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UNIVERSAL ACCESS TO HEALTH CARE IN RUSSIA: RIGHT OR REALITY?

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Abstract

Accessibility is one of the basic principles which ultimately determine structure, aims and objectives, evaluation of outcomes in health system. The citizens' right to health and health care is enshrined in the Constitution of the Russian Federation together with guarantees of their fulfillment - the possibility for citizens to receive decent quality and timely health care. Improving accessibility of health care is one of the mechanisms of smoothing social inequality in Russian society. In turn, population health status is considered as one of the criteria of effectiveness of social and economic policy. However, even if a country sets a political task to ensure universal access, its practical implementation is likely to face serious difficulties.

The paper is divided into two parts. The first part discusses theoretical issues as defining access to health care has a number of methodological difficulties, reflected in the works of both researchers and such bodies as WHO. As main indicators of access experts distinguish the share of population covered by health system, the content of health package, the presence of cost-sharing, geographic, organizational barriers and the level of utilization of available services. Access is often defined "negatively" via "absence of barriers" approach – territorial, financial, cultural that weakens the operational use of the concept. The authors put up a problem of developing aggregate indicator (induce) to provide a measure of access at the level of the health system.

The second part analyses the actual state of affairs with access to health care in Russia using the data available in two ways – summing up entitlements to health care fixed in legislation and defining barriers to access – financial and delivery. The analysis shows that low public spending together with increase in out of pocket payments as well as restructuring of health delivery network might hamper access for certain population groups. One of the problems might be the so called optimisation of Russian health system that reflects the contradiction between two roles of the state – a guardian of people's access to health care and a manager whose main task is cost-effective use of limited resources.

Introduction

Problems of developing health policy are increasingly attracting attention of academic community. How successfully health policy goals formulated and set at the level of decision-making are implemented in practice and why?

It is important for Russia, as no breakthrough in the living standards of citizens has yet been achieved. If in the 1990s social problems could be explained by difficulties of transition period, lack of funding, underdeveloped market infrastructure and so on, then, starting from 2000s social policy issues received considerable attention at the political level, a number of programs has been

adopted in various areas of social sphere, for example, the so-called national projects, the maternity capital, which provided for significant financial investments and in some cases institutional reforms. Moreover, economic recovery, which has been observed in Russia almost up to 2013, gave reason to hope for new constructive steps in social policy meeting the expectations of the majority of population. However, despite the fact that considerable efforts as well as resources have been put into key social sectors, including health care the results are evaluated by experts as limited. A gap is observed between social policy declarations and the real state of affairs. The question is whether it is the result of conceptual errors of goal and priority setting, selection of inadequate implementation mechanisms or imperfect management decisions. It is important for all countries, as in the social sphere there are areas of uncertainty, the correlation between inputs and outputs is not always clear.

It is suggested that discrepancy between the stated objectives and results obtained is best explained by problems in selection of implementation mechanisms. On the one hand, some mechanisms though not exactly compatible with the objectives defined might be selected because of other considerations (e.g., ease of implementation, using existing experience or institutions, ideological acceptability), or, on the other hand, it is possible that mechanisms that from the point of view of traditional wisdom seem inappropriate may in practice bring desirable outcomes.

This implies certain paradoxes, meaning real situations that seem illogical or incomprehensive. Particular paradoxes of social policy making might be mediated by contradictions in social policy model formed during transition period, when broadly positive social targets were defined (social-democratic) while market type mechanisms were chosen to achieve them (liberal). Handling / identification of important internal contradictions is important for both assessing the reality and forming the vision of common social policy problems.

It is within this framework that we analyse acess as a key health policy objective. Improving efficiency and accessibility of health care is one of the

mechanisms of smoothing social inequality in Russian society. In turn, population health status is considered as one of the criteria of effectiveness of social and economic policy.

It should be noted that significant changes in access to health care services have occurred in all countries of the former Soviet Union. Some countries are considering a universal access as a key principle of health policy, in others it is assumed, but not guaranteed. In some countries, the principle of universal access is declared, but in reality, the state is unable to provide it. In Constitutions adopted after the countries in question declared independence almost all of them fixed the right for “health protection”. But in three countries, namely Uzbekistan, Azerbaijan and Armenia, the right to “free health care” was not fixed. However in 2015 in the new constitution Armenia included free health care into constitutional guarantees. Though free health care is restricted by either state health services or basic package defined by law.

Access to Health Care: General Comments

Health system is based on certain principles, which ultimately determine its structure, aims and objectives, evaluaton of outcomes. The principle of accessibility is one of the basic in health care. Access refers to a possibility for a citizen to receive the required medical treatment according to need. It has different aspects, namely territorial, financial and cultural. However, even if the country sets a political task to ensure universal access, its practical implementation may face serious difficulties: there are barriers that prevent its implementation. Access implies the absence of financial barriers to health care delivery, the availability of an adequate supply of health services, the absence of discrimination based on social characteristics (Docteur, Oxley, 2003).

An important factor is patients’ satisfaction with medical care. As main indicators of access experts distinguish the proportion of population covered by health system, the content of health package, the presence of cost-sharing, geographic, organizational barriers and the level of utilization of available services.

It should be noted that the relationship between health status and access to care is mediated. This is important as ensuring access to health care - timely and qualitatively - is, first of all, the task of the state, and in this respect it is manageble. However, some factors that influence health status are connected with an individual private life, such as lifestyle and proper nutrition, that are more difficult to influence. Therefore, ensuring access to health care is both social and political problem.

Defininng access to health care has a number of methodological difficulties, which at various times have been reflected in the works of researchers who have linked the presence / absence of access to health care with social stratification in society (K. Marx, M. Weber, P. Sorokin), social inequality (F. Engels' “Condition of the working class in England "), or evolution of views on the relationship of personal and public (M. Foucault" Birth of the clinic "). In Russian history, Mikhail Lomonosov, whose name is Moscow University was one of the first to draw pudlic attention to the fact that medical aid should be one of the essential of government activities (Lomonosov, 1950).

Access and Paradoxes of Health Policy in Russia.

The citizens' right to health and health care is enshrined in the Constitution of Russia Federation and fixed in Articles 7 and 41, which have a direct effect and apply to the entire territory of the state. Article 7 says that Russia is a social state whose policy is aimed at creating conditions for a dignified life and free human development. And as Article 41 says Russian citizens are guaranteed the right to health and medical care, which is provided free of charge in the state and municipal health care services at the ex[ence of taxation, insurance payments and other revenues. In The Constitution of the Russian Federation not only the rights of Russian citizens – to include the right to health- are listed but also guarantees of their fullfulment - the possibility for citizens to receive decent quality and timely health care(The Constitution 1997). Two other basic federal laws that regulate functioning of the health system in Russia are Laws "On the basis of health

protection in the Russian Federation" (2011) and "On mandatory medical insurance in the Russian Federation" (2010).

Thus, the *first paradox* runs that law that regulated mechanisms, namely health insurance, was adopted before the basic law laying down principles and objectives of health system in the Russian Federation. It seems that goals and objectives were "fit" under the already chosen mechanism of their implementation.

The is no definition of access in these documents, although the Law "On the basis of health protection in the Russian Federation" contains a special article (Article 2, section 1), which explains the basic concepts that are used in this law, such as health, health , medical assistance, medical services, quality of care and others. Moreover, the concept of "quality of care" is at the end of this list. But in this document, separate articleexplains how to ensure access and quality of health care in the Russian Federation. It states that the availability and quality of care provided in Russia is secured by:

- proving medical care close to patient‘s place of residence, work or study;
- sufficient number of health professionals with appropriate qualifications;
- right to choose health service or a doctors;
- the use of standards of care;
- providing a guaranteed volume of medical care in accordance with the program of state guarantees of free medical care;
- establishing requirements for territorial distribution of health services, public health and community health centers and other facilities based on population needs assesment;
- transport accessibility of health services to all population groups, including people with disabilities;
- equipping health services with medical equipment, taking into account the special needs of the disabled.

The *the second paradox* follows that the concept of "access" is not clearly defined in legislation, though there are provisions (detailed or summary) enumerating the rules that must be followed to ensure such an access.

The concept of access to health care was well defined in the report "On improving the accessibility and quality of health care», which was prepared for the meeting of the Presidium of the State Council in 2005.

The report reffered to the Declaration of access to health care, adopted by the 40th World Medical Assembly in Vienna in September 1988. Accessibility of health care is understood as an access to health services, regardless of geographical, economic, social, cultural, organizational or language barriers. The report listed conditions to improve access to health care (Section 5), including nine major tasks, some of which were later transformed into subsequent legislation or national programs (Presidium, 2005). 11 years after the publication of this report, one can say that it had a crutial impact on the further steps that have been taken by the state in the field of health care.

The third paradox is that in health system a person consumes medical treatment, in most cases, individually, while health care system is organised as a public entity. Or to put it in terms of Bourdieu social space theory, health -is the social field, in which health care is consumed as a public good, and the power gives a patient the ability to influence the course and outcome of health care consumption, as well as to concentrate and convert various types of capital in access to effective care, meet medical needs and desires. It is advisable to distinguish between the three basic mechanisms of social differentiation of health consumers: economic, organizational/administrative and socio-cultural, each is updated at the system and individual levels. Mechanism of action at individual level depends on his/her social status as a consumer and healthcare behavior. Availability at system level is reflected in existing norms (formal and informal) and terms of health services functioning.

The country's leadership has set ambitious goals for the Russian health system. They are specified in the speeches of the President, when he explicitly states that "The future of Russia depends on the education and health of the nation", and sets targets to increase the average life expectancy to 75 years by 2020; stabilize population growth in the next 3-4 years; reduce mortality rate by

1.5 times by 2020. The prime minister also stressed that the state will fully financede the necessary medical care independently of the place of residence.

The fourth paradox is that at the level of formulatiing objectives and setting targets Russian government health policy seems to be in line with international standards, but, in practice, the situation is different.

During debates that took place on the eve of the last elections (September 2016) to the State Duma and local authorities rhetoric of representatives of various parties in the field of health care goals and objectives was practically the same. However, good intentions can become a reality only if adequate mechanisms for their implementation are developed. For example, the Law "On Mandatory Medical Insurance" substantially equalizes population access to health services: the insured is not tied to a specific health service and can receive medical treatment anywhere in the country, and also choose medical insurance company. But medical teatment is provided only within the framework of basic and territorial CHI programs (and in the case of high-tech care, a patient should pass though a certain administative procedure that takes time). Many provisions on freedom of choice of doctor and medical and insurance companies do not work, especially in small towns and rural areas.

In 2012 the Russian government adopted a "road map" of measures aimed at improving effectiveness and efficiency of health care in order to improve quality of medical care. In accordance with the measures proposed regional health authorities in 2014-2016 made steps to optimize the outpatient and inpatient care that resulted in health services consolidation, reduction of the number of beds. The reorganization of health system at the end of 2014 led to redundance of 12 800 physicians and 77 200 health workers, closure of 1,500 health services and reduction of 33,757 beds (Rosstat,2015).

Two-thirds of respondents (63%) negatively evaluate the effects of consolidation of health services, as optimization has led to an increase in travel time to health facilities, and in rural areas deprived residents of the possibility to receive medical help in the community (about 80 thousands small villages have no

units, providing primary health care). As a result outpatient visits declined by 40 million (3%) over the previous two years. The bulk of such a decline was due to shrinking network of health services in rural areas.

Public clinics / hospitals are the main source of medical treatment for more than 75% of Russians. The lower the wealth, the more often rerspondents use free medical care (80% of respondents in the group with low consumer status compared to 66% of the high-income group). The possibilities of alternative ways of getting medical care are very limited – for example, only 6% of respondents receive assistance under voluntary health insurance. Approximately the same number of respondents (7%) has the opportunity to regularly visit private clinics. In other words, as average only 13% of population uses medical on fee for service basis, among high-income group this share reaches 23% (Report, 2016).

Sociological data show that people with low income more often have to give up medical treatment because of lack of funds (Rusinova, Panova, 2015). Income inequality is complimented by inequality by social status (gender, age, education, occupation, ethnicity, etc.). Some studies confirm the fact of age discrimination. For example, patients of working age are usually hospitalized immediately in case of need while elderly have to wait longer, and thus use ambulance services to be referred to a hospital (Shishkin, 2007).

The sixth paradox is that, in Russia a special program of state guarantees for free medical care is adopted every year since 1990 and contains a list of medical services for which state funding is provided. However, constantly emphasizing the state responsibility for the observance of constitutional rights, the government permitted public health services to charge fees for treatment for services that are not covered by the mentioned above programme. As a result, state health services receive a stimulous to push citizens to pay for medical procedures that are included in the basic benefits package. They “learned” to manipulate patients within the framework of existing legislation, even though they are obliged to inform them about their rights to free medical care under the program of state guarantees (federal and territorial).

In our opinion, the contradiction lies in the fact that the state (its bodies) appears in two roles. On the one hand, it creates regulations influincing health services behavior, acting as a guarantor of the constitution and defining the boundaries of its responsibility to its citizens. In this sense, it favors equality of access to health services. On the other hand, the state performs functions of a manager in the health care system, whose main task is efficiency and cost-effectivenes.

These two roles do not always sit well with each other. In the rhetoric of the state as a guarantor principle of equality of access to health care is always present, the main task is defined as increasing public satisfaction with health system. But the state as a manager resorts to formalized procedures for standardization and optimization of medical treatments in resource-limited settings.

Access to Health Care in Russia: Financial and Spacial Barriers.

Acces is often defined negatevely via barriers to access approcah. Let us consider problems that arise in ensuring financial and special access to health services in Russia.

Financial barriers to access.

Trends in health care financing in Russia indicate that there might be problems with access to health care.

- *Underfunding* as far as public funds are conserned is chronic. Public health expenditure, which includes budget resources of all levels and compulsoty health insurance funds (CHI) in 2014, amounted to only 3.5% of GDP.

Table 1

Public health expenditures, selected countries (% GDP)

		Public health expenditures			Public health expenditures
Russia	**2014**	**3,5**	Armenia	2014	1,6
Europe			India	2013	1,3
Austria	2012	8,7	Kazakhstan	2014	2,2
Belorussia	2014	3,8	Kyrgyzstan	2014	3,0
Belgium	2012	8,2	China	2013	3,1
Bulgaria	2012	4,2	Repb Korea	2013	3,8
Hungary	2012	5,0	Tajikistan	2014	2,0
Germany	2012	8,6	Turkey	2012	4,7
Denmark	2012	9,6	Japan	2013	8,5
Italy	2012	7,2	***Africa***		

Latvia	2012	3,4	Algeria	2013	4,9
Netherlands	2012	9,9	Egypt	2013	2,1
Norway	2012	7,7	South Africa	2013	4,3
Poland	2012	4,7	***Americas***		
Moldova	2014	5,3	Argentina	2013	4,9
			Brazil	2013	4,7
UK	2012	7,8	Canada	2013	7,6
Ukraine	2014	3,6	Mexico	2013	3,2
Finland	2012	6,9	USA	2013	8,1
France	2012	9,0	***Australia and Oceania***		
Sweden	2012	7,9	Australia	2013	6,3
Estonia	2012	4,8	New Zeland	2013	8,1
Asia					
Azerbaijan	2012	1,1			

Source: Zdravookhraneniye in Russia, 2015.

The question is whether these funds are enough to ensure the efficient performance of health system. There are different ways to determine what proportion of public resources should be allocated to health. The most common is comparison with other countries. The "5% of GDP", allegedly recommended by WHO that are often referred to in Russia, has never been accepted by the organization as a formal recommendation (Chubarova, 2008).

The Organization for Economic Cooperation and Development (OECD) health data isoften used for international comparisons (Kulkova, 2014). In 2013, the share of total health expenditure in OECD member countries averaged 8.9% of GDP, ranging from 5.1% in Turkey to 16.4% in the US. Moreover, in the OECD countries the average share of public funds allocated to health care is more than 76% of total health expenditure. In Russia, this figure varies, and in 2013 was, according to the WHO, only 48.1%. Russia does not look atrcative when compared not only with the most developed but some developing countries as well (see: Table 1).

Health financing could also be compared with other branches of social sphere in the framework of the budget process. In 2014, the share of health in the social and cultural expenditures of the consolidated budget of the Russian Federation amounted to about 18%.

This shows that, on the one hand, there is serious competition for government funding between various social sectors, and on the other hand, health care in such a

competition losts to social benefits and education (nearly half). This rarises concerns about the ratio of cash and in-kind benefits in the social policy model.

- *The increase in private payments into the health system with underdevelopment of alternative pre-payment mechanisms*. In Russia, the share of private expenditure on health is significant. According to WHO, in 2012 it amounted to almost 50% of total health expenditure. From 1995 to 2013, private health care expenditure increased from 26% to 51.9% in total health expenditure, while public spending declined from 9.0% to 8.4% (WHO, World health statistics, respective years). To compare, in the OECD countries, the share is 30% on average.

However, a more exponential in terms of access is the share "out of pocket" payments in the structure of private health expenditures, which in Russia reaches 92%.

To neutralize the financial barriers to access, WHO recommends developing prepayment plans. Voluntary health insurance in Russia is not well developed including mostly corporate programs. It should be remembered that the voluntary health insurance is formed on the risk model, ie the size of contributions depends on the risk. Therefore, to reduce the amount of insurance benefits one must be insured continuously for a certain period of time.

The share of health care expenditures in the structure of household consumption expenditure during the period of 2003-2014 increased from 2.2% to 3.6%, accordingly. The largest increase is observed in the spendings on medicines and medical equipment- from 1.3% to 2.0%; for outpatient services- from 0.7% to 1.3%. It should be noted that the share of in-patient treatment expenditrures slightly declined in 2014 to 0.3% from 0.4% in 2010-2013. This indicator may not be a direct evidence of restrictions in access to medical treatment in Russia.

However, concerns arise if the data of sociological surveys and the socio-economic situation in the country are taken imto account.

Currently, issues of payment for medical care are increasingly being included into sociological survays on population health status and health care system in the

country. The Public Opinion Foundation (FOM) for a long time carries out research on such issues, and the questionnaires they use seem to be the most methodologically accurately constructed, when financial and economic issues are concerned (Public Opinion Fund, 2015). In 2015, 46% of respondents said that they had to pay for medical treatment, their share has increased since 2007 (42%). Accordingly, the proportion of respondents who do not pay for services decreased - from 57% to 53%, respectively.

Noteworthy is the fact that the majority of those who paid make it officially at medical institution. This 34% who “pay always” and 6% who “pay often”. In 2007, these indicators were 25% and 6%, respectively. This means that fee for services is being institutionalized, and are not just informal payments to thank medical staff. At that 29% of respondents paid for services when contact state health services, and 22% - private. The expansion of the sphere of services for which people have to pay in public health services is one of the most pressing and controversial issues in the country's health financing system.

Comprehensive survey of the population standard of living by Rosstat, two rounds of which were held in 2011 and 2014, reveals the share of respondents who consider the need to pay for health care as a barrier for access to medical treatment. The share of those who have not sought medical help because necessary treatment could be obtained only on a fee for service basis, nearly doubled from 2011 to 2014, especially in such groups as the rural population and the elderly. Though it should be noted that in general, the number of those who did not applied for the necessary assistance during the reporting periods decreased from 42.7% to 33.6% of the respondents.

Financial problems also arise in access to medicines. In 2011, 95.2% of respondents buy drugs at their own expense, with 17% of respondents noted a lack of funds for the purchase of medicines. 29.5% of respondents did not pass the prescribed treatment course at all or partly because they were offered paid treatment, for which there were no funds (Rosstat,2015).

To date, significant social differentiation has developed in Russia, as evidenced by a fairly high Gini coefficient, which reaches 0.4. As a result, averages hide significant differences in socio-economic status of households. Sociological surveys show the persistence of inequalities in health, based on the income factor, and self-rated health status indicators vary considerably between income groups (Grigorieva, 2016).

According to the sample survey of behavioral factors that influence population health, conducted by Rosstat in 2013, 70% of respondents with a high income and only about 18% of the respondents with low incomes rated their health status as good and very good. Accordingly, 7% of the respondents with high and 32.9% - with low income consider their health status to be bad and very bad. A similar trend is observed in relation to morbidity. Lack of any ailments mentioned only 18.6% of respondents with low income and 52.6% - with high income; the difference is almost 3 times. For all 10 diseases included in the survey, the share of respondents with low incomes was bigger, and in some cases quite substantially. For example, the incidence of diabetes was 5.6 times higher for low income groups.

Spatial barriers to access.

Russia has a vast territory occupying 1/7 of the land tops the list of the largest countries in the world. The internal (regional) structure of the Russian state is complex and diverse. The population of Russia at the beginning of 2017 was 146 838 993 million people (9th place in the world), the territory of 17.098.246 km (1 st place in the world).It is composed of 85 subjects of federation (regions) that are divided into Republics formed on the national basis (22); oblast (46), kray (9), 3 cities of federal significance as well as 1 autonomous province and 4 autonomous districts. They, in turn, have their own administrative-territorial division.

As one of the main factors influencing the development of the regions, researchers call uneven distribution of the Russian population (Bochkaryova 2009, Zubarevich, 2008, Podgornay, 2012, Novikov, 2013, and others) According to Rosstat in Russia, the average population density is about 8.4 people / sq. km. The

lowest population density among the subjects of the Russian Federation in Chukotka (0.1 man / sq. km), the highest in Moscow (4554.1 people / sq. km).

Over the past few years the numbers of regional hospitals were reduced up to 40%, and out-patient care and polyclinics up to 20%. These closure included 32 central regional hospitals, 103 regional hospitals (with 191 remained), over 8000 paramedics-midwifery service units (according to regulations one FMW unit should be present to serve every 700 residents in average), 5339 out-patient care and polyclinics, 232 ambulance units (and, as a result, the frequency of calls for an ambulance per 1000 residents in villages is 2.7 times lower than in cities), 600 clinics (with 1048 remaining), 1000 sanatoriums (with only 1945 remaining), and 25 children's homes. The number of hospital beds was reduced by 511,000 beds.

These closures were explained by the need to cut expenses, but in health care immediate benefits subsequently can often be followed by even higher medical expenditures. Only 400 rural municipal hospitals remained in the entire country (from 4,500) after reforms. This meant, for example, that in order to visit a paramedic one had to travel between 40-60 kilometers, that sharply reduced the availability of health care to those most in need. As a result, only 40 % of countrymen visit doctors when sick, their numbers among out-patients are half that of the urban centers, and they are hospitalized only in the most serious cases.

The main problem is that most regions do not have sufficient funds and resources. On the one hand, health care in regions highly depend on federal funds received through various channels. On the other hand, the federal centre aims to increase the role of regions in health care financing that vary considerably by region. At all stages of development of the Russian health system the federal centre used trial and error method to find optimal scheme of financial relations between the federal and regional authorities. Recent changes in the health system funding flows led to the formation of a rather complex system of financial relations between the federal centre and regions. Federal policies towards regions have to chose, or combine, between stimulating and levelling measures. Stimulating policy is aimed primarily at reducing institutional barriers to the development of regions

while equalization policy is aimed at ensuring a more equitable access to health services for people who live in regions with different levels of development, mitigating social inequality between regions being the most important task.

The regionalization of health care expenditures is associated with increase in the role of regions in health financing. In 2014 the federal budget expenditures on health care amounted to 535.5 billion rubles, or 0.7% of GDP, and expenditures of the consolidated budgets of regions - 1.3162 trillion rubles, or 1.8% of GDP. However, health care is a serious problem with fiscal federalism. The challenge is to ensure that all citizens have equal access to health care regardless of where they live. Meanwhile, in Russia there was a significant regional differentiation in terms of socio-economic development and their own capabilities to provide funding for health care (Chubarova, Grigorieva, 2015).

Conclusions

To conclude, problems with acceess to health services in Russia need further investigation. Financial indicators are indirect, and much depends on the general model of the organization of health system in the country. However, health financing indicators against the overall socio-economic situation in Russia give grounds to express concern about people's access to health services, which requires to take into account the impact of economic, especially fiscal, policy on health care.

Analysing the road map to make access not just a political right but a reality a number of paradoxes were formulated that reflect contradictions existing in Russia's health policy. Fixing these paradoxes and understanding the underlying contradictions that generate them is important both for an adequate assessment of reality and for identifying key problems in health policy. This is the basis on which health policy and mechanisms of its implementation can be aligned.

Currently, a number of indicators (factors) through which we determine the population's access to health care services. These indicators have different "weight" and it is very difficult to structure them. In some cases, the territorial factor may be more important than the financial one and vice versa. Cultural

traditions and stereotypes of behavior, conditioned by national traditions, play an important role in modern conditions. All this testifies that the study of access problems is an important direction of scientific research.

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