The fragmentary federation: experiences with the decentralized health system in Russia

KIRILL DANISHEVSKI,1,2 DINA BALABANOVA,2 MARTIN MCKEE2 AND SARAH ATKINSON3
1School of Public Health and Health Management, Moscow Sechenov Medical Academy, Moscow, Russia, 2London School of Hygiene and Tropical Medicine, London, UK and 3University of Manchester, Manchester, UK

The Russian Federation has undergone a process of major constitutional change in the post-communist period, as a strong central government has ceded extensive powers to the regions. This has important implications for the organization of the health care system which, as with other elements of the Soviet system, had previously been highly centralized. Although it is now well-recognized that the powers of the Federal Health Ministry have weakened considerably, the precise scale and nature of the process of decentralization remain imperfectly understood. This paper provides new evidence on the nature of decentralization in the Russian Federation since the breakdown of the USSR, reporting the results of case studies undertaken in six regions of Russia (Samara, Tver, Tula, Chelyabinsk, Sverdlovsk and Moscow oblasts) to describe the organization of health care financing, regulation and delivery. It shows that while there is a common model of health system (with the exception of Samara, where an innovative model was implemented), there are many minor variations. The study confirms the limited scope for action by Federal authorities, but also shows that the power vested in the regional governments is more limited than was previously thought. Instead, the municipalities (rayons) emerge as important bodies, as they own the facilities in which much of the routine health care is delivered and, both directly and indirectly, by virtue of their contributions of insurance premiums for the non-working, provide a substantial amount of health care financing. The study demonstrates the complexity of the Russian health care system and identifies the widespread absence of mechanisms that might be used to bring about much needed change.

Key words: decentralization, Russia, local government, ownership, finance

Introduction

The 1990s were witness to enormous political and economic transitions in regions as diverse as the former Soviet Union, Latin America and China. One feature they share is the promotion of decentralization as a leading principle following years of highly centralized government. Centralized systems of government are argued to be inefficient and resistant to change, whilst decentralization has been heralded in international development literature as not only improving the performance of such centralized systems, but also facilitating the deepening and embedding of democratization (Gorchakov 1990; Hannes et al. 2000). Over a decade later, the new forms of government established in the emergent nations afford a unique opportunity to explore experiences with decentralization and so to focus future support for policies.

Perhaps none face a greater challenge in decentralizing than the new Russian Federation, one of the world’s largest transitional economies (Garman et al. 2001). The huge challenges in decentralization faced by the Russian Federation are widely acknowledged; decentralization in Russia has been seen as a chaotic and opaque process, involving power struggles between different actors at different levels, and lacking channels through which the diverse interests could come together (Chernichovsky and Potapchik 1999; Hannes et al. 2000; Eckhardt 2002). More than one author draws attention to the major upheaval in every aspect of economic and political activity in which government decentralization is embedded:

‘The ongoing efforts to decentralize the public sectors of former socialist states encounter much the same set of issues [as so-called developing countries]. But the problems are in some ways even more complicated, inasmuch as the process of decentralization is going on alongside a process of privatization; the complicated and sometimes chaotic transition from a command economy to a market system does not provide a stable environment within which to restructure the public sector.’ (Oates 1999: 1144)

The move towards political and economic decentralization is mirrored in the health sector following a widely held view among international health communities that health care reform requires health system decentralization
(Saltman and Figueras 1997). The immediate post-transition period witnessed widespread enthusiasm for large-scale decentralization in many former communist countries, but greater recognition of the challenges involved has led to a more cautious stance. In the Russian health system, decentralization has been hampered by a lack of institutional capacity (Vlassov 2000) and preparedness of local administrators to take over responsibilities for managing revenue (Twigg 1999a,b). There has been insufficient clarity about the roles of the various actors and the effectiveness of coordination mechanisms. Transparent relationships between local and federal organizations have been lacking, and regulatory structures and mechanisms have been inadequate for the tasks involved (McKee and Healy 2000).

Whilst this litany of problems echoes concerns raised in other low- and middle-income countries undertaking processes of decentralization (Collins and Green 1994; Atkinson 1995), there is now a consensus that health care reform in Russia has made progress, albeit unsteadily and often in response to external factors, such as the health crisis and the economic consequences of shock-therapy (Scher and Baxandall 2000). In an attempt to move from listing general problems or signs of progress to identifying policy options, this paper makes a modest contribution to what is an ambitious but essential task of describing practice and experiences of decentralization in the Russian health system from the perspective of the decentralized tier, grouping the 89 regions into seven large Federal districts (okrugs), which was seen as an attempt to strengthen federal control (Grehem 2000). In addition, the central government is pushing for unification and enlargement of the regions, with two mergers of regions since the beginning of President Putin’s second term.

Every region is subdivided into smaller divisions: municipalities or rayons. These may be rural (consisting of a few villages) or urban (a town or town district). The total number of municipalities in Russia is over 11 000 and each has an elected administration; their number may increase to 25 000 in 2006 when the new legislation on local governance is enacted. In the federal cities of Moscow and St Petersburg, while consultants or representatives of the municipality authorities are also elected, the heads and some other senior executive positions are nominated by the city mayor, giving them much less autonomy than elsewhere.

In the early 1990s, there were wide geographical variations in the per capita health expenditure in Russia, increasingly reflecting the level of wealth rather than needs in the respective areas (Chernichevsk et al. 1998). This process demonstrates a departure from the more egalitarian but less efficient Soviet resource allocation according to beds (seen as a proxy to need) (ibid). A detailed description of the current Russian health care system is available elsewhere (Tragakes and Lessof 2003).

The decentralized political structure of Russia post-1993

The Russian Federation, following the 1993 Constitution, comprises 89 administrative units or regions. These regions are of different kinds and whilst constitutionally viewed as of ‘equal status’, in reality are not all alike, reflecting their particular historical development. There are:

- 49 oblasts, the commonest new government unit;
- six krais, generally larger in area than oblasts but with low density populations and located on the borders of the Russian Federation;
- 21 republics, with a majority non-Russian population;
- 11 autonomous areas, nine of which are linked with neighbours for certain purposes to form larger regions; and
- two ‘cities of federal significance’, Moscow and St Petersburg.

The regions are extremely diverse in terms of their economic resources, geographical size and population, climate and dependency on the federal government. Republics have their own constitution and an elected president; oblasts have a charter and an elected governor (although this is changing as the most recent reforms give the President of the Russian Federation the right to appoint governors). In addition, those located in the Far East and those with the status of Republic, despite having the same formal constitutional rights, seem to have more independence in enacting legislation (Shevchenko 2002) and a more centralized system of internal governance. In 2000, President Putin began to introduce an additional tier, grouping the 89 regions into seven large Federal districts (okrugs), which was seen as an attempt to strengthen federal control (Grehem 2000). In addition, the central government is pushing for unification and enlargement of the regions, with two mergers of regions since the beginning of President Putin’s second term.

Methods

This paper aims to describe practice and experiences of decentralization in the Russian health system at the
regional level, with a view to identifying unaddressed policy issues at that tier and any potential policy or leverage entry points. The research was undertaken using two approaches: a review of the Russian and international literature since 1995 on decentralization in the context of health reforms; and case studies, using rapid appraisal techniques, and interviews with health system personnel in six oblasts. The case studies provide the local, descriptive experience sought to fulfil the research aim, whilst the international and Russian literatures frame the local findings in their wider context.

**Literature review**

International literature was identified through a search of Medline. Search terms were “Russia”[MeSH] AND “Politics”[MeSH]; AND Decentralization [Multi]; AND “Health Care Reform”[MeSH]; AND “Insurance, Health”[MeSH], with follow up of cited references. Russian documents were sought among officially published documents of the State Duma (the Parliament) and Decrees (Prikaz) of the Ministry of Health referring to decentralization. In both cases, additional material and insights were sought from key informants in the case study oblasts.

**Selection of case studies**

As previously noted, the Russian Federation is made up of various kinds of political regions as well as representing a huge diversity of geographical, social and cultural settings. It is not possible in a study of this scope to try to represent this full diversity, and thus, in order to make some meaningful generalizations, we selected only one type of region—the oblast—and only one broad territory of Russia—Western or European Russia. The six case study oblasts were selected to represent:

- three considered as more innovative and that have received international donor inputs (Samara, Sverdlovsk, Tver oblast);
- three considered more typical across European Russia (Tula, Moscow region, Chelyabinsk), allowing at least partial generalization.

Some pragmatic criteria in terms of existing relationships with oblasts and logistical factors such as willingness of regional stakeholders to participate in the study also informed the final selection. The location of the case study oblasts is shown in Figure 1, with selected descriptive statistics for each in Table 1.

![Figure 1. Location of the case study oblasts in Russia](https://academic.oup.com/heapol/article-abstract/21/3/183/654580)

<table>
<thead>
<tr>
<th>Table 1. Basic indicators for study regions</th>
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<tr>
<td>Moscow region</td>
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<td>----------------</td>
</tr>
<tr>
<td>Resident population in thousands</td>
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<tr>
<td>Territory (km²)</td>
</tr>
<tr>
<td>Average income per capita (US$ per month)</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
</tr>
<tr>
<td>Physicians per 10000 population</td>
</tr>
<tr>
<td>Hospital beds per 10000 population</td>
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</tbody>
</table>

*Source: Goskomstat (2001).*
Case study rapid appraisal techniques

Data were collected from a wide variety of sources to capture the oblasts' experiences with decentralization, with particular emphasis on health care financing and provision, regulation, inter-governmental relationships and the role of municipalities. Initial contacts were made with an individual in each region who could facilitate access to others and to relevant written material. A list of potential key informants was drawn up. This included the head of the department of economics and of medical care in the oblast health department, heads of a selection of central municipal hospitals and municipal health authorities, and heads of the economic departments of regional health insurance funds.

Interviews were undertaken, based on a series of standard questions about structures and functions of those elements of the system that the interviewee was responsible for, as well as inter-relationships with other relevant areas, but also including an iterative series of questions to clarify certain issues that arose. These interviews were supplemented at the federal level with interviews with representatives of the Department of Organization of Medical Care at the Ministry of Health and the senior advisor in the Department of Transactions in the Federal Health Insurance Fund. In all cases, interviews were supplemented by study of relevant administrative and policy documents. Information from the various sources was then triangulated and any inconsistencies were resolved by returning to the interviewees for clarification.

Field work was conducted in December–January 2002 and researchers were recruited through the regional branches of the Association of Public Health Programs affiliated with the Moscow Medical Academy. The lead author, based in Moscow, conducted training sessions with the researchers in each region on study objectives, methods for data collection and data quality control.

Generalizability

To improve generalizability from only six case studies, the preliminary findings described in this paper were presented at the following meetings:

- National meeting of the heads of public health departments in medical schools, Moscow Medical Academy, December 2002;
- National Conference of General Practitioners, St Petersburg, February 2003;
- Inter-agency meeting of donors working in the health sector in Russia, chaired by the World Health Organization, August 2003.

These meetings were attended by representatives of over half of all Russian regions; we held individual discussions with officials from both regional and municipality levels in Archangelsk, Belgorod, Karelia, Khabarovsk, Kostroma, Kursk, Leningrad region, Nizhny Novgorod, Perm, Pskov and Yakutia, and with representatives of donor agencies working in Chuvashia, Ivanova and Murmansk (Figure 1). This consultation with practitioners in the health systems of other Russian regions confirmed the consistency of our findings from the six oblast case studies with their own experiences.

Results

Roles and responsibilities

The legal definition of responsibilities of the different scales of government is set out in the law on the Basis of Legislation of the Russian Federation on Health Care of 1993 (Government of the Russian Federation 1993) (see Table 4, first column). It should be noted that within this, the article on municipalities gives little specification of their role.

Financing sources and sharing

The Russian health system is financed from three main sources: taxation and duties, compulsory health insurance, and transfers from enterprises and other government ministries, channelled through a number of parallel subsystems. There are also widespread informal payments and a small voluntary health insurance sector, as well as some formal payments for privately delivered care and, in public facilities, for extra services. The legal framework covering the actors in the health insurance system is set out in the 1993 Health Insurance Law (Government of the Russian Federation 1993). The procedures for collection and distribution of the three main sources of finance are characterized by a mix of formal procedures and informal realities involved in implementing the financing systems (Table 2). Attention is drawn to four informal aspects of financing that are critical in the operation of the Russian health system, and whilst these reflect a lack of procedural transparency, in some cases they also represent an informal space for manoeuvre and an ambiguity around the universal virtue of transparency.

First, the municipality budget receives a relatively small share of taxes (Government of the Russian Federation 1991), but municipal authorities have been, perhaps surprisingly, effective in obtaining additional funds from the non-earmarked tax pool which is distributed following negotiations, rather than formulaic rules, between the three tiers.

Secondly, the regional health insurance funds collect premiums on the basis of 3.6% of payroll costs. 0.2% is transferred to the federal fund for redistribution between regions (Sheiman 1995; Chernichovsky and Potapchik 1997; Starodubov and Semenov 1997; Shishkin 1999a), however this transfer is inadequate given the large regional disparities and thus the federal capacity to address disparities remains minimal (Hannes et al. 2000). Moreover, what redistribution does occur takes place under opaque rules that, in practice, reflect a region’s relationship with the centre.
Thirdly, health care costs of the non-working population should be covered by the municipal government responsible for their place of residence. However, no precise basis has been established for operationalizing this principle and thus, in practice, municipal finance departments tend to pay these premiums late and at a token rate. In addition, even where municipalities have allocated funds to cover health care costs of the non-working population, some regional governors still subvert these funds into other activities, such as payment of agricultural wages or infrastructure projects (Twigg 1999a).

Finally, there are various other parallel systems and sources of financing, including voluntary insurance and unofficial payments. Informal payments have been a feature of health care in Russia since the Soviet period and can be significant sources of financing for services at the municipality level. Several studies have reported that, in recent years, between one-fifth and one-third of the overall health care budget is made up by informal payments (Feeley at al. 1999; Beliaeva and Doctorovitch 2001; Gololobova 2001; Shishkin et al. 2003). Moreover, this practice appears to be so ubiquitous that health professionals perceive it as both acceptable and official. In addition, in the present study, the head physicians in hospitals in Sverdlovsk and Tula regions suggested that up to 5% of their hospital budget was derived from official, over-the-counter payments.

**Delivery of care**

The federal, regional and municipality levels of the state system all own health care facilities. A limited number of highly specialized large hospitals (located mainly in the largest cities) are owned by the Federal Health Ministry. Some of the larger referral hospitals in each region belong to the regional government and are accountable to its health department. The majority of general hospitals and outpatient facilities are owned by municipalities. Municipality hospitals are of two kinds: municipality hospitals and small district (uchastok) hospitals, the latter often employing no physicians and acting mainly as nursing homes or facilities for minor illnesses and injuries. Table 3 summarizes the aspects of health care provision covered by the different sources of finance. Again, procedures by which finance is allocated and managed are both non-transparent and undermine local authority.

The federal health budget, derived largely from general government revenues, covers the maintenance and part of the operational costs of the few national facilities and procurement of certain pharmaceuticals and equipment.

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**Table 2. Formal and informal aspects of financing arrangements**

<table>
<thead>
<tr>
<th>Finance source</th>
<th>Formal aspects</th>
<th>Informal aspects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total tax revenue</td>
<td>Taxes distributed among levels of the government: Federal 40%, Regional 35%, Municipal 25%. The federal share increases.</td>
<td>Non-earmarked negotiated; wealthier municipalities, which collect funds, do quite well in accessing this pool</td>
</tr>
<tr>
<td>Compulsory medical insurance</td>
<td>3.6% of payroll costs 0.2% passed to Federal level to address inequities but inadequate</td>
<td>Redistribution is possible only for small part of the funds, rules are non-transparent and dependent on informal relationships between regional and federal scale</td>
</tr>
<tr>
<td>Non-working population</td>
<td>Costs covered by municipal budget through health insurance fund</td>
<td>No basis for payment – municipality pays late and at low premium 5% of costs of municipal hospitals</td>
</tr>
<tr>
<td>Formal payments</td>
<td>Illegal (article 41 of constitution), but accepted that happens in all facilities, at least for ‘extra services’</td>
<td>20-30% of overall health budget So ubiquitous that viewed as formal and acceptable</td>
</tr>
<tr>
<td>Informal payments</td>
<td>Illegal (article 41 of constitution)</td>
<td></td>
</tr>
</tbody>
</table>

**Table 3. Typical distribution of funds derived from various sources of finance in the Russian health system**

<table>
<thead>
<tr>
<th></th>
<th>Federal health budget</th>
<th>Regional budget</th>
<th>Municipal budget</th>
<th>Health insurance</th>
<th>Parallel systems budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal facilities: teaching hospitals, referral centres, research institutes</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Regional scale referral facilities</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Parallel systems hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social diseases (tuberculosis, venerology, emergency care, oncology etc., depending on the level of facility)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Central municipal hospitals</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small district hospitals, outpatient facilities</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>

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Decentralization in Russia 187

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for vertical programmes. However, the principles for distribution of in-kind contributions (drugs, equipment) from the federal to regional level are not made clear to the recipients in the regions.

Regional budgets, derived from taxes and duties, cover the costs of maintaining regional facilities, while their operational costs are covered by the health insurance system. The referral and specialized facilities owned by the regional health authorities rarely exceed 10–15% of total regional hospital bed supply. Interviewees both in the regional health authority and in the relevant hospitals stated that these funds are transferred directly to facilities by regional finance departments, based on numbers of beds and budgeted staff, and do not pass through health authorities. Thus the regional health authority has little say on how to spend much of the regional health funds, except for the small budget for its own administrative costs.

The majority of health care is provided through municipal health care facilities. As with the regional facilities, these receive capital allocations and funding from the municipality budget, estimated at 50–70% of total funding, and revenue from the health insurance system, estimated at about 50–30% of funding (Sinuraya 2000), but known to have increased since fieldwork was carried out.

The challenges of integrating care have been recognized, and in the early 1990s, they gave rise to an attempt to integrate all facilities within a municipality, creating what were, in effect, managed care organizations known as Territorial Medical Organizations (TMO) (Shishkin 1999b; Shchepin et al. 2001). However, there was no legal basis for these entities and there was no legal means of guaranteeing employment and pension rights. Most regions subsequently abolished the TMOs.

**Decision-making, management and regulation**

During the Soviet period, the Ministry of Health of the USSR held total formal control over the health system. The Ministry of Health had a personal fund of 300m Rubles (at a time when the cost of a medium-size hospital would be less than 30m Rubles). The systems of control within the Soviet system meant that it was unimaginable that the Ministry would be unable to enforce its policies. The strict separation of the executive and the legislature, established following independence and going beyond that in many other countries, means that ministries have lost the power to enact secondary legislation. Instead, a law can be enacted only by the federal or a regional Parliament. This creates a catch-22 situation. Financial flows at the municipality level are, in practice, still determined largely by regulations designed by the former Soviet Ministry of Health. As these are largely implemented by finance departments of municipal authorities, the current Russian Ministry of Health cannot influence the financial flows. However, having lost its power to regulate, neither can it change the rules for allocation. In fact, in the present situation, it is unclear who can do this.

Other elements of the Soviet system of central guidance similarly remain but without any regulatory muscle, leaving potential room for regional and municipality discretion over implementation. Prikazes, once orders but now only guidelines, are produced by panels of national experts, approved by the federal minister and sent to the regional health authorities. These can decide whether to distribute the prikaz without modification to municipalities, distribute it with comments, adapt it to produce an oblisk prikaz before distribution, or not disseminate it at all. There is no system at the Federal level for monitoring implementation of prikazes and we were unable to identify any serious attempt at follow-up of those issued. However, certain federal policies, on standards for, for example, hospital configuration, by the regional branches of the federally owned sanitary-epidemiological system, in some cases act as a substantial constraint to local decision-making aiming to rationalize the system (Rese et al. 2005).

At the regional level, the channels of authority are equally unclear. Each region has a management unit with overall authority for the provision of health care, although the terminology employed differs, giving a false impression of diversity. In practice, the management structures and functions of the regional health authorities are very similar. One area where diversity does exist is that several regions have defined specific, separate authorities to manage specific categories of health care: mother and child health in Samara, pharmacology regulation in Chelyabinsk and health information management in Tula. However, it is not clear to what extent the regional health authority has power to introduce such changes.

The regional insurance fund is managed by a supervisory board, usually including the head of the regional health authority, the deputy governor and the head of the fund; only in some cases are representatives of the public also on the board. Members of these boards report a series of constraints on their space for discretion; in practice, they have decision-making power over little more than whether to extend coverage to facilities such as small district hospitals or outpatient clinics, or to decide the financial value of a bed day.

One reason why the influence of the regional fund is limited is because it is only a means of collecting and pooling finances that are then transferred to the various individual insurance companies; it is the companies that contract with the health facilities for care for those individuals registered with them. In addition, funds are distributed according to a pre-defined formula based on the characteristics of those insured (Twigg 1999b; Sinuraya 2000). There is some variation to this pattern. In Tver city the insurance companies’ role is only to assess the quality provided by the facilities; funds are transferred directly from the regional fund to the facility. In a number of municipalities, private companies are not yet active and insurance is provided directly through the branches of the regional fund (Twigg 1999a).
A second constraint on decision-making power comes from the strict controls on selective contracting and on varying the terms of contracts for managing different diseases that are set by the Federal Ministry of Social Affairs. The influence of the insurance funds on health care provision is further constrained by the relatively small contribution they make to total health care budgets. Since insurance funds do not pay for care for the so-called socially important diseases, such as cancer, tuberculosis and sexually transmitted diseases, geriatric services, psychiatry and emergency care, which are covered by the corresponding tier of government, the funds only account for about 30% of the total funding of central municipal hospitals (Sinuraya 2000). Moreover, even for those disease categories they do cover, the insurance funds only pay for some elements of care, such as salaries, payroll taxes, pharmaceuticals, disposables and food for inpatients, and then only at some facilities, although this does include most federal and regional hospitals, some municipal hospitals and large hospitals owned by other ministries. To what extent other facilities and outpatient care are covered varies by region. In Tver and in Tula, insurance funds exclude district hospitals and outpatient facilities, which are funded entirely from municipal budgets. In Moscow oblast and Sverdlovsk, these are excluded in some municipalities and covered in others. In Chelyabinsk, all policlinics and some district hospitals are funded by the insurance fund. Nonetheless, in Russia as a whole, 60% of outpatient departments and facilities are part of the compulsory medical insurance system, with the other 40% not receiving any insurance funds (Goskomstat 2001).

These considerations may, however, underestimate the influence of the regional funds. Whilst the health insurance funds are quantitatively less important than other sources of funding, they are viewed as vital because, unlike federal, regional and municipal budgetary funds, they are usually paid on time. This enables regular payment of salaries, and municipal hospital managers can reallocate between budget headings during the course of a year to overcome problems of delayed payments from one or other source, providing they then reconcile the sums at the end of the financial year. In addition, regional health authorities may have some degree of influence on health care in poorer municipalities where municipal governments want to maintain good relationships with regional officials, or, as in Tula, where senior appointments at municipal level require approval by the regional health authority. In others, such as Tver and Chelyabinsk, where approval procedures are not routine, or Moscow area where it is done symbolically and heads of municipal health authorities are typically changed after every municipality leadership election, the regional health authority has little say in local health affairs. In some cases, however, even where there is no formal requirement for approval of the candidacy, municipality leaders are poorly informed about health care and rely on the head of the regional health authority when making appointments.

In contrast to the situation at the regional level, there is great diversity in how the municipal health facilities are managed, apparently reflecting urban-rural differences. Most urban territories, Tula, Tver, Chelyabinsk and Ekaterinburg, Samara and other towns being typical examples, have health authorities at municipal level. In these territories, all facilities including the hospitals are designated simply as municipal hospitals and are subordinate to the municipal health authority. However, in most rural localities in the regions of Sverdlovsk, Samara, Chelyabinsk and some municipalities of Tula and Tver, districts have not established a separate health authority and, as a result, the management team of the central municipal hospital assumes responsibility for all health facilities in the area.

As a significant share of the budget of the municipal hospitals is not covered by insurance funds, the full costs of outpatient facilities and small district hospitals often come from the municipal budget. These funds are transferred from the municipal department of finance to each facility, based on norms developed by the Ministry of Health of the USSR, and whilst these norms are still adhered to by the municipal finance departments, they now have only advisory status and could not be legally enforced if a municipality decided to exploit this potential discretionary space.

On the basis of these considerations, the location of decision-making power is diffuse. Responsibility for strategic management is vested in the Federal Ministry of Health but it has direct control over only a few specialized national facilities. Regional health authorities are accountable to regional governments, and although they are required to take account of the Ministry of Health’s policies, they too own only a small number of facilities. Consequently, efforts to reform health care delivery, which have been focused almost exclusively on these two levels, have left the majority of health care provision, which is owned and managed by the municipalities, almost untouched.

The case of Samara

Samara has a health care system that has been unique among the regions studied and that is recognized as an example of good practice. Its roots lie in the creation of the so-called new economic model of the health system formulated by VI Shevskiy and his team as early as 1986 and implemented in 1988 (Shevskiy 1996; Starodubov and Semenov 1997) with varying degrees of success in St Petersburg, Kemerovo and Samara (Sheiman 1995).

A distinctive feature of the Samara model is that all budget lines, including care for the socially important diseases, in all health care facilities except private and other parallel facilities, were, until 2003–4, paid for through the health insurance system. From 2000 to 2003, about 85% of all health services provided in public hospitals were paid for by the health insurance system.
The remaining 15% concerned specific programmes of support for disabled people, long-term care and prevention activities undertaken at municipal and regional levels. Samara was also the first region in Russia to legalize payments by the health insurance system to private health care facilities. The health insurance system in Samara was overseen by a large executive board, representing both the regional legislature and executive, members of the medical association, users, health insurance companies and major employers, and which met four times a year. The formalized collaboration of all main stakeholders facilitated integration of the different elements of the health care system and an equitable and transparent distribution of resources based on a per capita allocation adjusted for age and gender.

A further modification of practice elsewhere was that, following the economic crisis of August 1998, the premiums for the non-working population were no longer the responsibility of the municipality but are paid to the insurance funds from the regional budget.

The Samara model was not, however, without its problems. Like other parts of Russia there were still many complaints by patients, a high level of informal payment (although some interviewees link this to the relative wealth of the region), and slower than planned restructuring of facilities (although progress has been more rapid than in other regions).

The situation changed in 2003 when a range of federal agencies pressurized the Samara regional government to transfer responsibility for those budget lines not reserved for the health insurance system in other parts of Russia to the regional and municipal budgets. This removed many of the features that had supported greater motivation of personnel and integration of the work undertaken in different facilities.

So why was Samara different? Three factors, working in conjunction, emerge from the discussions with informants as critical in explaining why health insurance revenue and spending was more extensive in Samara than elsewhere, and how power was consolidated at the regional scale level. First, Samara is one of the wealthier regions of Russia (Table 1) and a centre of heavy industry, in particular automobile manufacture, bringing more regional tax revenue than in many other regions. This, in turn, has enabled the region to assume responsibility for premiums of the non-working population, greatly simplifying the transactions involved. However, wealth by itself, and in the absence of political will, is insufficient for the success of the reform initiatives, and a favourable political background and timing of the reform initiatives undertaken has enabled integration of powers at the level of regional government. Finally, Samara oblast benefited from both a critical mass of human capacity and donor involvement when initiating its reforms.

While the Samara model brought many advantages, its demise is a reminder of the challenge facing innovators in the Russian system. Implementation of such a model requires a more extensive reform at different tiers of government and one that is likely to be politically highly contentious.

Discussion and conclusions

This depiction of experiences with decentralization from the viewpoint of actors from the sub-national, regional and municipal levels leaves an impression of a formally structured, federated system. However, there is a significant lack of coherence among many aspects of the system. Rondinelli (1981) has identified four types of decentralization, all of which can be observed here to some extent, yet none of which is consistently implemented. Thus, there are elements of devolution, to regional governments, yet there remains considerable confusion about their (limited) space to act. There is delegation of certain functions to health insurance funds, although again the borders are blurred. Although not discussed above, there is an element of deconcentration, with the regional sanitary-epidemiological centres functioning as agents of the Federal Health Ministry. Finally, the introduction of health insurance private companies into financial transactions was, to some extent, a form of privatization. In practice, the task of trying to make this system work seems to be giving rise to a process of fragmentation.

We draw attention to four issues for consideration by policy-makers involved with the Russian health system: the very variable nature of inter-governmental relations between the three levels in different regions; relatively little variability in how health systems actually operate, reflecting the role of legislation outside the health sector as well as system rigidities; the complex interplay of factors related to success in Samara oblast; and the so far overlooked importance of the municipal tier in the provision of health care in Russia.

The variability of relationships between the three main levels of authority in health care provision is evident from the case study material. Decentralization explicitly aims to create greater discretionary space for decision-making at the different tiers in order to increase responsiveness to local needs, and whilst, with the exception of Samara, a common model of health care provision is found, there are many minor variations as might be expected where decentralization has truly occurred. However, ambivalence in the regulatory mechanisms and legal anomalies following the transition from the Soviet Union to the Russian Federation leave no clear route for monitoring and regulating of either financial or clinical practice by the Federal Health Ministry, a role normally accepted as appropriately carried out by the centre. More striking is the variation in inter-governmental relations between the regional and municipal levels, which appear haphazardly responsive to historical and local circumstances and result in very different degrees of autonomy, authority and accountability in different places. In none of the discussions held in the six regions did accountability to the local population emerge as an issue. This is in contrast to much
### Table 4. Analysis of the power relationships between different stakeholders in the post-transitional Russian health system

<table>
<thead>
<tr>
<th>Functions of administrative levels</th>
<th>Influencing agency</th>
<th>Agency under influence</th>
<th>Tools of influence</th>
<th>Barriers to influence</th>
<th>Barriers to influence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ability to hire/fire</td>
<td>Financial and in-kind incentives or sanctions</td>
<td>Indirect – through other organizations</td>
</tr>
<tr>
<td><strong>Federal level</strong></td>
<td></td>
<td></td>
<td>No</td>
<td>Very limited, through vertical programmes and quotas for referrals and medical education</td>
<td>Limited, through –Federal compulsory insurance fund –Parliament enacting laws –Poorer regions get transfers from the federal budget, but not earmarked for health</td>
</tr>
<tr>
<td>Strategic planning, coordination</td>
<td>Ministry of Health</td>
<td>Regional health authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creating and enforcing basic benefits package guidelines, quality control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidemiological monitoring and statistics</td>
<td>Ministry of Health</td>
<td>Central Municipal Hospital/Health authority</td>
<td>No legal powers to influence as links are through regional health authority. Insufficient capacity due to the large number of municipalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical education and research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs and equipment regulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regional level</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Regional health authority</td>
<td>Central Municipal Hospital/Municipal health authority</td>
<td>No. Some regions: chief municipal physician approved by regional health chief</td>
<td>Very limited: through referral quotas to tertiary facilities. Poorer municipalities can get subventions but usually not earmarked for health</td>
<td>Through legislature, regional laws, if not clashing with federal laws. Limited influence through Regional insurance fund</td>
</tr>
<tr>
<td>Part responsibility for health care financing, determining regional health care budget Implementing of federal programmes Managing health care delivery, own health services Co-ordinating the activities of municipal health facilities</td>
<td>Regional health insurance fund</td>
<td>Central Municipal Hospital/Municipal health authority</td>
<td>No</td>
<td>Very limited: through inclusion/exclusion of institutions in the funding list</td>
<td>No</td>
</tr>
<tr>
<td><strong>Municipal level</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Municipal government</td>
<td>Central Municipal Hospital/health authority</td>
<td>Yes</td>
<td>Very wide range: over half of Central Municipal Hospital funds; some services and facilities 100% of funds</td>
<td>Wide range of tools – including control of taxation authorities, police, licensing organizations</td>
</tr>
<tr>
<td>Health care delivery through their own facilities Allocating funding for health care from their budgets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>Legal references in Section II article 6 (republics) and Section II article 7 (other types of territories) of Basis of Legislation of the Russian Federation on Health Care of 1993 (Government of the Russian Federation 1993).

<sup>2</sup>Legal references in Section II article 8 of Basis of Legislation of the Russian Federation on Health Care of 1993 (Government of the Russian Federation 1993).
of the decentralization literature and accompanying rhetoric in which responsiveness to the local populations’ needs through mechanisms of participation and accountability feature large. Even within the level of the municipality, there is considerable variation in informal regulatory mechanisms and decision-making loci. Those rural municipalities with no separate health authority tend to face additional disadvantages, in particular being located in rural areas. Thus, without formal intervention, existing inequities are reproduced in the local health system structures, or lack of them.

The Samara experience appears to present an interesting case study of good practice from which others might draw lessons. Perhaps the main lesson is that developing and implementing a reasonably successful model for a local health system is not a simple matter. Samara oblast witnessed the combination of good resources, political will, human resource capacity and a history of engagement with more theoretical debates on health system organization. But it was still was unable to sustain its system in the long-term. There is, however, a generic issue; namely that there is a need for training in health systems thinking and management at regional and municipal levels.

Arguably, the most significant finding of the case studies presented here is the inattention that the municipal level has received from policy analysts and the very limited engagement of donors with this level, even though municipalities play an absolutely central role in all aspects of health care provision. A summary of the lines of relationships between the three levels in the Russian health system, presented in Table 4 and in a simple diagrammatic form in Figure 2, indicates not only that the scope for the Federal Ministry to exert influence is limited, but also that regional governments have few levers to introduce badly needed change. The recent administrative reforms begun by President Putin that seek to strengthen these lines of accountability may not be effective (Danishevski and McKee 2005). The need for this invisibility to be addressed is clear. As Gibbins (2001) has said,

‘For political systems with more embryonic federal institutions, a failure to reflect the importance of local government in the design of new federations could instil an institutional weakness for generations to come.’

(Gibbins 2001: 163)
Endnotes

1 Throughout the paper the term region will be used to refer to any of the decentralized administrative units: oblasts, krays, republics, autonomous areas, cities of federal significance.
2 The term municipality will be used throughout the paper for this administrative level.
3 The compulsory medical insurance system comprises a series of semi-independent organizations: a federal fund, 90 territorial funds and private health insurance companies. The territorial funds collect premiums through their branches and distribute them through private insurance companies who in turn contract service providers. In 1999, there were 1174 branches of the territorial funds and 424 private insurance companies (Taranov 1999).
4 Voluntary medical insurance exists mainly in the wealthier areas, such as Moscow and Saint Petersburg, and where oil or other large enterprises are the main employer. However, even in these cases the overall contribution is small. Reports from insurance companies suggest that in Moscow, only about 100 000 of a population of 10 million have private insurance; in St Petersburg the numbers are about 56,000 out of about 6 million (Dimkin and Lineva 2002).
5 Samara is an exception to this rule amongst our case studies.
6 There is no requirement for federal approval of the head of the oblast health authority.

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Biographies
Kirill Danishevski, MD, MPH, is a Lecturer at the School of Public Health and Health Management, Moscow Sechenow Medical Academy, Russia and a Research Fellow at the London School of Hygiene and Tropical Medicine, UK. Before joining the DFID Health Systems Development Programme, he had been teaching public health, health systems and epidemiology at the postgraduate department of Moscow Medical Sechenow Academy since 1999. In 2000 he joined the Open Society Institute (Soros Foundation – Moscow) as a consultant to public health programmes. The projects designed included implementation of general practice, development and dissemination of evidence-based clinical recommendations, improvement of the system of credentialing and accreditation. In addition, he undertook a number of short-term consultancies in several transitional countries: Georgia, Uzbekistan and Moldova. Current research areas include the determinants of clinical practices and levers to changing them, decentralization and the political process underlying current reforms in Russia, such as re-strengthening the role of the Ministry of Health.

Dina Balabanova, MPH, PhD, is a Lecturer at the London School of Hygiene and Tropical Medicine (LSHTM), UK. Before joining the DFID Health Systems Development Programme, she had previously worked on health financing reform in Bulgaria, based at LSHTM (EU PHARE project; PhD) and in development assistance, as Oxfam’s regional policy adviser for the Former Soviet Union and Yemen. She has a background in sociology and social policy, and since 1995, in health policy and health sector reform mainly in the transition countries of Eastern Europe and the former Soviet Union. Current research areas are understanding health systems responses to conditions requiring complex inputs (TB, diabetes, maternal care, cervical cancer), access to care and its determinants, as well as health sector restructuring (hospitals in Bulgaria, primary health care reform in Russia, and community-based financing in Armenia).

Martin McKee, CBE, MD, FRCP(UK), FRCPI, FFPH, FMedSci, is Professor of European Public Health at the London School of Hygiene and Tropical Medicine, UK, where he co-directs the School’s European Centre on Health of Societies in Transition. He is also a research director in the European Observatory on Health Systems and Policies.

Sara Atkinson, PhD, is an anthropologist at the University of Manchester, with a research focus on the informal and local influences on health system performance. She is co-ordinator of the Manchester partnership with the London School of Hygiene and Tropical Medicine for the DFID programme on Health Systems Development.

Correspondence: Kirill Danishevski, MD, MPH, Lecturer, School of Public Health and Health Management, Moscow Sechenow Medical Academy, 109507 Moscow. E-mail: kirill.danichevski@lshtm.ac.uk