Health Care in the Russian Federation

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KEYWORDS

• Russia • Health care • Public health • Global health • Epidemiology

KEY POINTS

- The Russian Federation has shown a willingness to work domestically to advance public health reform, and has increasingly asserting its global role in development, financial, environmental, and security matters, recalibrating its relations with international partners.
- Showing a commitment to the equal right of all citizens to health with emphasis on vulnerable groups, the government has prioritized efficient, high-quality health services; promoted a healthy lifestyle; and introduced innovative methods and medical interventions to respond to population needs.
- With ground-breaking legislative platform for improving the health care system by creating federal laws on compulsory medical insurance, there has been an attempt to create a sustainable national policy on the leading risk factors for communicable and noncommunicable diseases.
- With a global estimated prevalence of headache at 11%, the finding of the Global Burden of Disease Study 2010 of 14.7% indicates a major public health problem in Russia, not adequately addressed by the health care system.

INTRODUCTION

Brazil, Russia, India, China, and South Africa are members of the BRICS nations. Collectively, the BRICS are useful comparisons because of their size; racial, ethnic, and geographic diversity; and inherent problems of social inequality. Their lower per capita expenditures on health care and technological investments, incremental reforms, and exclusion of a large proportion of the population from health insurance make the BRICS nations useful comparisons to the United States. Russia's total health expenditures as a share of gross domestic product (GDP) have been low in comparison to other countries of the World Health Organization (WHO) European Region and, in comparison to other countries of the Group of Eight (G8), Russian health

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expenditures as a proportion of GDP have continued to trend downward. Public health funding is also very low in the Russian Federation in comparison to the WHO European Region in line with the inordinate level of out-of-pocket payments, particularly in outpatient pharmaceuticals that are excluded from guaranteed insurance packages. This article considers the background, social demography, health statistics, health care infrastructure, public health reforms, and global burden of neurologic disease.

BACKGROUND

The present Russian Federation health system has its roots in the country's complex political history and its major leaders. At independence from the United Soviet Socialist Republics (USSR), or Soviet Union, in 1991, the health system of the Russian Federation inherited an extensive and highly centralized Semashko system embodying the legacy of Nikolai Aleksandrovich Semashko,[1] a Russian statesman who served as the first People's Commissar of Public Health from 1918 to 1930, essentially organizing the extensive centralized Soviet health system. The Semashko model was constructed as a multitiered system of care with a strongly differentiated network of service providers, where each of the 5 levels (district, central rayon, municipal, oblast, and federal hospitals) corresponded to the severity of the disease and were connected by a referral system. Central to the model was the element of team work, overseen by a district physician responsible for providing and coordinating the medical care for the population in a given catchment area, making it possible to integrate the activities of other medical services with low-cost universal health care coverage.[2] Outpatient care, traditionally provided by state owned multispecialty polyclinics, district physicians, and specialists in their staff, served the local population with district physicians acting as the first contact provider and gatekeeper, referring patients to specialists and hospitals. The shift to the general practitioner model, common for most Eastern European countries, did not happen in the Russian Federation, wherein the number of general practitioners was only 0.7 per 10,000 residents in 2010[3] compared with the average of 8.2 for the European Union.[4] The hospital sector also inherited the Semashko model, constructed as a multilevel system of inpatient care serving rural, central rayon, city, regional, and federal hospitals as well as numerous specialty care facilities, with a referral system from one level to another. Hospitals varied substantially in their size and internal structure, with some having the polyclinic as a structural unit but without distinction between acute and long-term hospital care, a phenomenon that prevails in the Russian Federation.

The traditional Soviet health system was criticized for its lack of incentives, distorted structure of skewed inpatient care, predominance of administration over management, and a desire to promote integration through central administrative instruments. In 1994, 1 year after the transition, Sheiman[5] summarized the weaknesses of the traditional Soviet system referring to 6 other areas of deficiency. First, government dominance of the management, finance, and provision of health care wherein medical institutions, including primary care providers, were state owned and directly managed by health authorities. Second, lack of consumer choice of medical care providers such that citizens registered with a specific polyclinic were assigned a physician responsible for the community. Polyclinics unable to choose secondary care providers meant a lack of competition for patients such that the interests of providers dominated over those of the consumer. Third, hospital budgeting was based on the number of beds and failed to offer incentives to all actors in the inpatient care sector, with wide variations in performance. Fourth, polyclinics were paid according to the number of visits and staff, and physicians were remunerated by a salary lacking economic incentives.