Centre for East European Language Based Area Studies

Health and Welfare in Eastern Europe

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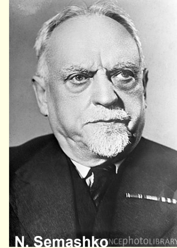
Project Summary


N. Semashko

Health care systems in the countries of Central and Eastern Europe and Russia have been facing a multidimensional challenge since the collapse of the socialist system. They had at once to cope with the negative sanitary impact of the transitional period, to adapt and to improve health care systems financing and delivery of Care in order to cope with the flaws of the inherited health care systems, but also to preserve their achievements.

After twenty years of transition, multiple options for the improvement of national health care systems have been chosen, and CEEC and NIS including Russia offer a mixed picture. Some countries coped better than others with health systems reforms, and the consistence and success of health financing reforms was a key determinant of the improvement of the quality of care delivered and of the fairness of access.

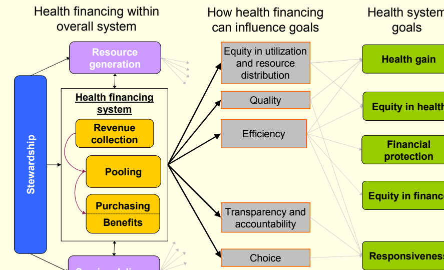
Aims

•To study the development paths of the health care systems in the CIS and CEEC during the first wave of reforms in the 1990s and early 2000s, with a special interest in the changes introduced in the financing mechanisms, the improvements they were expected to bring in terms of efficiency of resources allocation, quality of service delivered and fairness of access, and their actual achievements.

• To monitor recent measures taken at national/federal and regional levels in the domain of health policy (such as the Russian National Priority Project "Health"), and formulate policy prescriptions aimed at governing bodies and international advisers/NGOs.

Methodology

The theoretical background for this research is institutional economics of transition, and more especially theory of path dependency and institutional lock-in. The approach retained to describe the impact of health financing reforms is inspired by the WHO "four pillars".



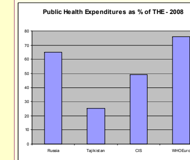
Source: Kutzin, WHO.

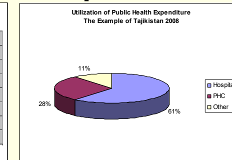
Studies mostly focused on the Russian Federation, but some aspects of the reforms in Central Asia were also included.
The initial situation (of the early 1990s) was investigated though review of literature and interviews of main stakeholders of the reforms, and then compared to the situation observed in the mid 2000s. It was then possible to draw the trajectories taken by the health financing reforms, the diversity of regional reforms paths and to assess their impact on the whole health system restructuring. It was also possible to assess which elements of the reforms explained either a beneficial trajectory or a lock-in.
Finally it was possible to analyze with the same grid if the most recent reforms were well targeted at these locks, and hence had a chance of success.

Outcomes

Initial situation:
Stewardship: fragmentation of the decision making process despite apparent centralization
Service delivery: over-reliance on hospital care and vertical structures, quantity of care more valued than quality.
Resources generation: HR overly specialized, pharmaceutical distribution networks inappropriate, aging infrastructures.
Health financing: low public funding, fragmented funding, misuse and waste of resources, no benefits structure except l'gotiniki.

Outcomes and Impacts





Reform paths and outcomes:
Health financing:
Public funding is still low, and does not allow an extension of the coverage (for instance for pharmaceuticals). The frequency of private payments, either formal or informal, raised over the period.
Main pooling reforms, including MHI inspired, generated more fragmentation than pooling in Russia. Voluntarily mixed funding approaches worked with more success than big bang approaches elsewhere.
Purchasing mechanisms in Russia are a jungle, with important discrepancies between regions…. And the question of unification of purchasing models was left unsolved.
The scope of benefits provided for free to the population is still unclear in many countries, and rendered virtual by widespread informal payments.
Service delivery:
after 20 years of reforms, service delivery in Russia and most CIS still massively relies on hospital care. The approach to service delivery is also still very much vertical. Latest health reforms initiatives like the National Priority Program Health are still very much relying on the hospital sector. On average, the link between health financing reforms and the rationalization and quality improvement of services is still weak.
Resources generation:
HR is overspecialized still. Efforts on infrastructures were mostly targeted at building additional hospitals rather than restructuring existing ones. PHC strengthening was often forgotten on the resources generation front.

Research Outputs and follow-ups

• Health System Reforms in Transition Countries: the Case of Russia. Revue de l'ISMEA, Paris, 2007.
• WHO InfoWay Project – Health Financing Notes for: Russian Federation, Tajikistan, Latvia, Kazakhstan, Moldova, Albania, Belarus, Uzbekistan, Turkmenistan.
•Contribution to "Health In Transition – Tajikistan 2010. (WHO)
•Organization of the CEELBAS Seminar Series on Health and Health Systems.
• Contribution to the organization of BEARR Trust/CEELBAS events.
•Inertia in health financing reforms: a comparison of Russia and Tajikistan (ongoing).

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