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THE ROLE OF LAW IN RUSSIAN HEALTH REFORM

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INTRODUCTION

True reform necessarily entails new law. In the newly independent Russian Federation, law has played a formative role in efforts to reform the health care system. Both historically and structurally, the health care system in Russia is more dependent on legal authorization than that in most Western industrialized countries. Reforms that providers might institute independently elsewhere are not likely to happen in Russia without specific laws authorizing them. Policy makers often formulate the substance of policy in the context of developing legislation, instead of drafting legislation to codify settled policy decisions. Thus, identifying and developing suitable laws has become an essential component of health care reform in Russia since the early 1990's.

The promise and peril of Russian health reform centers around its constitutional guarantee of free health care, contained in the Constitution of the Russian Federation:¹

“Everyone shall have the right to health care and medical assistance. Medical assistance shall be made available by state and municipal health care institutions to citizens free of charge, with the money from the relevant budget, insurance payments and other revenues.”

Russian health reform held promise because Russian health policy makers remained committed to the principle of solidarity—universal access to health care for the entire population. The peril arose from urgent needs for care from a health care system that no longer had either the money or the infrastructure to provide it.

In the 1990's, most European countries struggled to control the cost of health care while preserving health care as a social good based on the moral principle of social solidarity.^{2,3} But they did so largely in response to increasing pressure on reasonably well functioning health care systems.^{2,4} Aging populations with more medical needs, expanding use of new and expensive technologies, and tighter national budgets led

Western European governments to seek new ways to reduce the cost of care.^{5,6,7,8,9,10,11}

Russia, in contrast, did not have the comparative luxury of planning for a more expensive future. As described in the first section below, Russia faced mounting pressure for reform to save its health care system.

The need for reform created an acute need for new law. The role of law in Russian health reform is summarized in the second section. The third section describes four subjects of legal reform in Russia, as well as limitations on the effectiveness of law to achieve health goals. Paradoxically, although new laws cannot guarantee health to the Russian population, Russia may need even more new laws to enable it to honor its constitutional guarantee.

BACKGROUND AND NEED FOR HEALTH REFORM IN RUSSIA

The Russian Federation inherited the administration and Russian facilities of the Soviet health care system.¹² In the Soviet system, the national, oblast (state) and local governments received revenues and taxes from government-owned industries and allocated budget funds to the health care system to pay facilities and providers.¹³ Like its Soviet predecessor, the Russian Federation guaranteed medical care to all its citizens. The federal government continued to assume ultimate responsibility for providing its citizens health care, delegating to oblast and local governments the task of actual service provision. Oblast and local governments use their own tax revenues, together with a diminishing federal budget allocation, to operate their own hospitals, polyclinics, and specialized service centers where the general population is entitled to receive all types of medical care. The federal government operates certain specialized national health

facilities and clinics. Physicians are salaried and employed by the various levels of government to provide services in all these facilities. Thus, there is a longstanding network of facilities, staff, and services built decades ago on the solidarity principle.

Beginning in the mid 1960's, the Soviet government funded its health care budget only with the meager revenues left over after paying for an expensive military build-up and other higher priority commitments.¹⁴ The dwindling funds became a trickle after the Soviet Union was disbanded. The Russian Federation retained the largest population, richest natural resources, and best-developed industries of the new Commonwealth of Independent States, but its economy no longer produced sufficient revenues to pay for essential government programs. The federal government began to denationalize industries in the mid 1990's. It transferred the revenue-producing enterprises (oil, natural gas, nickel, banking, media) to private ownership, often at prices representing a tiny fraction of their value, leaving the government with a tenuous commitment to private enterprise but few resources to fund its continuing social obligations.¹⁵ The oligarchs, many of whom obtained ownership shareholdings in formerly state-owned enterprises in the scandalous 1994 loans-for-shares program, helped maintain the Yeltsin administration in power but returned little in taxes to the depleted federal, oblast or municipal budgets.¹⁶

When Russia's economy collapsed and the ruble was devalued in 1998, the health care system had suffered decades of neglect. The Russian population was experiencing rising morbidity and mortality rates that demanded immediate attention with modern prevention and treatment. Although Russians' health status had been decreasing since the mid-1980s, its even more precipitous decline in the 1990's has been well documented.^{17,18,19} Between 1990 and 1994, life expectancy fell from 63.8 to 57.5 for

men and from 74.4 to 71.2 for women, an unprecedented drop for a country not at war.²⁰ Although life expectancy increased significantly after 1994, improvement halted again in 1998.²¹ With a population of about 146 million, Russia has negative population growth,¹⁸ and within this decade could fall to a smaller population than Russia had before the 1917 revolution. Rising mortality from cardiovascular diseases and injuries (including homicide and suicide) accounted for more than 64% of deaths.²² The incidence of infectious diseases—especially tuberculosis, sexually transmitted diseases, HIV/AIDS, and diphtheria—grew faster than the public health system could respond.^{23,24,25,26,27,28} Illicit drug use began to rise.²⁹ Alcohol consumption, traditionally high in Russia, became increasingly dangerous when cheap impure vodka offered the only solace available to many Russians who had lost their jobs, their homes, or their sense of security.^{30,31,32} Falling levels of nutrition, industrial pollution, rising crime, and increasing numbers of homeless all contributed to an assault on the health of Russians.³³

Although health indicators improved slightly in the mid-1990's, the health care system has been unable to respond adequately to such an onslaught of disease. Hospitals had little money for new equipment or even routine maintenance; physicians and other health workers often relied on under-the-table payments to supplement their low salaries, which government sometimes delayed paying; and modern drugs and services ordinarily provided by the government were generally unavailable or unaffordable.^{34,35,36} The health care system could not keep pace with technology or standards of care that were the norm in the industrialized West—for lack of access to medical information or funds. Formal government health care expenditures were 4.8% of GDP in 1994. By 1998, they

had dropped to about 3.2% (including federal mandatory health insurance) of GDP, among the lowest in Europe, which averaged about 8% of GDP.¹⁷

With a crumbling health care infrastructure and insufficient government funds to pay for improvements, Russia could not provide adequate care to the population by simply continuing its government controlled system. One way to supplement funds for health care was to permit private financing of some medical services.³⁷ The World Bank and International Monetary Fund, as well as some Western economists, had urged reducing the entire federal budget and encouraged introducing some market reforms into the health system.^{38,39}

Fear of commercialization, however, made recourse to private financing anathema to the Ministry of Health (MinZdrav), most Members of Parliament, and many local health authorities and health professionals. Russia's economic collapse had left health professionals profoundly skeptical of bringing private ownership and market competition into the health care system. From their perspective, the introduction of capitalism had thrown the country's economy into chaos, deprived the elderly of their pensions—often their only means of support, thrown millions of formerly secure workers into the street with no prospect of remunerative employment, and allowed a small band of oligarchs to spirit the country's assets away into Swiss bank accounts. Few in the health field were willing to risk a similar looting of their hospitals and polyclinics. It appeared that Russia's health care system was backed into a corner. Yet, almost everyone recognized that the status quo could not continue and, in the absence of new federal funding, policy makers accepted the need for reform in almost every sector of the health system.⁴⁰

THE ROLE OF LAW IN HEALTH REFORM

Although law had little to do with the need for reform, Russia has given law a far larger role in reform than have most European countries. Why is law so important in Russia?

ONLY WHAT IS AUTHORIZED IS PERMITTED

In most Western democracies, the first principle of the legal system is that anything is permitted unless the law expressly forbids it. Its first corollary is that nothing is required unless the law specifically requires it. Historically, Russia has operated on the opposite principle: nothing is permitted unless the law expressly authorizes it.

The presumption that nothing is permitted unless the law authorizes it obviously inhibits spontaneous reform by private parties. Without explicit legal authority, anyone who initiates a new program might be accused of violating the law. This does not mean that Russia has no illegal or extra-legal activity. On the contrary, there are elaborate networks of black markets and underground activities, including under-the-table payments to physicians for medical care. But most such activities remain clandestine because they are recognized as illegal or at least of questionable legality and kept hidden from government view.⁴¹

Russia remains steeped in a Soviet civil law tradition that entails extensive legislation.⁴² The codification of so much business and personal activity leaves little room for creative lawyering, such as that practiced in the West. Lawyers rarely try to interpret ambiguous laws to permit doing something new.⁴³ Indeed, most lawyers still work for government agencies. The number of lawyers engaged in private practice, especially to represent private individuals, has only recently begun to expand.⁴⁴ Thus,

physicians and others who propose new forms of practice or administrators who propose new financing mechanisms are not likely to test their ideas without seeking specific new authorizing legislation or orders. This means that new laws must be developed to define and regulate reform measures before significant change occurs.

FREEDOM ENTAILS MORE LAW THAN DOES TYRANNY

The paradox of social regulation is that more laws may be needed to grant or preserve freedom than to maintain tyranny. In Russia, federal legislation has traditionally been written in very general terms granting jurisdiction to a Ministry or other agency to regulate a sector of the social or economic order. Laws are relatively brief by Western standards and rarely delegate specific powers to administrative agencies or lower levels of government in explicit terms. Even rarer are limitations on the exercise of power or mechanisms for redressing errors or complaints.

With respect to health, legislation typically states that a particular subject area, such as medical care, shall be the responsibility of the federal government (and lower levels of government) and that the relevant Ministry, such as the MinZdrav, carries out that responsibility and protects the rights of citizens.⁴⁵ Even where oblast and municipal health departments are expected to carry out certain functions on behalf of the federal Ministry, legislation rarely defines what those functions are, how they should be administered, or how the department might be held accountable. Thus, for both legal and practical reasons, a Ministry enjoys remarkably broad discretion to run programs as it sees best or as the leadership dictates. Ministry orders fill in the details left unmentioned in the legislation, sometimes including clinical protocols for medical therapies. The

governing legislation rarely expressly limits the scope or content of such orders, and there is little recourse against orders thought to be burdensome, obsolete, or unwise.

This “broad-authorization/discretionary-implementation” approach to legislation produces a legal structure that is remarkably simple to administer. It also discourages innovation and criticism. Lower level government authorities are ordinarily reluctant to respond creatively to problems or to initiate new ventures without direct authorization from the federal Ministry. Health professionals are similarly reluctant to change their practices without receiving prior government authorization.

Several of the 1990’s proposed reforms sought to decentralize the ownership or management of health care facilities, redistribute financial obligations, and grant both health professionals and patients more freedom. Russia’s traditional format for legislation is not well suited to these goals. New legislation in a more specific format was needed, both to create new institutions and to coordinate their relationships. First, change itself must be authorized—new forms of ownership, responsibility, financing, and accountability; power to make contracts, freedom to use new forms of treatment, and new mechanisms to enforce patient rights.⁴⁶ Then, if the reforms are to meet the larger goal of serving the entire population, the new mix must be regulated to ensure an equitable distribution of health services.

The reformed health care system envisioned for Russia, as elsewhere, is not a single entity or market, but encompasses several different types of relationships: between government and insurers, health care facilities, and providers; insurers and patients; insurers and hospitals, clinics, physicians, and suppliers; physicians and hospitals; and patients and physicians, hospitals and clinics.² Each of these relationships can be

structured in several ways, yet all must work together if they are to succeed. Thus, each relationship may require several laws, where only a few sufficed for all in the past. To introduce more freedom of action into the system, Russia was obliged to create new laws, both authorizing that freedom and regulating it to serve the national goal of solidarity.

DISTRIBUTIONAL GOALS REQUIRE SPECIFIC LAWS TO ACHIEVE EQUITY

The greater the freedom given to health care providers and insurers, the more specific and complex is the law needed to ensure universal access to resources and services. Some Russian policy makers are considering introducing something like internal markets in health care, in which some providers gain financial and managerial independence from the state but remain obligated to provide everyone services covered by the constitutional guarantee.⁴⁷ Completely free markets could soon render health care unaffordable to even larger numbers of Russians. Therefore, each piece of legislation that frees providers from direct government control and supervision necessitates additional provisions authorizing alternative mechanisms for making sure that the right mix of services remain available to all patients.

Moreover, because each sector of the health care system should be able to operate in several different ways, new regulatory law needs to take all possible mechanisms into account. This produces complex, detailed legislation and regulations. In particular, where it is important to restrain the exercise of discretion (for example, to prevent abuses like political favoritism), more specific rules are needed to delineate not only what is permissible, but also the procedures for fair decision making. Indeed, democratic states committed to social solidarity tend to experience the paradox of decentralization in which the complexity of the law increases directly with extent of individual freedom.

THE RULE OF LAW

Of course, no matter how well constructed new laws may be, they cannot enforce themselves. And laws are not likely to be enforced in the absence of a genuine social commitment to the rule of law. In Russia, the rule of law has gained only a tenuous hold.¹⁶ For much of its history, Russia's law was used as window dressing for authoritarian regimes.^{48,49} Often-exemplary legal texts were meaningless in practice. The Soviet government, for example, ignored guarantees of human rights in the Soviet constitutions. Actual law enforcement was often selective.

It should not be surprising that Russians have little confidence that enacting a law will protect them from arbitrary actions.⁵⁰ Yet that is what the rule of law requires—faith in the continued, impartial application of publicly known laws in a civil society.⁵¹ Health care reforms are not likely to succeed if, for example, providers and insurers cannot rely on the enforceability of the contracts they make. Hospitals are not likely to change their treatment modalities unless they believe that their continued operation and financing remain secure from arbitrary government intervention. Patients are not likely to seek care if they cannot rely on legal protection of their confidentiality. Thus, the rule of law may be the most important prerequisite to effective health care reform in Russia.

Belief in the rule of law ordinarily takes years, even generations, to develop. Nevertheless, and in spite of their history, Russians retain a surprising faith in law as both a catalyst and a tool for reform, perhaps because change has often come in the name of the law, perhaps because they have few alternatives. The need for sound law is especially acute in an era of economic turmoil. If social solidarity is not to unravel

further, Russia will need the power of law to knit health care together into a more effective system for everyone.

CATEGORIES OF REFORM MEASURES IN RUSSIA

The United States Agency for International Development (USAID) recognized the potential for law reform to further health system reform in Russia. The Boston University Project on Legal and Regulatory Health Care Reform in the Russian Federation (BU Project) has provided legal technical assistance in drafting legislation and regulations to Russian federal and oblast government entities since late 1995 with USAID funding under a series of cooperative agreements.⁵² The BU Project has offered technical assistance in legislative drafting for laws in four subject categories: (1) system structure, (2) financing, (3) providers, and (4) infectious disease. A few examples from the BU Project's experience, described below, illustrate the law's potential to advance health reform and its limits in achieving effective change.

SYSTEM STRUCTURE

The importance of additional legislation to reforming the health system can be seen in efforts of the lower house of parliament (the Duma) since 1995 to develop new federal law on the structure of the health system. Duma Members (Deputies) assumed that health reform could not progress without creating a new legal structure for the entire system. Consistent with past practice, their initial goal was to lay out legal responsibility for all elements of a health system in a new comprehensive federal statute. This General Structure Law would cover medical facilities, health professionals, quality of care, entitlement to care, insurance and financing, public health and prevention programs,

sanitation, and environmental protection. To Western idealists frustrated with multiple, incomplete and conflicting laws scattered in many volumes of code, this would be a dream come true. To skeptics, it was an impossible dream.

In order to draft legislation describing the General Structure, the Deputies confronted difficult questions about how each component of the health care system should function and what was required to make that happen. Decentralizing the system to give more flexibility to lower level government entities and medical facilities required deciding how much legal authority oblast and municipal governments should have over their local facilities, the services they provided, and the payments they received. These decisions depended upon whether some or all government facilities should be given budgetary, administrative, managerial or other forms of independence within a government-owned system or turned over to private (commercial or nonprofit) ownership. These options in turn gave rise to questions about whether and how to preserve the citizens' right to health care when providers had more freedom to determine what services they would provide. Each question could be answered in several plausible ways, and each answer affected how other components of the health care system should be structured.

Writing the General Structure Law served as an exercise in policy development as well as legislative drafting. The Duma had relatively limited experience in producing its own vision of law independent of the Kremlin because its constitutional powers are constrained by the President's authority.⁴⁷ Yet it was the Deputies, especially the recent chairs of the Health Care Committee, who, alarmed by the deteriorating health conditions in Russia, pushed for reform. The General Structure Law provided the focus for

conceptualizing alternative approaches to achieving the goals of health reform. The BU Project provided examples of legislation from different countries and supported meetings with experts from different countries to discuss their experience with different approaches to specific problems. Not surprisingly, the more the Deputies debated, the more detailed the legislation became. Soon, it included something for everyone to dislike and could not attract enough votes for passage.

The exercise was not in vain, however. The Deputies recognized that the traditional “broad-authorization” approach to legislation could not easily capture their vision of reform. They benefited from analyzing reform options, and they wanted and needed to get more specific to solve the problems of health care. The result is a two-pronged approach to drafting legislation. Where agreement can be reached on a component of reform, the Deputies propose separate, more detailed, subject-specific legislation for that component. Although this means that Russia—like everyone else—is not likely to have a perfectly integrated health code, it allows the Duma to analyze its reform options in a thoughtful, deliberative process. At the same time, work continues sporadically on a General Structure Law of more limited scope—more descriptive than prescriptive—consistent with the tradition of comprehensive statements of legal responsibility. This may serve as a symbol of reform and a unifying framework for separate pieces of future legislation.

Among the subject-specific statutes drafted is a Medical Devices Law authorizing the federal government to approve and regulate medical devices for distribution in Russia.⁵³ The growth of needed medical device imports calls for sensible national regulation, and the draft law is a welcome response. However, the current draft contains

an awkward division of responsibilities among several ministries that may hamper its passage and, if passed, its administration. It lies dormant in the Duma, perhaps because interests profiting from the existing chaos (and a lack of clarity concerning the effect of US and European Union equipment certification) do not support an imperfect clarification of rights and governmental responsibilities.

In the late 1990's, as economic and political turmoil increased, the Duma's reform efforts slowed. The MinZdrav may have favored continued federal control of the system, but its budget was too small to influence oblast and municipal programs. In this climate, several oblast governments took the initiative to develop their own reforms, which may serve as models for other oblasts. For example, Novgorod Oblast enacted a pharmaceutical law authorizing the oblast to create its own drug formulary and to purchase drugs using competitive bidding.⁵⁴ No such powers were necessary when the state produced and provided all drugs—usually only one or two in each therapeutic class—and controlled price and supply. Recently, however, the high cost of buying pharmaceuticals from private companies, including a proliferation of imported patented drugs, prompted the oblast to find new ways to limit drug expenditures. Its first impulse was to limit the drugs available under the national guarantee by creating a formulary. When the oblast recognized that it could not completely control external market prices, it added competitive bidding for government purchases. Finally, it added a “generic substitution” provision, enabling pharmacies to substitute cheaper generic drugs for expensive patented products. The new law is helping the oblast use its scarce funds more efficiently.

FINANCING

Russian policy makers recognized that the constitutional guarantee of medical care could not be realized without finding additional financial resources.⁵⁵ The financial pressure was exacerbated by an oversupply of hospital facilities and beds, a legacy of the Soviet practice of lengthy in-patient care for most medical conditions. The best option for decreasing costs was to reduce inpatient facilities and improve the efficiency of care, including changing medical practice to encourage general practice, outpatient treatment and shorter inpatient stays. However, hospital administrators, whose budgets increased with the number of beds and volume of care actually provided, had little incentive to reduce their own services. Moreover, the MinZdrav and many lawmakers did not believe that Russia had excess capacity.

The first major health reform initiative in Russia was a step toward converting the Soviet state-run health care structure into an insurance-based system. The Law of Medical Insurance of Citizens of the Russian Federation (first enacted as a law of the Soviet Union in 1991) provided a limited additional source of health financing. Known as the Mandatory Health Insurance (MHI) law, it assessed a targeted payroll tax on employers.⁵⁶ Municipal governments were expected to pay the MHI fees for the non-working population (elderly, unemployed, children), but many have not done so. Economic decline and the under-reporting of income also limit the yield of the current MHI assessment to about 0.75% of GDP. Moreover, the 1993 constitution's guarantee of free care to all Russian citizens has been interpreted to preclude employee contributions to MHI funds or an assessment on the employee for coverage of dependents.

Although supporters hoped the MHI law would unleash quasi-market forces to reform Russian health financing, it has produced little change in the size, structure or management of Russian health care institutions. In part, this is because MHI payments are still only a tiny portion of total health facility funding. Line-item government budgets continue to provide the largest portion of total revenues for most institutions.

Although the MHI law was amended in 1993 (partly to activate it), it fails to clarify the insurance functions that its national regulatory body, the federal MHI Fund, should exercise. Perhaps as a result, the Fund has been reluctant to take affirmative steps to improve medical care by paying only for effective services. The regional insurance funds that administer the MHI throughout the country are similarly reluctant. Some of this resistance may be ascribed to old habits that die hard, especially where those who administer the regional funds are the same people who worked in Soviet programs.⁵⁷ Still, the absence of statutory provisions authorizing specific insurance powers undoubtedly discourages the innovation that insurance was intended to introduce.

For-profit insurance companies are allowed to compete to obtain the MHI "accounts" of employers. These "insurers" generally act as passive intermediaries, disbursing available MHI funds to all qualified institutions using reimbursement schemes approved by government authorities. The "insurer" takes no risk and is only paid an administrative fee. Insurance companies working under the MHI law do not develop selective networks or managed care programs.⁵⁸ However, the insurers sign contracts with providers, which could become the basis for new reimbursement methodologies or greater insurer activism in the future. Claims processing by the insurers generates utilization data that were not previously available. Insurers often

justify their continued role in the health care system by pointing to actions taken to protect the insureds—recoveries obtained from providers who have injured patients through poor medical practice.

Before the Russian "financial" bubble burst in the 1998 crash, some insurance companies profited from the "float" in MHI payments. They invested receipts in high yielding investments and delayed payments to providers. Patients as well as providers express discontent with the MHI system. Because it is the one visible innovation in Russian health financing in the 1990's, MHI is often blamed for inadequate funding of the overextended health system inherited from the Soviets and for the decline in health outcomes of the post Soviet years. There have been a number of calls in the Federal Duma for the repeal of MHI, but none have yet succeeded.

Although the MHI law, as currently written, has not reformed the system, the need for a national law to reform health care financing remains. Solving problems of inadequate financing and oversupply of facilities and services in Russia will require more than merely encouraging consumers or providers to change their behavior. It will require new law.

In the meantime, the MinZdrav retains the power to institute some reforms without new laws by issuing orders under its broad existing authority. The MinZdrav recently developed two sets of guidelines with the potential for reducing costs and improving efficiency. One set of planning guidelines sets targets for modest reductions in bed capacity and usage, consistent with a 1997-1998 ministry policy statement. The other provides guidelines for payments to federal tertiary care facilities. Both guidelines essentially articulate the conditions for continued government operation of existing

government health care facilities. They demonstrate what the federal government can do if it is inclined to initiate reform. Few oblasts are willing to take similar official reforms without federal approval.

At the same time, the federal government has been generally unwilling to relax its control over financing government facilities. Moscow Oblast wanted to allow overbedded hospitals to lease out their excess capacity and use the lease revenues to improve their medical services. Under existing law, a hospital must send any such lease revenues to the central funds of the hospital's oblast government. To avoid this result, in a rare example of creative lawyering, Moscow Oblast sought to appropriate—from its own government revenues—the amount of the hospital's lease revenues back to the hospital. However, the federal Finance Ministry then issued new, strict guidelines on leasing, reiterating that all revenues from the lease of excess capacity in government facilities be returned to the government as owner of the facility. This precludes the oblast from conducting its reform experiment, so that hospitals are unlikely to attempt to lease excess capacity or will do so only in a clandestine manner. The federal reaction may reflect fears that entrepreneurial activities will take money out of the health care system that is intended to serve everyone.

PROVIDERS

Russian physicians and other health professionals have been government employees working in federal, oblast, regional or city hospitals, polyclinics (multispecialty clinics that serve as the primary health centers for most Russians), and specialized clinics (for narcotic addiction, sexually transmitted diseases, HIV/AIDS, tuberculosis and other infectious diseases, and groups at risk, such as miners). Under the

centralized Soviet system, the Ministry of Education controlled the supply of physicians through medical school admissions. Oblast and municipal health departments, operating under national standards established by the MinZdrav, hired physicians, determined what kind of work they would perform, where they worked, and how much they were paid.¹⁴ The Ministry also set standards for the volume of services it expected physicians to perform. In this system, private practice did not officially exist.⁵⁹

The Russian Federation generally continued this system, although health departments were not always able to meet their payrolls for physicians (or anyone else). One way to bring more money into the system and, ideally, improve the quality of medical practice was to allow physicians to practice outside government facilities and compete for fee-paying patients. Patients were already making under-the-table payments to physicians, polyclinics, and hospitals to obtain care and supplies for treatment and hospitalization. A Boston University sponsored household survey in January 1998 found that an average of 14% of Russians' monthly household expenditures were for medical services and drugs (including over-the-counter drugs).^{60,61} This percentage included 1.5% for outpatient care and 2.6% for inpatient care, most of which occurred in government hospitals and clinics. The survey estimated that these out-of-pocket payments constituted 43% to 55% of total Russian health expenditures. If these payments could be rechannelled into the national financing scheme for redistribution in more efficient ways, total public and private funds available for financing medical care could equal between 6.43% to 8.13% of GDP instead of the official government estimate of 3.49% of GDP, and allow the government to fund needed services.

Some physicians have been eager to begin a private practice independent of government employment, seeking freedom from outdated and unscientific government treatment protocols as well as increased income. Although some physicians in fact offered services privately, few were willing to open a practice without the official approval conferred by legislation. At first, federal legislators resisted the idea of privatizing medical practice, fearing it would unravel the national health system. As several scholars have noted, although market competition can theoretically achieve an efficient distribution of consumer goods and services, it may not, without constraints, necessarily achieve equity in the distribution of health care.^{2,62} Moreover, health care systems rarely display the characteristics of the economist's ideal free market.^{63, 64} Only when convinced that suitable law could protect constitutionally guaranteed services from erosion by private practice did members of the Duma begin drafting legislation authorizing the private practice of medicine.

When more pressing national matters cut the Duma's effort short, several oblasts considered similar measures. In February 2000, Samara became the first oblast to enact a law formally structuring the private practice of medicine.⁶⁵ A significant minority of physicians in Samara began to formally offer services in private offices. Many exhibited relief at being able to practice in the open under a law that promises to protect their practices as legitimate and to treat them equally with government physicians.

Allowing private medical practice raised policy issues that did not exist when physicians were government employees. A major concern was whether to permit private practitioners to provide services that are part of the constitutional guarantee. On one hand, if private practitioners offered more efficient and higher quality care, they could

encourage productive competition with government facilities and ultimately improve care for everyone. On the other hand, it was generally agreed that patients should not have to pay for constitutionally guaranteed services. Of course, it was possible to allow private practitioners to provide guaranteed services if the physicians were bound by contract to accept the MHI Fund standard payment and not to charge patients any additional out-of-pocket fee. However, the idea that government or an MHI Fund could create binding contracts with private physicians to carry out the constitutional guarantee was sufficiently unusual in the health arena that it required specific statutory provisions not typical of traditional Russian legislation, as well as more detailed contract models.

Private practice in Samara raised even more basic questions. Without government screening conducted as part of its hiring practices, should there be restrictions on who would be entitled to practice medicine? Samara wanted to limit medical practice to qualified physicians and thus found it necessary to create a new legal system for licensing physicians. Some private practitioners feared that a licensing agency dominated by the more numerous government-employed physicians might restrict private practitioners ability to obtain or maintain a license. Samara decided that it should no longer rely on the discretion traditionally accorded government agencies and developed regulations for the composition, powers, and operation of a medical licensure commission, as well as qualifications for physician licensure, grounds for discipline and license termination, and procedures for decision making. The level of detail is less than in United States licensure laws and regulations, but strikingly more than most Russian laws. The Samara law may well serve as a model for the national private medical practice law that the Duma hopes to pass in the future.

Novgorod oblast addressed the difficult issue of what services it would pay for as part of the constitutional guarantee of free care. The Novgorod Oblast law on Guaranteed Free Health Services makes free care a function of available resources and allows private providers to compete with government facilities to provide such services.⁶⁶ Kaluga Oblast proposed a similar law to create a minimum benefit package. Hospitals and physicians could be penalized for charging patients for services that are guaranteed as free care. The law also would permit the government to charge co-payments to patients when government funding falls below certain levels. However, the constitutional free care guarantee was believed to preclude charging patients a co-payment at the point of service, so the constitutionality of this provision remains in question.

The vast network of government controlled hospitals and health facilities put an enormous strain on Russia's national health care budget and bound practitioners to often out-moded treatment methods. Closing hospitals or converting beds to other uses could reduce costs and encourage more effective care. But, as government entities, the hospitals do not have the freedom or authority to make such changes unilaterally. There has been discussion of reorganizing hospitals into non-profit organizations or trusts to allow them the financial and managerial flexibility to operate more efficiently, thereby reducing local, and ultimately national, costs. This approach holds particular promise because cost savings would remain within the health system to be used for improving the quality of care, rather than, as in the United States, being transferred as profits to private investors in commercial for-profit corporations. However, such organizational restructuring requires new law authorizing the non-profit entity. Until recently, proposals for such a law have been kept off the federal legislature's agenda because they might be

misconstrued as “back-door privatization” or commercialization of the hospitals.

However, the Putin administration is currently drafting a new law to permit a more independent form of organization for certain federal, oblast and municipal government institutions, such as cultural, educational and health facilities.

PUBLIC HEALTH AND DISEASE PREVENTION

Health reform has not been limited to financing and delivery. Lawmakers have struggled to restructure their public health services to slow the spread of infectious diseases. The major Russian laws on this subject look more like Western European laws, perhaps because they are more targeted than laws on restructuring the financing or delivery of health care, or because they concern basic health problems that are less culturally bound than political or medical institutions.

For example, Russia’s federal law on the prevention and treatment of HIV/AIDS, enacted in 1995, prescribes a reasonably enlightened regime for prevention education, free treatment for people with HIV/AIDS, and protection of the rights of people with HIV/AIDS.⁶⁷ However, prevention programs have never received the promised funding, so government has been unable to provide the type of public education that has reduced HIV transmission in other countries. Hospitals may even contribute to the spread of infection by failing to take universal precautions, possibly for lack of supplies, training or awareness of the growing epidemic.

Instead, HIV policy in practice has focused on testing patients for HIV infection, even though there are few drugs available for treatment and testing serves little purpose. Some of the emphasis on testing may be due to the law’s failure to specify priorities among the comprehensive list of measures for which the federal government is

responsible. Some may arise from ingrained habits from the Soviet era when people with infectious diseases were routinely identified and isolated in specialty hospitals. Indeed, there have been reports of local officials seeking the names of AIDS patients even though the federal law requires physicians to keep that information confidential. In the absence of adequate treatment, testing may appear to be all that government can afford to do, although prevention education may be both less expensive and more effective in preventing transmission. The considerable promise of the federal HIV/AIDS law has not yet been realized.

The federal Parliament also passed a federal Tuberculosis Control bill to ensure treatment for the rapidly growing population with TB.⁶⁸ President Putin, however, declined to sign the bill into law, claiming that it contradicts existing laws on federal responsibilities. The administration's objection may lie in the bill's reliance on physicians, rather than national ministry protocols, to decide whether to hospitalize patients. The bill expressly protects patients from discrimination. Legislators unenthusiastically agreed to authorize involuntary treatment for recalcitrant patients who could or would not complete treatment (to prevent drug resistance as well as to ensure cure). Russia's experience with involuntary "hospitalization" of political dissidents undoubtedly made lawmakers reluctant to use involuntary hospitalization for genuine treatment, but they were eager to learn how other countries used due process procedures to protect patients from unjustified confinement and incorporated a few due process elements, including judicial review of involuntary hospitalization, into the bill.

If the Tuberculosis Control bill were enacted, it would still face practical obstacles. The federal government has not been able to provide sufficient funding for

appropriate drug therapy in the past and may not be able to do so in the near future. In addition, like the HIV law, the Tuberculosis Control bill calls for changes in ingrained medical practices. Although the law makes clear that patients are to be treated (voluntarily) primarily on an outpatient basis, providers still tend to routinely hospitalize TB patients as in the past, and many continue to use outdated therapies. It will take more than the law to change medical practice.

CONCLUSIONS

Health reform in Russia is unlikely without law reform. Law reform is a prerequisite to Russian health reform because few relevant changes can be made without changing the law. Russian health care has not been released from government control except by new laws authorizing specific actions. As more freedom is introduced into the health care system, new laws are needed to ensure the equitable distribution of services; and the more things change, the more complex the law becomes.

At the same time, new laws are not sufficient to produce real reform. Law reform only works where the rule of law is respected. In the past decade, policy makers have been working to introduce health reforms laws in an era in which the rule of law is under enormous strain and openly flouted in many sectors of the economy. Russia also faces severe financial constraints on carrying out even the best-constructed laws. Moreover, many people are uncomfortable with proposed changes and some actively resist. President Putin has indicated little enthusiasm for reforms that diminish federal control over health care funding or personnel.

Nonetheless, there are brighter prospects for the rule of law in the health care system than in other sectors of Russian's economy. Most health care providers and policy makers remain committed to both improving the system and making it serve everyone, and they recognize that law is necessary for achieving both goals. Progress may be inching forward. Legislators who decried any private activity in health care only a few years ago have argued more recently in favor of such reforms. The Putin administration has expressed interest in recommendations for future health reform, including alternative organizational forms, like hospital trusts, and using private payments to reduce the costs of guaranteed health care for the poor.

First on Russia's health reform agenda is preservation of the constitutional guarantee of free medical care for all. While economic and financial reforms are recommended to make the best use of scarce resources, they are not supposed to operate to exclude Russians from care. Thus, law has played a central role in determining what reforms have been produced and whether additional reforms are likely to materialize in the future.

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