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Can Russia's Health and Welfare Systems Handle the Pandemic?

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Russia recorded its first confirmed case of COVID-19 in early March 2020. Through most of April and May, Russia was second only to the United States in total number of reported cases, though Brazil pushed Russia to third in late June, and India bumped it to fourth in early July. Russia had carried out over 26 million coronavirus tests by late July, and was officially reporting about 800,000 positive cases and just over 13,000 deaths.

The Russian government initially responded to the pandemic by mandating isolation regimes to limit the spread of the virus and adopting a program of measures to mitigate the economic impacts, among other steps. These efforts softened the effects of the crisis for much of the population. However, three groups—labor migrants, informal-sector workers, and rural populations living far from medical facilities—were largely excluded from these mitigation measures.

As in China, the United States, and other countries, Russia's first COVID-19 cases were concentrated primarily in large urban areas. The burden fell disproportionately on Moscow through the pandemic's early months. But the caseload then spread rapidly across other parts of the country in mid- to late May.

During the first week of May, more than half of all reported new infections were in Moscow, and well over 60 percent were in the broader capital region. But by the end of June, fewer than 10 percent were in Moscow proper, as hot spots emerged in some poorer regions where health infrastructure was inadequate and infection control measures fell short in an array of contexts, such as hospitals, construction and other work sites, and large social gatherings.

The quality of Russia's COVID-19 data emerged early in the pandemic as a hot-button political issue. Through March and early April, as reported case numbers surged in Europe and the United States, the number of new cases confirmed daily in Russia seemed implausibly small. Doubts swirled around the coverage and reliability of Russia's homegrown test kits. As the number of detected cases increased, even more pointed questions arose regarding Russia's still remarkably low number and rate of reported deaths from COVID-19.

Some observers have speculated that mortality data are being deliberately manipulated to make it appear that the government has handled the pandemic well. At lower levels of the health system, political pressure to avoid sending bad news up the bureaucratic chain is clearly a factor. But it is more likely that the comparatively low fatality rate results from classification rules that differ from global standards.

Russia's rules are more flexible and highly decentralized, allowing medical professionals to focus on comorbidities that contribute to a death. Even if a patient who had tested positive for coronavirus dies, and the death might not have occurred in the absence of the virus, that death

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can be recorded as due to something other than COVID-19. In other words, standard operating procedures in Russia allow for distinctions between deaths *from* COVID-19 and deaths *with* COVID-19, producing undercounts of the former.

In any event, international reporting (in the *New York Times*, the *Financial Times*, and other outlets) questioning the accuracy of the death toll prompted the Russian ambassador in Washington to demand a retraction in mid-May. But further analysis comparing the total number of deaths in March, April, and May 2020 with the same months in 2019 led the Russian authorities to adjust their counting rules in early June so that the reported death rate ticked slightly upward.

Ready or Not?

There are plenty of factors that may have rendered Russia comparatively less vulnerable than other large countries to this pandemic. First of all, Russia has mandatory health insurance that, in principle, guarantees medically necessary treatment free at the point of service for all citizens. Although that insurance system continues to struggle with gaps in coverage and persistent inequities, few stories of financial barriers to testing or treatment for COVID-19 have emerged.

The system has functioned largely as intended in Moscow and other larger cities.

Relatively low internal mobility—especially among Russia's elderly population, which is most susceptible to severe disease requiring hospitalization—lowers risk. Russia's older population also relies less on institutional long-term care than is the case in most industrial societies. Reduction of that risk factor is notable, since 40–45 percent of COVID-19 deaths in the United States have been in nursing homes and other elder care facilities.

Another possible factor is that Russia widely uses the Bacille Calmette-Guérin (BCG) vaccine for tuberculosis. Although the World Health Organization cautions that the evidence is scant, there is speculation that this vaccine offers some protection against the coronavirus.

Last, but not least, the Russian government made good policy decisions early in the pandemic. It closed international borders in March and instituted isolation regimes across most of the country throughout April and most of May.

Other factors, however, have intensified the pandemic's negative impact on Russia. There is significant variation in health expenditures and health system capacity between urban and rural areas, and in general across Russia's many regions and municipalities, producing wide divergences in access to and quality of care. Shortages of personal protective equipment plagued medical facilities early in the pandemic, causing an alarming number of fatalities among health care workers.

Russians also have disproportionately high rates of chronic underlying health conditions that increase the risk of severe complications from COVID-19, including heart disease, diabetes, and hypertension.

In addition, several vulnerable population groups—such as undocumented migrant workers, the homeless, and residents of communal apartments in St. Petersburg and some other cities—tend to live in crowded conditions with few resources. It is impossible for them to maintain consistent physical distancing from others.

Finally, as the pandemic has dragged on, economic and especially political considerations have overtaken public health imperatives in driving key elements of decision making. As in other countries, there has been strong pressure to end lockdowns and reopen in order to limit damage to the national economy, but other political considerations specific to Russia have also influenced the government's response. A national referendum on constitutional amendments, originally planned for April 22, was somewhat hastily rescheduled to run from June 25 to July 1. It was held despite the fact that Moscow and other parts of the country were still falling short of established benchmarks that would indicate that the virus was under control.

The timetable for reopening was accelerated so that in-person voting could occur with maximum turnout. The referendum was important to President Vladimir Putin because it included a clause that would make him eligible to run for two more six-year terms, potentially extending his presidency to 2036. The referendum, which called for an up-or-down vote, also promised increases in pensions and other social benefits, though any raises would be imperiled by a prolonged pandemic-induced recession.

In the government's upper echelons, winning passage of the referendum was clearly a higher priority than caution about public safety. The Kremlin

got the result it wanted. Amid widespread accusations and evidence of fraud, nearly 68 percent of the electorate turned out, and over 78 percent voted in favor of the reforms, according to the official results.

Planning Problems

Although an initial rush of seriously ill COVID-19 patients overwhelmed hospitals in Moscow during the first wave of the pandemic in April and May, expedited construction of new facilities and the repurposing of existing infrastructure quickly caught up to demand in the capital. But outside well-funded and privileged Moscow, the situation is different. Enduring legacies of Soviet health care, coupled with substantial but sometimes erratic and poorly implemented reforms over the subsequent three decades, have left health facilities underprepared for a pandemic like COVID-19 and its possible resurgence due to premature relaxation of restrictions on social gatherings and business activities.

Like the rest of the Soviet economy, health care through most of the twentieth century was structured on principles of input-based planning (success was measured by resources allocated to a problem rather than results). Universal access to care was prioritized, and in this case the achievement justified the boasts of Soviet propaganda: virtually everyone, even in the most remote corners of a nation sprawling across eleven time zones, had free access to some basic level of care. Of course, members of the Communist Party's upper ranks and others with high status enjoyed access to superior facilities, and large cities were better served than outlying and especially rural areas. But even those with privileges suffered from a planning process that prioritized the number of patients treated rather than health outcomes.

This system gave clinic doctors an incentive to limit their work to two primary tasks: signing the sickness certificates that excused ill patients from work, and referring those patients to specialists. Hospital-based specialists met their plan targets by maximizing the number of occupied beds, leading to overcrowding and one of the longest average hospital stays in the world.

Overall financing of health care followed the "residual" principle: the sector got its allocation of funding from what was left after higher-priority industrial sectors like defense and heavy industry had their fill. That explained why health expenditure, at about 3 percent of gross domestic product, was low by international standards. The scarce resources that the health sector received were often wasted, and quality of care was neglected. Although many Soviet physicians were skilled, compassionate professionals who did their best to ensure their patients' well-being, they did so in spite of, not because of, the system in which they operated.

Post-Soviet Reforms

A steady stream of post-Soviet legislation, regulation, and investment has aimed, at least in principle, to end the overemphasis on hospitalization versus primary care, improve quality, and prioritize positive outcomes instead of the quantities of treatment delivered. Nationwide compulsory medical insurance, inaugurated in 1993 to replace the state-run Soviet single-payer system, was designed to create mechanisms for market-based competition. People would be free to choose their health care providers at all levels, either directly or through their choice of health insurance companies that contract with providers.

This system has functioned largely as intended in Moscow and other larger cities. But many other areas lack sufficient numbers of providers, insurance companies, or both, for the competitive incentives to take effect. Meanwhile, private medical facilities have flourished in Moscow, St. Petersburg, and a few other urban centers, adding resources to the health care system while simultaneously increasing inequality of access.

The central and regional governments have made substantial investments in the health sector, beginning in 2006 with the Priority National Health Project, which improved salaries and training for health professionals and increased funding for health infrastructure. These investments ramped up to a new level with Putin's "May decrees" of 2012 and 2018, calling for billions of dollars in new hospital construction, clinic refurbishment, and equipment purchases, among other priorities. The increased spending—now stabilized at around 6.5 percent of GDP annually—has targeted areas where Russia's health and demographic challenges are most severe, including maternal and neonatal care and the treatment of cardiovascular disease, cancer, and other noncommunicable diseases. Such investments are a clear response to long-standing and increasing concern at the highest levels of the Russian government about low birth rates, premature mortality (especially among men), and overall population decline.

The central government has also implemented public policies aimed at changing personal behaviors that contribute to poor health, especially the alcohol and tobacco consumption responsible for much of the country's premature mortality from noncommunicable disease. Over the past fifteen years, Russia has rolled out an impressive array of laws and regulations on taxation, sales, consumption, and advertising of alcohol and tobacco, as well as related measures on issues like drunk driving and overall road safety. In conjunction with general improvements in the country's economy, these policies have contributed to meaningful reductions in smoking and drinking, and likely to a remarkable improvement in life expectancy, from age 65 in 2003 to almost 73 in 2018.

Russia's recent experience with control of communicable disease, more immediately applicable to the COVID-19 outbreak, has also produced some successes. Take tuberculosis (TB), for example. The country experienced a surge of cases beginning in the 1990s, but investments in testing, laboratory capacity, infection control for airborne diseases, and treatment regimes, coupled with strong community outreach in some areas, have brought the rate of new cases down by 5–6 percent annually since 2010.

Rural areas have borne the brunt of recent infrastructure and staff reductions.

GAPS EXPOSED

Despite such improvements, the coronavirus pandemic has exposed persistent shortcomings in Russia's health care system. The financing reforms aimed at improving the system's efficiency have been implemented unevenly and, at times, counterproductively over the past two decades. An important and necessary byproduct of correcting the Soviet-era imbalance between inpatient and primary care is the downsizing or closure of excess hospital capacity. This kind of politically controversial "rationalization" process ideally is preceded by hospital mapping or other analyses that ensure continued availability of care across locations and income groups.

In Russia, however, the hasty closure of thousands of small, rural health facilities left millions of poor and isolated residents with dramatically reduced access to care. Plans to repurpose some of the excess capacity into long-term care or community centers have seldom led to action. Health care workers have faced similar cuts: in some regions, edicts from above to raise wages have amounted to unfunded mandates, leading to careless layoffs of some staff in order to free up funds to pay the rest.

As was the case with hospital capacity, Soviet central planning left Russia's health sector overstaffed by comparison with international standards. But rushed and sometimes politically motivated decisions have outweighed rational human-resources policies in too many cases when reductions are implemented. Doctors, nurses, and other medical personnel across the country have taken to the streets to protest both the loss of jobs and the increased workloads for those still employed.

Under emergency pandemic conditions, hospital staffing and bed capacity beyond what is medically necessary, which yesterday would have been viewed as requiring downsizing, may become today's vital surge capacity. As COVID-19 makes its way from Moscow out to the other cities, towns, and rural areas that have borne the brunt of recent infrastructure and staff reductions, hospital systems could find themselves rapidly overwhelmed.

This dynamic has already played out in parts of the North Caucasus, where distrust in government and poor health infrastructure have tragically combined to produce some of the country's largest regional outbreaks. In several such instances across the country, the Kremlin has had to deploy military medical-construction brigades and treatment personnel.

Similarly, the kinds of health infrastructure investments that made sense before the pandemic—geared toward maternal and child health and noncommunicable disease—may not be directly translatable into treatment of a highly communicable, severe acute respiratory infection.

Finally, COVID-19 has highlighted the extent to which Russia's health care system fails to provide outreach and coverage to marginalized populations. Undocumented labor migrants, estimated to number in the millions, are excluded from free access to care. Gaps in services make it difficult for many TB patients—especially the homeless, the currently and formerly incarcerated, and members of other vulnerable groups—to remain in treatment, resulting in one of the highest rates of drug-resistant TB in the world.

The neglect of those infected with or at risk of contracting HIV/AIDS is even more pronounced. The government has refused to legalize methadone or other opioid substitutes and restricts access to

clean syringes, leaving injectable drug users—who represent a majority of the country's HIV cases—without access to basic harm reduction services that could prevent the spread of infection. HIV services are similarly restricted for sex workers, men having sex with men, and other key populations.

HIV prevention education and outreach are offered primarily by a small number of courageous nongovernmental organizations that continue to function even in Russia's highly conservative social and political environment, but they are too few and far between to meet more than a small fraction of the total need. Substitution of previously imported pharmaceuticals with domestically produced alternatives that are often less effective has worsened the situation. Largely as a result of these policies, Russia is one of the few countries in the world whose HIV/AIDS epidemic continues to grow.

Preexisting Conditions

As the COVID-19 pandemic arrived in Russia this March, was the welfare state prepared to cushion the economic shock? From 2000 through 2008, years of strong and steady economic growth, social spending increased greatly and health and other social programs were revived and expanded. Despite a slowdown in growth after the 2008 recession, selected new health policies were funded, pensions were sustained, and child benefits were increased, though improvements were patchy and driven by the Putin administration's priorities—mainly reversing population decline and keeping promises to pensioners.

The economy's exposure to volatile global energy prices was the main source of both rapid growth for almost a decade after 2000 and the more recent years of stagnation. Beginning in 2014, another downturn took hold, driven by declining oil prices and international sanctions in response to Russia's annexation of Crimea.

The positive trend in spending on health care from 2000 to 2013 was reversed. The poverty rate increased. Unemployment insurance was drastically underfunded, with a maximum payout below the officially designated minimum needed for subsistence.

The labor market approached full employment, but wages in most sectors remained low because of poor productivity, which in turn resulted from insufficient investments by the state or mostly oligarchic business owners in modernizing the economy and diversifying away from its dependence on oil and gas exports. Interregional inequalities in per capita incomes and social expenditures remained high. GDP grew just 1.6 percent in the first quarter of 2020, even before many effects of the coronavirus were felt.

On the positive side, the government had accumulated very little debt and a $125 billion National Wealth Fund that could be used to stabilize the economy. The administrative architecture for distributing unemployment, family, and pension benefits was in place: most households were receiving social transfers from the state well before 2020. The largest and most populous cities, those that were initially hardest hit by the coronavirus, were also the most prosperous. All these factors should have made the country more resilient in the face of the pandemic.

Beginning in April, the government initiated a range of crisis measures targeting workers, households, small and medium enterprises, and others. While modestly funded by comparison with emergency programs launched by other industrialized nations in response to the pandemic, these measures provided at least some relief for many in Russia's formal economy. But they largely excluded the estimated 15 percent of the labor force working in the informal economy, as well as several million long-term and seasonal labor migrants.

Immediate Impacts

The government closed Russia's borders on March 18 and stopped all nonessential economic activity on March 28. Air traffic was suspended, and major highways in and out of the country were shut down. Schools and universities were closed; students and staff switched to remote learning, which, just as elsewhere, was beset by Internet access limitations and technical failures. Putin announced a paid, nonworking "holiday" week and instructed citizens to self-quarantine. The quarantine period was subsequently extended to June 9 in Moscow and to varying lengths in other regions.

When the government introduced these measures to control the spread of COVID-19, incomes immediately began to fall. According to surveys conducted by the Higher School of Economics in late May, 13.5 percent of respondents reported that they had lost their entire income, while nearly one-third reported a significant reduction. In total, 61 percent reported that their earnings were lower than before the coronavirus outbreak.

While 30–40 percent of respondents reported that they continued to work between early April and

late May, almost 10 percent had lost their jobs. An additional 13 percent went on unpaid leave or did not know how they would be compensated for their time in self-isolation. The official unemployment rate increased to a little over 6 percent in May. From the beginning of the pandemic, private consumption dropped sharply, and the service sector suffered large revenue losses.

Official statistics as well as survey research show that most Russians were poorly prepared to cope with this economic shock. In the spring of 2020, 13.5 percent of the population, almost 20 million people, were officially classified as poor, with incomes below the minimum subsistence level. Forty percent considered themselves poor.

Even a majority of the nonpoor had limited financial reserves. More than 50 percent of those surveyed said that they could not cope with unexpected expenses. Another survey, commissioned by the insurance company Rosgosstrakh Life and Otkritie Bank, showed that 63.6 percent of Russians had no savings at all.

Even as COVID-19 brought another steep decline in oil prices and instability in financial markets, the government moved quickly to put in place emergency measures designed to support households and businesses. Initially these included extra pay for notoriously underpaid medical staff and sick leave pay for those affected by the virus. The very low unemployment benefit was increased and extended, as were child benefits. Mortgage loans and household utility and rent payments were deferred. (Although part of the population continues to live in apartments acquired at nominal cost when the Soviet Union collapsed, all must pay for utilities and maintenance, and by this point many pay market rents to private owners, or have taken out mortgage loans.)

Small and medium-sized enterprises were granted a range of tax and loan deferrals and holidays, loan restructuring, and a temporary 50-percent reduction in wage-tax payments. They also received grants, subsidies, and forgivable loans to cover their employees' minimum wages for several months, as long as they maintained 90 percent of their workforces. Interest rates were reduced. Tariffs on some imported pharmaceuticals were eliminated and other restrictions eased in an effort to improve the supply of medications for patients infected with COVID-19.

Most households were receiving social transfers from the state well before 2020.

Putin called on regional governments to preserve their populations' jobs and incomes, putting much of the responsibility for dealing with the crisis on governors. But their economic capacity to supplement the federal measures varies greatly, reinforcing interregional inequality.

The crisis measures at both the federal and regional levels were far from comprehensive, amounting to only about 3 percent of GDP by April. This was low relative to emergency measures in the advanced economies, though at par with other middle-income countries at similar levels of GDP per capita. But Russian economists and business owners called for a more comprehensive response.

Falling through the Cracks

Large groups were mostly excluded from these relief measures. First were the estimated 15 percent of Russians who worked informally, off the books. Lacking employment protections or social security even in normal times, they were not eligible for emergency benefits such as wage support or unemployment payments. As Russian citizens, they were eligible for state-funded medical insurance and should have received family and child benefits, which afforded minimal support at best.

Labor migrants faced an even more difficult situation. In Russia, as in other countries, both long-term and seasonal migrant workers comprised the group most fully excluded from any type of social welfare. Russia annually hosts several million migrant workers, most of whom come from Central Asia, along with smaller numbers from other countries, including China. Some have regularized their status, but the majority remain unregistered and overlooked by the state.

Migrant workers are at elevated risk of exposure to the virus because they often live and work in crowded conditions and have limited access to public health care. Many lost their jobs as construction sites and factories closed, and they were ineligible for the government's economic and health aid. When transport in and out of Russia was suspended, hundreds were trapped at airports or at closed border crossings, unable either to remain and work or to return home.

In late March, just as the effects of the pandemic began to be felt, hundreds of thousands of young seasonal labor migrants, primarily in Central Asia,

were preparing to return to Russia for work in construction and agriculture. Closed borders meant loss of crucial income for many vulnerable families, as well as shortages of labor needed to harvest crops.

Over the previous two decades, some Central Asian states had become dependent on migrants' remittances for 30–50 percent of GDP. Russia's economic crisis reverberated through these countries and their populations. Many families relied on remittances from relatives who migrated to Russia for work. Loss of this income resulted in extreme financial hardship.

The Russian government began easing its pandemic lockdowns in mid-May. By that time the number of new cases was declining but still substantial. Moscow, the epicenter of the country's outbreak, canceled all remaining restrictions on movement on June 9.

Supplementing its earlier measures, the government announced a 5 trillion ruble National Economic Recovery Plan—equal to 5 percent of GDP, but still much smaller than recovery programs amounting to 10–30 percent of GDP in the United States and Europe—to usher the economy through reopening and a hoped-for return to growth in 2020–21.

The recovery is likely to be complicated by the relief measures themselves. Some that were directed to small and medium-sized businesses merely deferred loan repayments, but did not forgive them. Reserves in pension and health insurance funds are dwindling because of the halving of employers' wage taxes, another relief measure for businesses. A study by experts at the Higher School of Economics' Social Policy Institute predicted further declines in payments to social funds because of expected cuts in salaries, rising unemployment, and falling real incomes. Yet demands on these funds are likely to continue increasing.

Russia's response to the COVID-19 pandemic highlights both strengths and weaknesses of its health and welfare systems. The Soviet legacy of universal health care proved an asset in handling the pandemic, as did the experience gained in recent successful public health campaigns to slow the spread of tuberculosis. But efforts to control the coronavirus have been undercut by unevenly distributed medical facilities and poorly implemented Putin-era reforms that worsened inequalities, leaving some populations virtually without access to health care.

The government responded to the economic impact of its lockdown with a broad package of relief measures directed to households and businesses. Although its National Economic Recovery Plan is comparable to counterparts in other middle-income countries, it may prove inadequate. In surveys, two-thirds of Russians report having limited savings to see them through a crisis.

The near-poverty of so many Russian households is a consequence of a dysfunctional economic system that keeps productivity low, maintains high levels of inequality, and is too dependent on energy markets that are severely depressed by the global economic slowdown. Although the majority of Russia's population has some degree of social protection, the most excluded groups—rural populations, informal sector workers, labor migrants (and the families and countries that rely on their remittances), the homeless, and the incarcerated—have been left to face the pandemic without adequate health services, financial relief, or other basic assistance. ■