudinal Monitoring surveys, the retired spend 2.2 times more on drugs than the employed in per capita terms (Shishkin et al, 2014, p. 20). This also explains why the elderly poor are less likely to use outpatient care services than the rich (Figure 9).

**The Accounting Chamber (a major Russian control agency) recently provided evidence on the under-provision of oncological care drugs relative to the list of drugs established by the regional programs of state guarantees.** Some regional drug program beneficiaries in Stavropol, Kaliningrad, Moscow, Tomsk oblasts, Moscow city have been denied the oncological drugs. The major reason is unavailability of these drugs in pharmacies and hospitals. Formal prosecution of the health authorities in the cases identified but the Accounting Chamber has started (Evidence Medicine, 2016), though the actual number of drug denials is higher.

**Several options for extending outpatient drug coverage are under discussion.** For example, Kirov oblast has set its own list of outpatient drugs for cardio-vascular diseases with a resulting decrease in inpatient care utilization per capita, less ambulance care calls by this group of patients, and reductions in mortality amongst the working age population. However, a nationwide scale-up of this program was postponed due to budgetary cuts.

**In addition, hospitals often ask patients to buy supplies for major medical equipment.** Though documented evidence does not exist, interviews with Moscow hospital physicians indicate that requests for the purchase of medical equipment and required drugs are common in their clinical activity.

## 9. Conclusions

### Did Russia make Significant Progress towards UHC?

**An assessment of Russia's progress towards UHC must use the status of the health sector in the early 1990s as the starting point.** The economic and political transformations of the early 1990s and the associated near collapse of the health sector resulted in a significant deterioration in health outcomes. Financial protection deteriorated considerably as health facilities increasingly relied on OOP financing. Although health outcomes improved during the 2000s, they continue to lag behind that of other comparator countries due to the tumultuous developments of the 1990s.

**The quantitative evidence presented in this paper suggests that Russia made important gains in improving financial protection and access to care for the poor, which were largely sustained through the economic crisis of the 2000s.** Much of the improvement in financial protection occurred during the late 1990s and early 2000s when rates of catastrophic spending and impoverishment due to OOPs declined dramatically. Financial protection indicators deteriorated slightly following the economic crisis. Inpatient use became more pro-poor, especially for the elderly, but outpatient use more pro-rich. Despite modest rates of improvement, these are significant when compared to the situation in the early 1990s.

**Large PSG related investments and reforms during the 2000s supported the achievement of health gains and moderated the reversal of trends during the fiscal crisis.** The State's commitment to universal coverage meant that explicit targeting was not considered. Given Russia's federal governance structure, fiscal redistribution was used as a mechanism to increase resource allocation to less well-off areas. Increased public spending on hospital care, including capital investments, improved access to inpatient care for the poor, particularly the elderly. Increased investment in diagnostic equipment at outpatient care facilities was associated with increased access to diagnostic tests and services, but only in major cities. Limited PSG coverage for outpatient drugs means that high OOPs drug payments remain one of the biggest threats to financial risk protection. It has resulted in a deterioration in outpatient care access, particularly for the poor and elderly. There was, initially at least a strong push to reallocate spending towards primary care. This increased access to both physicians and services in remote, rural areas even if these trends were reversed later. Last, but not the least, informal payments declined as overall governance improved and health care payments were formalized.

### Pending Agenda

**To further deepen and expand coverage for the poor, there is a critical need to narrow the divergence between PSG's *de jure* and actual coverage.** This gap is largely due to resource constraints. Although the Federal PSG establishes requirements for the volume of care and their funding in the regions, some regions do not have the financial resources to provide all of those services. The Accounting Office reports funding shortages in 2016 of 937 million roubles in Pskovskay oblast, 703 million roubles in Altai Republic, and 468 million roubles in Kaliningradskayoblast. Thus, the unit cost in these oblasts was 30-70 percent lower than federal financial targets (Evidence Medicine, 2016). These and other regions (not necessarily the poorest) cannot meet the federal funding targets despite the federal transfers they receive resulting in both explicit

and implicit rationing of services. Higher OOP spending by richer households and those living in the large cities as well as other forms of implicit rationing discussed above suggest that public health spending is falling short of providing good quality, effective health care services to the population.

**Expanding outpatient drug coverage is a PSG priority.** The lack of coverage of outpatient drugs in Russia is arguably the biggest barrier to improve both health outcomes for NCDs (given what we know about this from the West) and financial protection (given prominent role of drugs in OOP spending). To date, public health spending has focused on inpatient care, leaving households to pay for outpatient drugs, with potentially deleterious effects on outpatient care use by the poor and especially the older poor. Given rapid ageing and the high NCD burden, Russia needs to prioritize cost-effective approaches to addressing NCDs like the pharmacological treatment of cardiovascular disease and diabetes. The latter would require reducing the OOP cost of key outpatient drugs and strengthening access to good quality outpatient care services.

**Strengthening the service delivery system, particularly primary care, is important for sustaining and expanding recent financial protection and equity gains.** The first important steps have been made by the Russian government for the rationalization of health infrastructure, including a shift from inpatient to outpatient care, deployment of day care centers, development of multi-level service delivery system, a substantial rise in tertiary care provision, establishment of a rehabilitation and palliative services sector and strengthening care in rural and remote areas. The equalization policy has helped re-distribute public spending more effectively. Historic supply variations across regions and local areas have narrowed due to a substantial improvement in access to care in some regions. The use of inpatient care has become more pro-poor, especially for those over 65 years of age. However, service delivery reforms have fallen short of significantly strengthening primary care services. Inadequate care coordination, chronic disease management and the over-use of hospital services are all associated with inadequate access to good quality, affordable primary care services.

**Several organizational changes are being tested in different regions in order to strengthen and transform the service delivery system.** The objective is to make outpatient care more patient-oriented and increase efficiency of internal processes in polyclinics. For example, the current project “Resources saving polyclinics” being piloted in three regions (Jaroslavl, Kaliningrad oblasts and Sebastopol city) includes the following activities (MOH, 2017): i) delegation of some physicians’ functions to nurses; ii) building more efficient logistics in polyclinics, including a more careful separation of patient flows across individual providers’ offices; iii) introduction of electronic communication and paper work reduction; iv) building a new polyclinic image; and v) establishing new infrastructure for preventive activities (new structural units). Two years of project implementation (2015-2016) have shown promising results. According to the MOH (2017), physicians’ average time with patients doubled in these regions, appointments with physicians were radically facilitated, and patient waiting times to see a physician fell by 12 times. More detailed evidence of the project’ results will become available in future. Another example is the creation of a new “layer” – inter-territorial health center – to supplement the traditional model of outpatient care. This layer will provide both outpatient and inpatient care to the inhabitants of a few neighboring territories. The regional governments built these centers for clusters of communities to encourage the cross-border movement of patients.

**Going forward, additional fiscal space for health is needed and health policy must make more effective use of available resources.** An increase in tobacco and alcohol taxes would not only raise revenue, if earmarked for the health sector, but also reduce tobacco and alcohol consumption, which contributes to NCDs. Once the additional fiscal space has been identified, expanding coverage for outpatient drugs and strengthening primary care are immediate priorities.

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## Annex 1: Supplementary Tables

**Annex Table 1. Public Health Funding Structure by Revenue Source in Russia in 2000-2014, %**

	2000	2005	2010	2014
Federal	8.8	22.7	26.5	21.7
Regional	23.9	21.0	25.8	24.8
Local	26.9	21.2	14.7	1.2
SHI Funds*	40.4	35.1	32.9	52.3
Total	100.0	100.0	100.0	100.0 (2620 bln roubles)

\* Includes contributions of regional governments to SHI for the non-working population

Source: Flek, 2015, p.114

**Annex Table 2. Public Health Funding Structure by Financial Agents in Russia in 2000-2014, %**

	2000	2005	2010	2014
Federal	8.8	15.7	19.2	17.57
Regional	24.1	21.1	31.9	28.2
Local	26.9	21.2	14.7	1.22
SHI Funds*	40.4	42.0	34.2	53.1
Total	100	100	100	100

\* Includes SHI contributions for the non-working population

Source: estimate based on Flek, 2015, p. 115.

**Annex Table 3: Public/Private Mix by Level of Service Provision in Russia**

	<b>Public</b>	<b>Private</b>	<b>Comments</b>
<b>Primary Care (number of consultations)</b>	Large (around 90%)	Small (around 10%)	Private outpatient facilities (practically all for-profit) participate in the implementation of the State Guarantees of Free Care through health insurer contracts. Their share in the total number of medical facilities under SHI contracts amounts to 19.9% (FOMS, 2015, p.7). But the share in volumes of care is much lower, as most of them are small organizations (much smaller than public polyclinics). These are our estimates since exact data is not available.
<b>Secondary care (number of bed-days)</b>	Large (90-95%)	Small (5-10%)	Private hospitals are rare in Russia. Our estimate relates to the hospitals owned by a few of the biggest corporations and private entities.
<b>Tertiary Care (number of bed-days)</b>	Large (95-98%)	Small 3-5%)	Private hospitals are rare in Russia. Our estimate relates to the hospitals owned by a few of the biggest corporations and private entities.

*Source: Authors estimates*

## Annex 2: Measuring Financial Protection in Russia

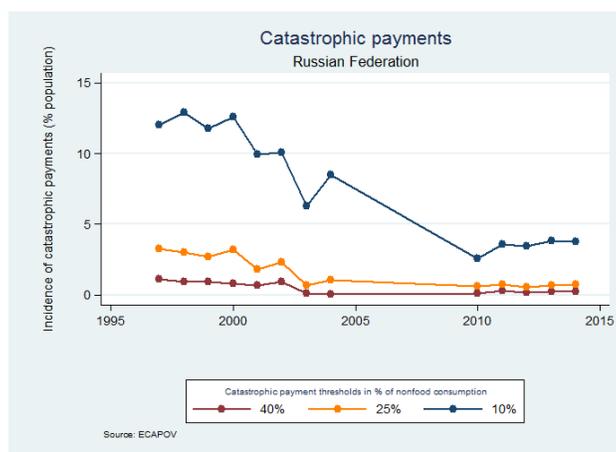
Measures of Financial Protection relate OOP to a Threshold.

### Catastrophic Health Expenditures

One approach is to classify spending as ‘catastrophic’ if it exceeds a certain fraction of household income or consumption or nonfood consumption. Catastrophic payments are defined as healthcare payments in excess of a predetermined percentage (i.e., 10 percent to 40 percent) of total household spending or nonfood spending. The three lines in Figure A2.1 show the catastrophic payment ‘headcount’, i.e., the proportion of households with a health payment budget share greater than the given threshold (10 percent, 25 percent and 40 percent).

In 1997, 4 percent of all households spent more than 10 percent of their total household spending on health payments. When health spending is compared against non-food consumption, or discretionary household spending, “catastrophic” spending is higher. In 1997, 12 percent of households spent more than 10 percent of nonfood spending on health payments (Figure A2.1). This share declined to around 2 percent by 2010 and rose slightly to around 4 percent in 2014.

**Figure A2.1: Catastrophic Health Payments, in Percent of Nonfood Consumption**



Source: World Bank Analysis of Household Budget Surveys for Russia for 1997-2004 and 2010-2012.

An important concern is whether catastrophic spending is concentrated among richer households, who may be able to draw on savings and other sources of income or among poorer households, who may not have a financial cushion. The concentration indices in Table A2.1 reveal with a 40 percent threshold whether there is a greater tendency for the better-off to have OOP spending in excess of the payment threshold (positive value), or whether the poor are more likely to have OOP spending in excess of the threshold (negative value). In Russia, large and positive concentration index values suggest that catastrophic spending was largely concentrated among richer households and increasingly so during the 2000s.

**Table A2.1: Catastrophic Payment Indices**

	<u>Total household consumption</u>	<u>Nonfood consumption</u>
<b>Year</b>	<b>40%</b>	<b>40%</b>
<b>1997</b>	0.580	0.159
<b>1998</b>	0.404	0.019
<b>1999</b>	0.199	-0.070
<b>2000</b>	0.348	0.071
<b>2001</b>	0.432	0.098
<b>2002</b>	0.812	0.330
<b>2003</b>	0.969	0.730
<b>2004</b>	0.945	0.143
<b>2010</b>	0.670	0.493
<b>2011</b>	0.750	0.454
<b>2012</b>	0.778	0.459
<b>2013</b>	0.693	0.481
<b>2014</b>	0.564	0.497

Source: Author's estimates as part of analysis carried out for the study.

### **Impoverishing Health Expenditures**

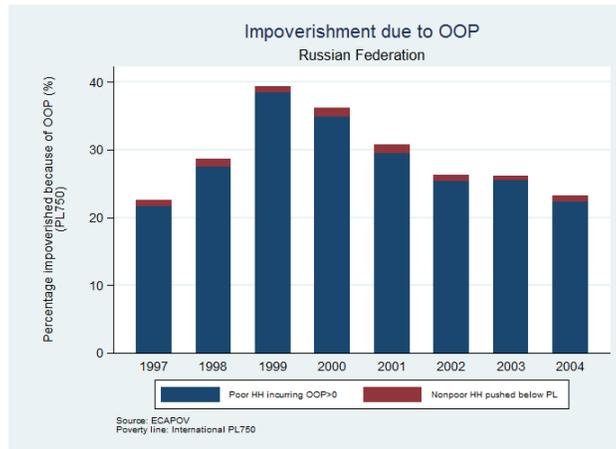
Another approach to measure financial protection is to classify health spending as 'impoverishing' if it is sufficiently large push households over the poverty line, i.e., the household would not have been poor had it been able to use what it spent on healthcare for general consumption. In Russia, impoverishment is measured by estimating the percentage of households that are driven below the poverty line due to OOP spending (Figures A2.2 and A2.3).

Figures A2.2 and A2.3 show the percentage of households (that have OOP spending) with total household consumption below the international poverty line of \$7.50 per capita/day<sup>8</sup> for the different years (blue segment of bars) and the percentage of households pushed below the poverty line as a result of OOP payments (red segment of bars). Notably, the percentage of households pushed below the poverty line as a result of OOP payments has been declining, though there was a slight increase in 2014.

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<sup>8</sup> Construction of international poverty lines: In the ECAPOV (ECA Poverty) surveys, expenditures are expressed in local currency units (LCU) per capita/day. We express the international poverty lines in LCU per capita/day. The international poverty lines were constructed using purchasing power parity (PPP) data from 2011 and by nomillay adjusting the value using the Consumer Price Index (CPI) inflation rate between the survey year and 2011.

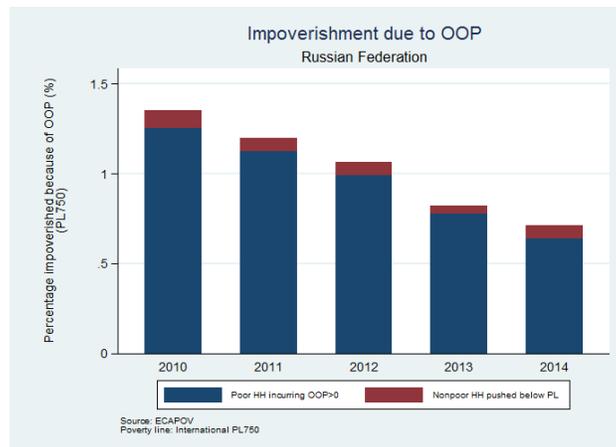
**Figure A2.2: Impoverishment Due to OOP for 1997-2004\***



Notes: The years 1997-2004 and 2010-2014 are presented in different figures because of the large difference in the poverty headcount (see y-axis of both figures).

Source: World Bank analysis of Household Budget Surveys for Russia for 1997-2004 and 2010-2012.

**Figure A2.3: Impoverishment Due to OOP for 2010-2014**



Notes: The years 1997-2004 and 2010-2014 are presented in different figures because of the large difference in the poverty headcount (see y-axis of both figures).

Source: World Bank analysis of Household Budget Surveys for Russia for 1997-2004 and 2010-2012.

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- **Progressive Universalism:** expanding coverage while ensuring that the poor and vulnerable are not left behind
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- **Raising revenues** to finance health care in fiscally sustainable ways
- **Improving the availability and quality of health-care providers**
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions

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By 2017, the Series had published 24 country case studies and a book analyzing and comparing the initial 24 case studies. In 2018 the Series will publish 15 additional case studies. Links to the country case studies and the book are included below.

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