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Analysing Health Policy in the Post Soviet Russia: Contribution of Diffusion Approach

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Introduction.

Russian health reforms should be analysed within a broader societal context as in the early 1990s it stepped on a transition from a planned to a market economy and democracy that involved dramatic changes in all areas of societal live, including values and institutional arrangements. This inevitably posed a problem of mechanisms (institutions) to be used (developed) to implement such a transition.

It is suggested that in post Soviet Russia the influence of ideas and practices on health policy increased as in the course of transformation Russian leadership was searching for new ways of health system organisation relevant to new social and economic realities. To find effective mechanisms to achieve health policy goals – or to be precise a new model - Russian policy makers sought to learn from international experience, first of all countries with developed market economies and democratic institutions.

However, the question remains to what extend health care model that emerged as a result of post Soviet health reforms is successful. It is particularly acute as in Russia no breakthrough in the living standards and population health status has yet been achieved. Despite considerable efforts as well as resources being put into key social welfare sectors, including health care, results are limited. A gap is observed between health policy declarations and the real state of affairs. The question is whether it might result from conceptual or implementation problems in selecting model of health care.

The aim of the paper is to apply diffusion perspective to understanding health care reform policies in Russia that started in the early 1990-s. Diffusion theory seems to be a useful theoretical approach to conceptualise the process of borrowing other countries' practices. In the paper it is used as an umbrella term to characterise situations when social institutions that successfully operate in one country are transferred to another country. To understand if "borrowed" institutions are appropriate for local conditions it is necessary to evaluate other countries' best practices to select ones that are suitable to a new environment, and ensure that they are adequately transferred, or adapted. In Russia diffusion coincided with transition posing one more methodological and practical problem of the role of Soviet-type institutions (Semashko model in case of health care) in Russian post socialist society, their compatibility with emerging new societal order.

The paper is divided into three parts. The first one sets methodological framework for applying diffusion approach to understanding changes in health policy in Russia. The second part describes the Soviet health care system as a starting point of modern Russian health reforms and suggests reasons that underline changes in health care. The third one analyses practice of introduction of compulsory health insurance (CHI) as mainstream of Russian health reforms and example of implementation of diffusion. To conclude some reflections are

summarized related to the role of diffusion in shaping modern Russian health care policy.

1. Diffusion and health policy: methodological aspects

In the paper diffusion is used as an umbrella term meaning that 'knowledge about policies, administrative arrangements, institutions in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place' (Dolowitz and Marsh 1996: 344). Four main mechanisms of policy diffusion include learning from earlier adopters, economic competition, imitation, and coercion. (Shipan Volden, 2008)

The relevance of diffusion to understand health policy flows from the fact that reforms carried out in different countries are not so independent of each other, and national governments are definitely influenced by what is happening in other countries. It might be explained as countries face similar problems of providing access to health services, both physical and financial, quality of medical treatment, etc. Even more, there is a tendency towards a certain convergence: many countries with strong state participation have taken the path of strengthening the role of market in health systems, while more liberal systems are strengthening the role of the state.

Diffusion approach poses several methodological questions, namely:

• possibilities and limits of applying experience of other countries - under what conditions measures from the arsenal of reforms of some states can be transferred to the practice of other countries (Marmor et al 2005);

• impact of globalization, namely the formation of a single space in healthcare, the dissemination of common ideas, principles and approaches in the functioning of health systems in different countries.

Social diffusion is often analysed using the concept of "diffusion of innovations" (Tard, 1890, Rogers, 2003б, Djellal, Gallouj, 2014) that is about a process through which innovations (in our case, new ideas and processes in health care system) are transmitted over time through certain channels to other social systems, what, strictly speaking, was observed at the beginning of post Soviet health reforms in Russia.

Various theoretical constructions are developed to explain dissemination process, particularly in political science, for example policy convergence (Bennett,1995), policy transfer (Dolowitz, Marsh, 2000) or lesson drawing (Rose, 1993). They discuss what could be transferred to achieve the desired results and what should not in order not to step on the same rake. It is important to take into account time and spatial factors, history of formation of institutions and their basic principles. Other approaches analyse development and functioning of social

institutions or influence of ideologies (power of ideas) (James, Lodge, 2003), formation of networks of active participants, who are involved in the process through training, retraining and other forms of transfer of knowledge or information. An example is the various advocacy coalitions or epistemic communities, which are structured in a certain way and are included in the teaching of political science disciplines and competencies (policy learning and policy expertise) (Sabatier,1988, Haas,1992). Research in this area analyses how members of such coalitions update their knowledge, and what channels are used to influence formation and implementation of policies[1].

Diffusion as dissemination of ideas and practices is intensified by globalization. Traditionally social welfare institutions emerged at local level and only later were institutionalized at the national level, together with the emergence of nation states. However, globalization strengthens international influence on the solution of national social problems. At the same time, many social problems become global, crossing national borders and to overcome them international efforts are required. It is in this context that the role of international organizations in the formation of national social and health policy is discussed. Some studies emphasize that in the context of globalization, the state is trying, first of all, to promote its international competitiveness in an open, global and competitive economy. As a result, very complex interdependencies arise when transnational forces make states only to imitate successful competitors (Cerny, 2009).

In this context, the following processes can explain similar trends in health policy, namely:

development of homogeneous processes, such as industrial and social modernization (for example, demographic shifts and changes in the structure of households, the growth of service sector employment, etc). Although these changes occur at the national level, they are similar in different countries, forming the general characteristics of a postindustrial society;

transfer of models and best practices on a voluntary basis, when, for example, a country takes other country's experience or program and introduce it according to the already developed scheme;

influence of various international organisations, especially when certain internal norms are regulated by international bodies and organizations and

[1] Networks of non-governmental organizations advancing women issues is a good example. Advocacy refers to organized actions of various groups aimed at gaining support of influential individuals and politicians in dealing with specific political issues. The advocacy process consists of three components that are closely related: the search for like-minded people and the creation of networks or coalitions, finding political opportunities to influence decision-making process and activities to achieve the objectives.

international networks, and in fact they can dictate or force, openly or indirectly, to implement a certain policy (Global Social Policy 1997).

For post socialist countries experience of developed capitalist countries is obviously important and is often taken for granted as best practice. But one should be cautions evaluating its appropriateness for transitional health care reforms.

First, health care systems in Western countries are quite diversified; Bismarckian and Beveridge models present a good example of such conceptual and practical diversity. Besides, health care in any country often comprises elements of various models. There are nuances typically rooted in national traditions that are not always properly understood by a "stranger". Use of conceptual tools adopted in Western science, based on some universal approach, might detach from the real contexts of change **(**Kennett, 2013)

Second, it is likely that some national practices in health care could (and should) have survived from socialism to capitalism as socially accepted mechanisms to reach universal goals in health care.

The decay of socialism gave raise to a number of theoretical problems. There are both supporters and critics of separating analysis of transition problems as a specific theoretical stream. However, whatever theoretical approach is adopted there is a need to solve quite practical issues (Jordan, 2004).

Transformation from socialist to capitalist society means a transition from one model to another, dramatic changes in values and institutions. Under these conditions, the transfer of experience of the developed countries becomes practically inevitable. However, the basic question is if general approaches or experience derived from one country fit other countries with very different starting points in terms of political regimes, historical traditions and cultural norms.

Transition is characterized by uncertainty, unintended consequences, forming of hybrid institutions. Transformation process put a problem of not only forming new institutions relevant to a new society but also two more questions, namely:

- how to move from one institution to the other, to solve transitional problems (Russia had experience in moving from insurance to budget medicine but no experience of a reverse transition) first of all mechanisms, speed and sequence of actions;
- what to do with old institutions, what ones could be fitted into a new environment and what will have to be "demolished".

In transition the role of an agency deems crucial as depending on the mode, reformers "may be compelled to make choices in a great hurry, with imperfect information about the available alternatives and without much reflection about longer-term consequences" (Schmitter, 2014). The role of partisan politics in the

development and implementation of reforms should not be underestimated as inter-party contradictions impede the dynamics of reforms in progress. Investigating interplay between actors and institutions in health policy formation, E. Immergurt showed the importance of so-called «veto points» in determining influence of various actors on the decision-making process (Immergurt, 1990). Studies also show the importance of organized interests in the formation of reforms' agenda, in particular the organizations of doctors in networks that form health policy (Contandriopoulos, 2011).

In this context, it is important to identify directions of actions that are most effective in the long run and secure a transition from existing institutions to the desired ones. Russian economist V. Polterovich introduced a notion of "prospective trajectory" of reforms coordinated with resources, technological and institutional constraints, and providing built-in mechanisms that stimulate planned changes in institutions and prevent their dysfunctions and institutional traps. The latter arise when institution from one environment is transferred to another and is ineffective under the new conditions, but reformers continue to keep it for some reasons (for example, political) (Polterovich, 2004). This theoretical frame allows to take into account such important reform parameters as speed and sequence of changes and stresses that initial state of a system to be reformed significantly affects success of reform and determine its mechanisms.

2. Starting point of post-Soviet Russian health reforms: from Semashko to CHI model

At the time when Russian transformation started health care was organised as *budget medicine* (Semashko model), when for the first time in the world the political responsibility of the state was proclaimed "for carrying out wide health and sanitary measures aimed at preventing the incidence of diseases" [2].

The Semashko model assumed free provision of medical treatment by state-owned health services. The goal of health policy was to ensure universal access to health care for the whole population (Essays on Health, 1957). And in a fairly short period of time there was a positive dynamic in population health status, many infectious diseases were eliminated: cholera was eradicated by 1923, and smallpox and plague by 1936. Expenditures on health care and physical culture increased dramatically compared to the pre-revolutionary period. The number of doctors by 1940 increased by almost 6 times, other medical personnel – by more than 10 times, the number of beds – by 3.8 times.

[2] This was recorded in the proceedings of the 7th Congress of the RSDLP in 1917, and in 1936 in the first Constitution of the USSR (Article 120) the right of citizens to material security at old age, as well as in case of illness and disability, was guaranteed through provision of free healrg care based on need as aell as recreation fasilities (sanatoriums and health resorts).

It should be noted that budget medicine does exist in other countries. The classical example is the NHS in the Great Britain but it was founded in 1948, almost 20 years later. The pros and cons of budget medicine are well discussed (see Barr, 2000 for a more detailed account). One of its most important advantages is that no financial barriers restrict population access to health care.

The specific characteristics of Semashko model (Semashko, 1947) are as follows:

- universal coverage;
- provision of a comprehensive package of medical care in the state owned health services that combine medical treatment with prevention;
- doctors were state employed and received salaries as state employees;
- continuity of treatment was secured by multi-tired and yet integrated system of health services – from primary care in *policlinik* to tertiary care provided in large clinics;
- maternity and child welfare service was a priority, medical care for children was provided in separate health services (paediatric care);
- emergency care system.

A system of health services was built, based on uniform principles of organization of health services for the entire population, from remote villages to metropolitan cities: paramedic *(feldsher)* and midwife posts (FAP) - *uchastok* polyclinic - district hospital - regional hospital – tertiary care hospitals. Occupational health services function at large industrial enterprises, in railways and in the army. The accessibility of health services was secured by providing medical treatment free of charge, all citizens were attached to district polyclinics at their place of residence and, depending on the complexity of need, could be referred for treatment to higher levels of health care pyramid.[3]

However, by 1980s problems in the Soviet healthcare system manifested in decline of some population health status indicators (e.g., life expectancy and disability) and low quality of medical treatment. Budget appropriation for health care decreased: 1960 (65) - 6.6%, 1970 - 6.1%, 1980 - 5.0%, 1985 - 4.6%. Doctors salaries by 1985 amounted only to 70% of the average monthly pay nationwide. A majority of health services were in need of renovation and new equipment. The health system was developing ‘in width” meaning increasing number of health services, doctors and beds. As a result, its structure shifted towards hospital care, it

[3] At the WHO Alma-Ata Conference on Primary Health Care (USSR, Kazakhstan, 1978) the Soviet model of primary care was acknowledged and development of primary care was set as a priority. These assessments were confirmed at the World Health Assembly, and later at the UN General Assembly and recorded in the UN resolution on "Health as an integral part of development" (WHO, 2008).

was slow to incorporate the changing patterns of diseases, namely increasing the incidence of chronic diseases.

Problems in health care did not went unnoticed and in 1980s attempts were made to address them via several pilot projects aimed to make more efficient use of health system resources (1982 – 5 hospitals in Russia to make rational use of hospital stock through improvement of treatment and diagnostics process; 1985 – fundholding experiment in 3 regions (Kemerovo, Kuybyshev and Leningrad); 1987 – introduction of collective management in health services). Unfortunately, these experiments were interrupted by new reforms and their preliminary results were not properly evaluated.

But when transformation started it was decided to change the model of health care as well. Interestingly at that time no possibility to reform Semashko model was discussed. Compulsory health insurance (CHI) became a strategic line of health reform, first of all, because of ideological and political factors.

Firstly, according to Russian reform ideologists introducing health insurance was declared as the main idea of health reform of in Russia because: 1) the transition to market will automatically solve social problems of Russian society; 2) health insurance will give healthcare additional money and 3) positive experience of countries where health systems were based on health insurance will guarantee its success in Russia.

In course of transition in Russia the role of the state in society as well as in health care has changed alongside strengthening of ideology of individualism (Chubarova Grigorieva, 2013). On the crest of the democratic up tide of the late 1980's and early 1990's it was believed that the state should withdraw from direct participation in the economy providing space for market self-regulation. In the early years of reform hopes were high that market will regulate the relationship between all the actors in health system. The Soviet state was regarded as too paternalistic for market economy, thus state intervention in social welfare should be reduced leaving room for personal responsibility for well-being and health.

Secondly, the Law on CHI was adopted by the Supreme Council of the RFSR in 1991 at a time when Russia was still a part of the USSR, and Russian leadership wanted to demonstrate its independence from the federal authorities. In seems that CHI was introduced to counter the Soviet budget medicine that reformed consider not suitable for a market economy. Even more, enacting CHI legislation Russia put itself in opposition to other republics of the Soviet Union, which at the time did not set such a task (Chubarova, Shestakova, 1998). The Law was worked out very fast and transition mechanism was not well thought, rather it was a print from European health insurance models (Grigorieva, Chubarova, 2013).

Thirdly, the CHI Law was initiated by representatives of the Democratic Russia movement (now the Union of Right Forces), that were heading the Health Committee of the Supreme Soviet. They believe that market is the only way for Russia to transform its social and economic life and secure democracy.

Thus, the decision to change the model of health care was in fact made by a group of persons having power and influence rather than a public at large.

Economic factors were also important as it was suggested that additional funds alongside budget appropriations would be raised via employers' contributions that would allow to provide for health care financing adequate to meet population health needs.

From historic point of view, it is interesting to note that attempts to introduce health insurance were undertaken in Russia three times in the 20th century- in Imperial, Soviet and post Soviet Russia. All these attempts were based on Bismarckian model that was probably the most influential social insurance model at that time.

It was not by chance that Bismarck model was selected by reformer as "best practice". It was considered as successful one guaranteeing medical care to the entire population at relatively low cost but also incorporating choice and competition. Besides, Germany, as Russia, is a federal state with relevant specifics in relations between regions.

The German experience in organization of health care system undoubtedly deserved close attention, however, transferring it to a new environment needed a more careful assessment. It seems that the Russian government in the early 1990s was focused on shock reforms to obtain quick results. Less attention was paid to the fact that formation of CHI in Russia took place in fundamentally different social and economic conditions.

Historically, many countries moved from private health care to health care systems with state participation. Health insurance was a means of increasing social guarantees as related to private healthcare. The peculiarity of Russia was that it moved from free budget provision of health care to health insurance with no relevant experience available elsewhere. At the same time, during transition Russia had to ensure a high level of social guarantees set by previous health care development in the country.

There were certain risks in switching to insurance that could be seen already at the first steps of transformation.

First, in Russia, unlike in Germany at the beginning of transformation, there was practically no private medicine. The competition was not possible, due to the fact that there were no insurance companies and health services to compete.

Secondly, at the beginning of reforms, people's income fell sharply, while the relatively high level of income is important for the effective operation of insurance systems (Chubarova Grigorieva, 2013). In Russia the choice of insurance system was driven – among other things- by a desire to secure additional funding for health care. It was assumed that insurance will create institutional conditions for improving efficiency of resource use in health care.

Thirdly, in Russia institutional organization of health care was quite different. For example, a (poly)clinic was the main structural unit of health care system providing primary medical care. In Germany doctors work in hospital setting or in private practice.

Finally, there are differences in social and cultural characteristics of interactions between patients and health system. For example, in Russia if a child has a fever, doctor usually comes to see him/her at home. In Germany in such a situation parents need to transport him/her to a doctor.

3. CHI as mainstream of Russian health reforms: constant adaptations?

Interestingly, adaptation of CHI started even before CHI system was put in place, at the stage of enacting legislation. The government constantly introduced changes in the CHI in order to ensure its functioning. Adaptation became the main mechanism for CHI development in Russia.

The 1991 law introduced health insurance in Russia in two forms: compulsory (CHI) and voluntary. Initially, Bismarkian variant of health insurance was taken as a model of health care that was supposed to be organized via health insurance companies, based on employers' contributions. The provisions of the law, related to compulsory health insurance, were to be implemented by 1993. Until that time, it was necessary to develop institutional and regulatory framework for managing and financing a new system.

But establishment of insurance companies as well as development of all the necessary regulations turned out to be much slower than it was expected. As a result, by January 1, 1993, financial and institutional basis for CHI was not created. Expectations that insurance companies, independently emerging and expanding their activities, will cover all citizens, were not justified. As a result significant part of population might remain uninsured due to both administrative obstacles imposed in many regions, and "cream skimming" when insurers seek to select categories of insured with lower morbidity risks. In the emerging system of CHI no one seems to be responsible for securing population coverage (Grishin 1997).

The 1991 law also failed to provide for any special organizations for collecting, accumulating and redistributing CHI contributions. Also the need to level financial conditions for the provision of medical care for various groups of insured depending on age and gender and place of residence become clear. In order

to solve the problems that have arisen while not delaying the CHI introduction and establishment of mandatory employers' health insurance contributions, the reformers went on to adjust the initial CHI model was altered.

In 1993, the 1991 Law was supplemented by provisions on establishment of the Federal compulsory health insurance fund (FFOMS) and regional compulsory health insurance funds (TFOMS) as independent financial institutions. The federalism also influenced functioning of CHI as it was organized on a territorial basis (Chubarova, Grigorieva, 2015).[4]

Since the reform in question was not accompanied by any other organizational changes, new structures were introduced into the old administrative system, which, in turn, remained virtually untouched. As a result, relations between CHI funds and regional health authorities were quite tense. With the creation of CHI funds regional health authorities lost direct control over considerable money while CHI funds have acquired their own interests, which do not always coincide with the interests of regional health authorities.

In the 1990s the division of responsibilities between government bodies and CHI funds in health system were not clearly defined in federal legislation. This task was delegated to regional authorities, which led to significant regional differences in the speed and scope of health reform, up to formation of various regional CHI models. The situation was resolved only in new 2010 CHI Law.

At present, the general scheme is as follows: CHI funds accumulate money that they transfer to private health insurance companies that in turn compensate health services expenses on a contract basis.

Changes in CHI financing mechanisms provide a good illustration of CHI functioning.

In 1990-ies a dual-channel system of health financing was established in Russia - from the state budget and CHI. The CHI funds received CHI premiums for working people paid by their employers; self-employed pay for themselves, as well as contributions for the non-working population transferred from the corresponding regional budget. Initially, employers' contributions amounted to 3.6% of payroll, while regional authorities determine the size of contributions and benefits and often do not fulfil their obligations in full.

[4] Russia is a federal state, composed of 85 subjects of federation (regions) that are subdivided into republics formed on ethnic basis (22); oblast (46), kray (9), cities of federal significance (3) as well as one autonomous province and four autonomous districts[4]. The rights of regions are fixed in the 1993 Constitution.

CHI funds covered expenses directly related to a particular case of medical treatment including salaries, medicines, food, and other soft equipment. At the same time large costs, such as buying equipment and maintenance of buildings, were financed directly from regional budgets. Employers contributions were divided into 0.2% paid to the Federal Fund, the rest went directly to the regional CHI fund. By the early 2010s. CHI's share in health financing amounted to only 35% of total health expenditure; other expenditures were covered by federal and regional budgets.

Government health financing is tied to the program of state guarantees of free medical care that every year is approved by the Federal Government, and in accordance with it regions are developing their regional programs, which can set targets beyond federal averages if they have resources available. The program includes two blocks- responsibilities that are financed directly by regional budget and those funded by CHI. Gradually the role of CHI is increasing, resulting in the growth of its share in total health financing.

In 2001, the mode of paying employers' CHI contributions was changed- they were channelled to CHI funds via the tax system and were included together with contributions to other social fund into the so-called unified social tax (UST). Employers' contributions were still divided between Federal CHI fund (0.8%) and regional CHI funds (2%). UST was regressive, i.e. a certain salary threshold was set (cumulative from the beginning of the year), above which the said rate did not apply, employers' paying a flat fee.

In 2011 a number of measures were undertaken to change the funding flows in health care to ensure financial stability of CHI. It was decided to centralize CHI money previously collected by regional CHI funds in the Federal CHI Fund to be then transferred to regions as financial subsidies based on a unified methodology adopted at the federal level; to establish uniform requirements for regional CHI contributions for those not working as well as strengthen their responsibility for the timeliness of such payments.

First, there was an increase in employers' premiums for CHI, they now have to pay 5.1%, since 2015 contributions threshold has been abolished.

Second, regional contributions for the non-working were for the first time fixed in the federal legislation. Earlier, regional authorities themselves decided how much to pay and as a result in regions developed different rates of insurance premiums, which led to differences in CHI financing, while some regions did not transfer CHI contributions at all or just symbolic sums. As a result, CHI premiums for the non-working amounted for about a quarter of all CHI funds revenues. The problem was aggravated further by the fact that the non-working population in recent decades reached one-half or more of the population in regions.

Third, starting from the 1st January, 2012 the flow of funds in CHI has changed, all CHI contributions - from both employers and regional budgets are now accumulated in the Federal CHI fund that distributes them to regional CHI funds along the rules specified by the federal law. Contributions to the regional CHI funds were cancelled. As a result, the main sources of revenues of regional CHI funds are now subsidies from the federal fund of CHI (640.6 billion rbl., or 61.5% of total revenues regional CHI funds in 2012). Thus, Federal CHI fund controls collection and spending of CHI money.

The Federal CHI fund transfers money to regional CHI funds subject to regional authorities' contributions to CHI for not working paid in amount and on time stipulated by the federal regulations. In total, these subsidies amounted to in 2015 - 1351, 8 billion rubles, in 2016 -. 1 588.6 billion rubles, in 2017 -. 1675, 8 billion rubles.

Thus, a phased transition to a single-channel financing occurred, when all costs, including high-tech assistance, previously financed from the budget, communal, transport and communication expenses and other maintenance costs, as well as employees' social security were covered by CHI premiums. The idea is that a single-channel financing will link financial resources available to health services with the volumes and complexity of medical care they provide and the results achieved, that is, making them spend public funds effectively (Chubarova, 2016).

CHI has been developing in Russia for more than 25 years, and it is already possible to analyze its merits and demerits from the point of view of how Russia used the experience of other countries as well as its own experience in health policy.

Sociological studies show dissatisfaction of Russian population with the quality of medical care. According to the Levada Centre research, the majority of Russians are not satisfied with the state of affairs in health care (58% in 2015) (Levada Centre, 2016). Similar results were obtained in a recent poll by the VCIOM — 52% of respondents rated health care as bad and only 9% as good (VCIOM, 2017).

At the beginning of transformation in the early 1990s many Russian people sincerely believed that transition period would be short, and then social and economic situation together with the standards of living would improve. However, in the 1990s - early 2000, the situation in Russian health care system was really hard.

Almost all health status indicators are worse, that at the turn of the 1990s. Until 2006, a sharp increase in morbidity rates of adult and child population for all classes of causes, is observed that slows down in 2006-2012, but later continue their upward movement, though not at such a fast pace. For the period from 1990

to 2016, the overall morbidity rate increased by 50% (from 106890.6 cases per 100 thousand in 1990 to 161628.4 in 2016), and the primary incidence rate by 20% (from 65120, 6 per 100 thousand in 1990 to 78532.6 in 2016).

This is an evidence though indirect of deterioration of population health and ineffectiveness of the health system as morbidity rates largely depend on population coverage, quality of medical care. The changes in societal life also contributed to poor health status. The negative impact of transition on health resulted in socio-psychological stress leading to increased incidence of cardiovascular diseases, hypertension, neurosis, mortality from accidents, homicides and suicides.

The overall mortality rate (the number of deaths from all causes per 1000 population) since 1990 has steadily increased and by 2003 reached its maximum (16.4 per 1000 population) (Fig.1). Since 2003, it has declined (except in 2005, 2010 and 2014), but it is still 1.2–1.6 times higher than in European countries. The standardized mortality rate from all causes that takes into account the population age in the Russia is 1.5-2 times higher than in European countries (Fig.2).

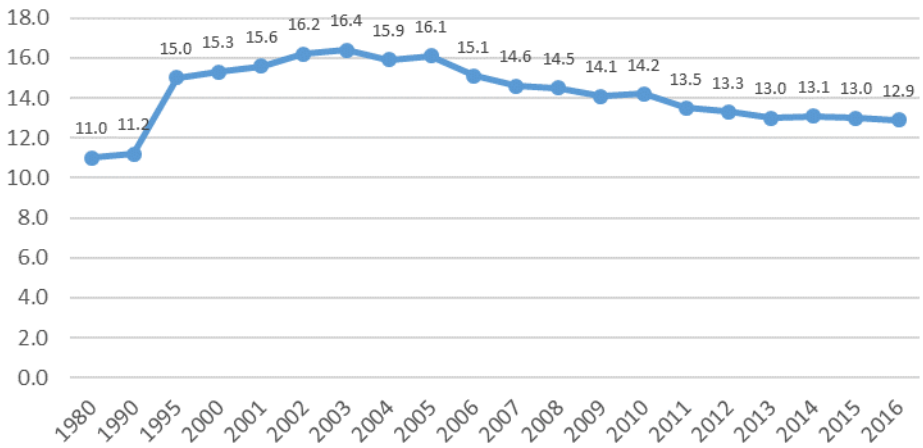

Figure 1. Mortality rates in Russia, selected years

The problem of high working age mortality (men 16–59 years old, women 16–54 years old) is acute, despite the declining trend that has developed since 2006 (Fig. 2). The highest mortality rate at working age - 8.3 deaths per 1000 working age people - was recorded in 2005. The share of working age people among all the dead exceeded 32%. In 2013, the mortality rate of the working-age population decreased to 5.6 ‰, and the proportion of people who died at working age — to 25.6%. In 2014, the proportion of deaths at working age continued to decline, reaching 23.5%, but the mortality rate at working age increased slightly to 5.7 deaths per 1000 people of working age. Since 2015, the mortality rate at working age has again begun to decline.

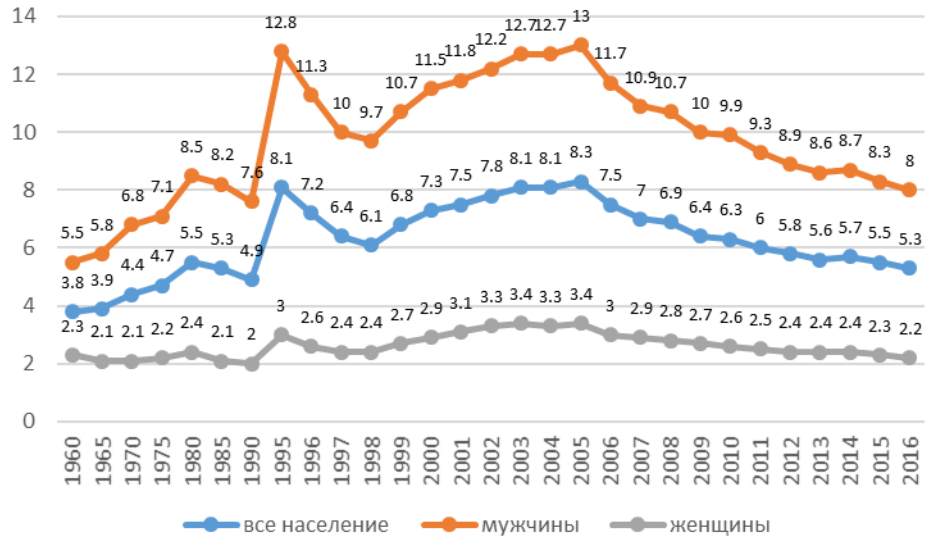

Figure 2. Mortality rates for working age population (per 1000 population of relevant sex and age)

The highest level of life expectancy 64.9 years for men, and women - 74.5 years for women - was in 1986-1987, the period of the Gorbachov anti-alcohol campaign. By 1994 compared to 1986, life expectancy for men was reduced by 7.3 years, for women - by 4.3 years. The growth in life expectancy observed since 2004 should be considered as recovery (Zakharov, 2016). Only by the beginning of the second decade of the XXI century it was possible to compensate for the loss of life expectancy and even slightly exceed the maximum values achieved earlier. However, by modern standards, the observed level of life expectancy is still low (Fig. 3).

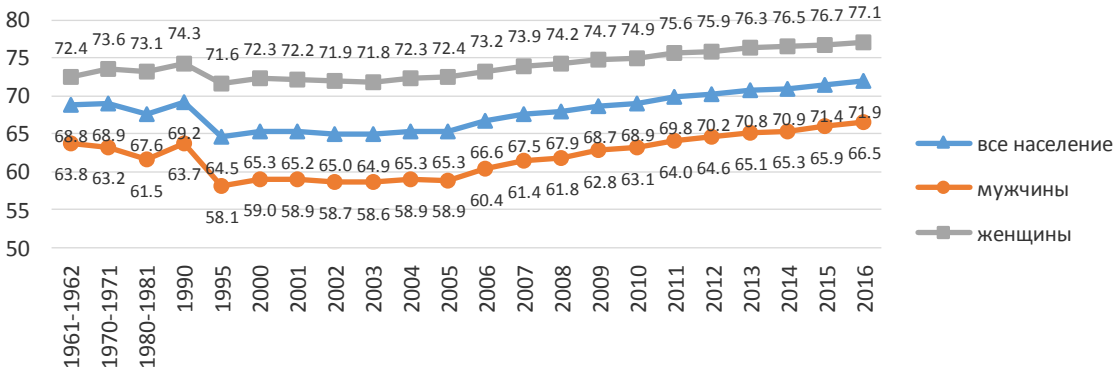

Figure 3. Life expectancy at birth in Russia (years)

The difference between Russia and Western Europe in healthy years of life is still quite significant. Compared to other developed countries, Russia has one of the lowest rates that in 2015 equal to 63.4 years (67.8 years for women and 59 years for men), which is about 5 years less than the European average (68.3 years) and by 8 years than average in EU countries (71.1 years) (WHO, 2017).

The CHI failed to ensure the inflow of additional funds into health care system. Reformers impressed by the success of CHI in other countries, completely ignore the peculiarities of CHI functioning during the transition period. In the beginning of 1990s N. Barr suggested that at the early stages of transformation two factors would not allow insurance premiums to fulfil their role, namely shrinking of potential tax basis because of raising unemployment and growth of informal economy while effective mechanisms of money collection had not yet been developed (Barr, 1994).

Health care system in Russia is chronically underfinanced. In 1990s Russian GDP dramatically dropped due to disintegration processes and resources devoted by the state to the public needs had decreased. This was reflected in low government health financing that during the period discussed was about 3,5 % of GDP. Insufficient financing entails certain restrictions in access and quality of medical care.

As a result, the volume of fee for service is constantly increasing, as lack of public funds force people to mobilize their private resources. Private health expenses in Russia mainly consist of out-of-pocket payments (OPP). This means that people pay cash at the moment of receiving medical treatment. The share of OPP in private health expenditures reached 92% and amounted to 36% of current health expenditures in Russia in 2015.

The emerging public-private mix in health finance and delivery in Russia is characterized by introduction of fee for services in state health services and raise of private sector in health care delivery. State health services have a right to charge fee for medical treatment provided extra to a guaranteed package. However, there is a big concern that they often make patients pay fees for services that should be provided free of charge (to overcome waiting lists, to visit a certain specialist). Besides, services for fee are provided at the same facility, using the same equipment, etc.

The growth of fee for service leads to an increase in inequality of access to health care of different social groups. Thus, income inequality is aggravated by health inequality. Taking into account the “sustainable” low level of government health expenditures coupled with high income inequality, it is suggested that certain population groups, first of all low income and living in remote areas are likely to experience problems in obtaining medical care (Grigorieva 2016).

The spatial factor makes functioning of CHI difficult - on the entire huge Russian territory with uneven population settlement, the specifics of transport networks, weak municipal health care, especially in rural areas, competition between insurance companies or health services is difficult or almost impossible to install. Regions differ by their social and economic status that is reflected in the population health status.

A number of problems relates to activities of health insurance companies. First, competition between them is weak, the CHI market in Russia is controlled by a small number of large health insurance companies. Second, health insurance companies are private entities primarily interested in profit making. A scheme when public money is transferred to state health services through private commercial intermediaries seems not very effective and increase administrative costs. Third, up till now they are not effective in controlling quality of care provided by health services.

In recent years, discussions have intensified on the prospects of CHI in Russia. Some experts discussing the pros and cons of the CHI system in Russia suggest returning back to budget medicine (Komarov, 2015). In the last years it shifted from academic to political community. In 2016, at the meeting of Commission for Monitoring the Economic Situation at the Council of the Federation, it was proposed to introduce budget medicine, with money coming to healthy services directly from the budget. Particular attention was paid to the fact that the budget has compensatory capabilities: low revenues from one tax can to some extent be offset by higher receipts from other taxes. In March 2018, the Federation Council Speaker V. Matvienko sharply criticized the CHI as being inefficient stating it should be abolished.

At the same time, Russian government and pro-government analytical centres believe that Russia needs to stick to CHI model, overcoming its negative aspects. The aim is to stabilize the situation in health care not taking risks of big changes that can lead to undesirable social consequences. In May 2018, the Russian President stressed the need to improve CHI system, but carefully, so as not to "come to complete chaos in this area."

Discussion

Russian experience of (re)forming social and health policy is instructive as it demonstrates that diffusion in the context of rapid societal change is a powerful tool of shaping systemic characteristic of a new model. It is argued that international influence was “diffused” into health care via two channels, namely:

- ideological – following liberal market ideas and policies;
- institutional – borrowing concrete institutional and financial aggangements, first of all compulsory health insurance (CHI).

Post Soviet health policy in Russia was formed under influences of mainstream western ideas and practices, on one hand, and enthusiasm of Russian elite at a time over liberal political ideology, on the other hand. The Russian government also received a lot of advice from consultants from international organizations that were actively present, and at that time in the political arena, in particular, the World Bank. Much less attention was paid on how well institutions

introduced in health care sited with Russian economic, social and cultural realities (especially taking into account a long tradition of state-provided free budget medicine).

Several observations flow from analysis of Russian experience in health reforms through diffusion approach.

First, changes implemented in health care led to high social costs in terms of low population life expectancy, high mortality and morbidity rates and contribute to emergence of a number of problems with access and quality of health care. Among the drawbacks are departure from preventive principles, shifting health expenditures to population, concentrating on "easy diseases", deterioration of primary care services, ineffective work of health insurance companies that are expected to monitor quality of medical treatment and protect interests of patients, etc. It might be taken as an evidence of a disfunction of CHI as an institution, its limited contribution to achievement of officially stated health policy goals. However, the question of changing model for health care is not on political agenda.

Second, applying experience of other countries is likely to be successful if two factors are taken into account: specifics of cultural, political and historical development of a country in general and health care in particular and concrete goals to be reached. Historically in Russia, traditions of public provision of health care were strong while the insurance mechanism implying “direct” contribution from population up till modern time did not manage to get any serious support in health policy. Two attempts to introduce it in early 1900s were short term and incomplete.

It should be remembered that Russia had a strong influence on health care development in the world. At the beginning of the twentieth century it offered a new model of health care, known as "Semashko model" managing to achieve almost universal health coverage. The Soviet model of healthcare was a unique state-organised health care system build on understanding health care as a public good rather than a commercial enterprise. By 1980s it was in need of change that was reinforced by decay of the Soviet Union that brought dramatic changes into Russian society.

Third, theoretical models of health care can not always be clearly identified in practice. In each country, elements of a particular model dominate, but it does not prevent certain arrangements that are characteristic of other models. At present most developed countries tend to concentrate on rational practical solutions to problems, rather than following stereotypes and ideological attitudes.

In the paper, health care problems in Russia are considered from the point of view of diffusion approach that stresses significant influence of experience of developed countries. However, to our mind, it did not allow Russia to go beyond

the existing models of health care, that have already demonstrated their pros and cons, without gaining significant positive results for the majority of population. At the beginning of transition in an environment of societal social reforms there was a chance (window of opportunity?) to introduce new ideas in health care based on a combination of traditions and innovations (Sadovnichy et al, 2012). Russian reformers were not prepared for it. The "old" health insurance model was used but its adaptation to post Soviet conditions proved to be much more expensive in economic and social terms than expected.

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