Reflections on a Painful Transition: From Socialized to Insurance Medicine in Russia

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After the collapse of the Soviet Union in 1991, Russia decided to replace its deeply flawed and under-funded system of socialized medicine by a scheme of health insurance that involved the decentralization of health services and of off-budget financing. Every enterprise would pay 3.6% of its salary fund into a Regional Health Insurance Fund, and the Fund would finance private insurance companies that would compete for clients. The non-working population would have its insurance premiums paid from the budgets of regions or municipalities. The transition from one system to another has been problematic and plagued with a variety of problems not the least of which is that the Russian economic structure is not geared to sustain an insurance system at the present time. The Russian case presents an instructive experiment with the premature introduction of a scheme touted as an "anti-model" to socialized medicine and geared to market and legal arrangements that are, as yet, largely non-existent. Under-funding of health services remains and leads to the polarization of the population into those few who can afford private care, and the vast majority for whom this care is difficult to obtain, or unobtainable. This has ominous political implications.

Key Words: assessment of health care needs; availability of health services; budgets; financial support; financing; government; financing; public; health insurance; health services administration; health transition; Russia

If variety is the spice of life, then any sudden, unexpected change is its bane and is bound to be unsettling or anxiety provoking. Man is a creature of habit, and social life is based on a probabilistic assumption i.e., on a certain predictability of social processes. A transition from one state to another is therefore bound to be, to some extent, traumatic until a new adjustment to new conditions is established that creates a "normal" order. This seems to be the rule, whether the transition is for the worse or for the better, as Durkheim pointed out more than a hundred years ago (1). Rapid change, according to him, results in a temporary disruption of the normal mechanisms through which society imposes its rules on behavior. Once some sort of social equilibrium is reestablished and individuals are able to reposition themselves in the new social order, self-destructive behavior should decline. The following paper will examine some aspects of an on-going and difficult transition in the Former Soviet Union, from a well-established but deeply flawed and underfunded system of socialized medicine to insurance medicine. This reflects the larger macroscopic ideological, political, economic, and social transformations going on in Russia at the present time and particularly the move from a centralized command to a decentralized economy oriented to the market. This has affected the provision of health care and related services, and raised a series of unresolved issues, many of which are also familiar to other societies and their health care system as they attempt to sort out the provision of health services to their populations. In Russia the stage of stabilization and equilibrium is still in the future.

Socialized Medicine: Soviet Style

The major contours of socialized medicine in the Soviet Union are generally well-known, and only a basic outline of its main features will be presented here because, as we shall see later, the concept of insurance medicine or (as some might call it) market medicine does represent essentially an "anti-model", in line with the ideological changes that characterize the post-Soviet period in Russia and the wholesale rejection of Soviet patterns. In Soviet times, socialized medicine constituted, in fact, one of the few redeeming features of an otherwise bleak totalitarian system. It was trotted out during critical assessments of the regime in the same exculpatory vein as the argument that Mussolini made the trains run on time (which apparently he did not!) justified the excesses of Italian fascism. Socialized medicine, therefore, had an important role in the Soviet propagandistic inventory both at home and abroad. Domestically, the regime vaunted its merits by comparing it with the situation in capitalistic countries where the poor people were dying because they could not afford the exorbitant costs of
hospitalization and the fees of greedy physicians. Abroad Soviet socialized medicine symbolized the "progressive" nature of the Soviet system compared to the "reactionary" essence of capitalism. It was an already existing window into the bright future of communism.

The establishment of such a system of health care, it should be noted for the record, was historic: the Soviet Union was the first state to promise and to guarantee, constitutionally, that every citizen was entitled to quality medical care at no cost at the time of the service. Medical care became a right of citizenship. This right was to be secured by the state itself, and funded from its treasury. Health care thus became a public service, a department of government which rejected, on principle either the private practice of medicine or the private ownership of health care institutions, and by the same token charitable or religious activities in providing or paying for health services. Neither was it an insurance indemnity scheme that would reimburse patients for out-of-pocket expenses. It was simply one of universal, though not necessarily equal, entitlement. Socialized medicine was thus public medicine in which it was the state itself that was in the business of dispensing health care to the citizenry. Physicians, for example, were trained at state expense in state-supported medical institutes, then deployed and salaried as state employees. They practiced in hospitals, out-patient clinics, and other medical institutions that were built, owned and managed by the state and financed from the central, republican, regional and local budgets. The health system was part of the governmental structure: as such it was one of the major departments of the government, and under the supreme authority of a Minister of Health, always a physician. The Ministry (earlier Commissariat) was a highly centralized administration, operating from Moscow through counterpart republican ministries and health departments at lower levels. In Russian the name of the Ministry (and indeed of the whole health structure) was not precisely The "Health" Ministry or the Ministry of "Public Health" as it is customarily rendered in English translation. It was the Ministry of "Health Protection" (zdravoohranenie) a term that embraced both the concept of public health (with its preventive orientation) and clinical care (treatment), although philosophically the orientation was primarily preventive. It thus combined what in Greek mythology was held as the domains of two goddesses: Hygiea, the goddess of good health and prevention through healthy living habits, and Panacea, the goddess of treatment or cure once a pathological condition had developed. As a creature and instrumentality of the state, the health system was meant to be integrated with the aims and programs of the state as determined by the Communist Party of the Soviet Union. Health policies were decided at the center, and elaborated at the republican and lower levels.

Generally speaking, Soviet socialized medicine was considered a major achievement, a historical first as we have seen, and a success story, and its blueprint was often held as a model for other nations to emulate, particularly before World War II. Observers came from all over the world to learn about it (2-7). Although the relationship between the health of a population and its system of medical care is more tenuous than usually assumed (8) and accounts for only a small part of the variance (according to the World Health Organization, medical care accounts for only 10% of the variance) as against life styles, economic conditions, genetics and the environment, socialized medicine took the credit for a life expectancy that about doubled by the beginning of the 1960's compared to the situation before the Revolution; mortality decreased considerably, particularly infant mortality that reached at that time a figure of about 10% of what it had been in 1913. In addition, the major infectious diseases were largely controlled during the years of the Soviet regime through massive efforts, and there were no major epidemics after World War II as there had been after the First World War. In essence, mortality went down in the post-war period, parallelising the decline in the countries of the West, and due to a large extent to the introduction of antibiotics. The situation radically changed in the 1960's.

The Turning Point: The Crisis of the Mid-60's

Beginning in the mid-60's, a health crisis began to unfold. The first inkling the West had about the emergence of a problem was the unexpected rise of infant mortality (9,10) generally recognized as a proxy index for medical care and the well-being of a population (11). Other vital indices followed suit. But what was more ominous, as the evidence of a crisis, was gradual and then almost total suppression of statistical data, thus reverting to the policy of secrecy that had characterized the Stalin days. Statistics, such as for example, the number of infants born each year, particularly boys, or mortality by age and sex, became secrets not to be divulged to potential enemies. According to demographer Leonid Rybakovsky, the Party Central Committee created in 1976 a "Commission on the Non-Publication of Data." At a meeting of the commission a general argued that "We must not reveal the number of boys born. Our enemies could use this information. We must make it a state secret." (12).

There were apparently several political and economic factors that caused the problems and eventually exposed the structural weaknesses of the Soviet system of socialized medicine as well as
the larger problems of Soviet society that eventually led to the collapse of the USSR in December 1991. The first element was, in all probability, the intensification of the Cold War following the Cuban crisis in the early 1960's. This was considered, by the Soviets, a national humiliation leading to the dismissal in 1964 of Khrushchev as the architect of that policy, dubbed as one of his "hare-brained schemes". This must have led to a decision never to be in a position of military and nuclear inferiority to the United States, and thus to establish and maintain at least parity if not superiority to the United States. It ushered the build-up of a very strong military-industrial complex in a society whose Gross National Product was about a quarter to one third of that of its main adversary. The result was a disproportionately heavy drain on an economy that could ill afford it, leading to the classical dilemma of guns versus butter in which the "butter", i.e., the civilian sector got short shrift, particularly those "low priority" items like health care, and other elements that contributed to the safety-nets and the health of the population such as housing, child care, treatment of the handicapped, and so on. It is therefore not surprising that in 1983, eight years before the collapse of the Soviet Union, and about twenty years after the intensification of the Cold War, a French demographer, Roland Pressat, published a paper on the mortality increase in the USSR, remarking that "one has never seen, in time of peace, a regression of health conditions (such as can be measured by mortality) on such a scale" (13). But was it a time of peace? In fact the Cold War was a "war" though of a special kind that also exacted a heavy toll. According to Slobodan Vitanovic (14), …it would be a great error to think that the Third World has been avoided. It took place and it was long. The particularity of that war consists in the fact that it was political, ideological and first of all economic. Fortunately there were no combats but if the weapons were not for this time utilized, they were constantly being produced and military expenditures have surpassed those of all preceding wars...if the Third World War has been political, ideological and... economic, victory, or seen from the other side capitulation, was of the same type.

When Gorbachev came to power in 1985, he was amazed at the amount of national resources (both human and financial) devoted to the defense establishment. In his Memoirs, he wrote (15):

…we…were aware of how heavily our exorbitant military expenditures weighed on the economy, but I did not realize the true scale of militarization of the country…although the leaders of the military-industrial complex opposed it, we published those data…military expenditures were not 16% of the state budget…but rather 40%...it was not 6% but 20% of the Gross National Product. Of 25 billion rubles in total expenditures on science, 20 billion went to the military for technical research and development.

Expenditures of resources on armaments, it can be assumed, would have an impact on the funding of health services. In the American context, defense spending has been called metaphorically as "buying death with taxes" (16), meaning that every dollar spent on defense was a dollar less available for health care or the welfare of the people. In the Soviet Union, a country considerably poorer than the United States, the percentage of the GNP that went to health decreased from a respectable 6-6.5% in the 1960's (a figure in line with what Western countries were spending at that time), to 2 or 3% or perhaps even less at the time of the breakup in 1991. Indeed, during the perestroika period, the Health Minister appointed by Gorbachev resigned his portfolio two years into the job, complaining about the "residual" principle applied to budgeting health expenditures: after all other items had been funded, whatever was left, and there was very little, went to health care (17). In addition, the greater openness that characterized the perestroika period also revealed that the rosy picture painted earlier about Soviet socialized medicine did not square with reality, and that the system suffered from a series of structural and organizational problems of major proportions, in addition to its penury.

The dwindling of the necessary support had its impact at all levels of the health system, particularly in the provision of equipment and capital repairs to medical institutions. The regime, it is true, boasted of having the largest number of hospital beds per capita in the world, but many of these beds were in poorly equipped buildings, often unsuited for medical care, and lacking, particularly in the countryside the most elementary facilities. According to the Health Minister writing in 1987, only 35% of rural district hospitals have hot running water, 27% have no sewerage, and 17% have no running water. The minister asked rhetorically: "What good are such hospitals for modern medical care?" (18). By the same token, although the Soviet Union boasted of having the largest number of physicians per population, they were among the most poorly paid (their income was equivalent to about 70% of workers' income), and too many were incompetent. Some of these doctors had been admitted through bribery and had received their diplomas without being able to perform the most basic medical tasks such as interpreting an EKG or delivering a baby (19,20). As a matter of fact there was no medical "profession" if by that term is meant a corporate group of professionals with some degree of associative freedom and autonomy, and capable of articulating their views in public forums and at the political level. Such a "profession" would have constituted an independent source of power the regime
was not willing to countenance. Thus doctors constituted, at best, a group of state employees. Furthermore, the health care system suffered from perverse economic incentives: there was, for example, very little latitude to reward physicians who did good work because the salaries were fixed. This penalized the capable doctors who were overworked and rewarded the poor ones (Notes of Judyth L. Twigg, Trip Report Moscow 1998, unpublished, p. 29). Hospital directors received their allocations on the basis of the number of beds and lengths of stay, so that there was motivation to increase both beds and lengths of stay, irrespective of the needs of the population, to the neglect of the quality of services, the result of the typically Soviet obsession with quantitative indices. Because of shortages in the production of medical equipment, even the availability of money frequently did not allow hospital directors to purchase such equipment. At that point money became as useful as a $100 bill to someone stranded alone in the desert. And since the emphasis was on hospitalization and specialization, there was little effort to develop general practitioners and the management of patients on an ambulatory basis.

As a result the health system was unable to cope with the epidemiological transition because of its heavily centralized organization, its bureaucratic rigidities and its hierarchical nature, nor was it able to face such emergencies as the Chernobyl disaster. The epidemiological transition was the result of the success, after World War II, in controlling infectious diseases, as noted earlier. As the mortality from such conditions decreased, attention was turned to the chronic, degenerative, non-infectious conditions, which began to account for the bulk of mortality, such as atherosclerosis, heart diseases, strokes, cancer, and diabetes. Such conditions required a more sophisticated, nuanced, and expensive approach than the mass measures to control infectious diseases, and which the Soviet system was unable to deliver. While the Western countries were able to turn their attention to these conditions and their mortality continued to decline, the Soviet Union, as was noted by Pressat (and others) earlier (13), diverged from that trend. At the present time, mortality in Russia, for example, is greater than natality, life expectancy, particularly for men is at a level of a developing country, and the infectious diseases that had been controlled have come back with a vengeance, including tuberculosis, which is now reaching epidemic proportions, owing to the absence of an effective public health system.

The Search for Reforms

It was thus clear, toward the end of the Soviet regime, that the vaunted system of socialized medicine had become a dismal failure. Though its blueprint and its purposes had a certain nobility and grandeur, the soil in which that idea was planted was unable, and for many reasons, to sustain its growth, particularly after the mid-1960’s: it was, as we have seen, starved for financial means; it could not cope with the chronic and degenerative conditions that became the major sources of mortality; the quality of medical institutions was, in many instances, deplorable if not abysmal; the availability of medical equipment and particularly pharmaceuticals was erratic; personnel were very poorly paid although some of them could compensate for this by asking or demanding money from patients; the level of clinical care was often very poor, and trailed behind progress elsewhere, suffering among other from isolation from the rest of the world; the amount of health promotion, aimed at the population, was not sufficient or adequate to change styles of life, particularly alcohol abuse, smoking, poor diet, and sedentarity; and the country suffered from environmental deterioration, including polluted surface waters, air, and soil (21) due to neglect in the heedless drive to industrialize and militarize.

There was some discussion about health reform in the years that preceded the breakup, and some experiments were mounted to streamline the system, and improve quality of care and the economic conditions of health personnel, but very little came of it. But in mid-1991, six months before the breakup, a law on Obligatory Health Insurance was passed by the Russian Republic of the Soviet Union. It remained mostly a dead letter until 1993, when it was revived and an attempt made to implement it at the national level.

Obligatory Health Insurance as the Anti-Model

The concept of Obligatory Health Insurance (22-24) is a radical departure from that of socialized medicine. It is on the same ideological wavelength as the changes that were made in Russia, in particular the rejection of the idea of a centralized command economy that characterized the Communist system. If that command economy had failed, then the market was hailed as the solution, a solution that was seen as the source of the success of the West. The major aspect of the insurance law was to eliminate the 70-year old pattern of financing health care as a line item in the budget, where monies appropriated by the government could be “raided” for other purposes than health. It was also in line with the idea of downsizing the central authorities, and devolving power to the regions and municipalities. The expectation was also that with price liberalization and the move to the market, health insurance would provide additional funding, while maintaining, as stated in Article 41 of the
Russian Federation's constitution, the guaranteed entitlement of health care to every individual, to be financed from a variety of sources, including but not limited to insurance funds. In addition, the reform emphasizing decentralization sundered the ties and the dependence on Moscow to a very large extent by devolving powers to the regions and municipalities to do pretty much as they pleased (25). But the reform involved many risks and problems. Symbolically Preker and Feachem have described it as follows (cf. 23):

To revitalize their health services, governments in the former socialist states...are experimenting with a new wonder drug called market mechanisms. This is...like a doctor who gives penicillin to a patient who has a known allergy to it but will die without it. It is necessary to understand the associated dangers so that appropriate measures may be taken to prevent the treatment from killing the patient. The central aspect of the Obligatory Health Insurance reform is that every enterprise must pay 3.6% of its salary fund to a Regional Insurance Fund, thus moving it "off-budget." The Regional Fund would keep 3.4%, and send 0.2% to Moscow to finance a federal equalization fund that would be used to bolster the health services of poorer regions, research, public health and dealing with epidemics at the national level. The Regional Funds, in turn, would finance private health insurance companies that would compete with each other to attract clients and thus hopefully improve the quality of medical care. By moving the transfer of funds from the budget to the insurance companies, the payer for treatment would be separated from the provider of that treatment, and could exercise some control over the latter (Notes of Judyth L. Twigg, Trip Report Moscow 1998, unpublished, p. 8). Steps would also be taken to encourage the financial rewarding of good physicians and penalizing the poor ones. But this scheme applied only to those members of the population who were employed. Those who were not working would have their insurance contributions paid from the budgets of municipal or regional authorities; this has been a constant source of problems as many of these authorities, strapped for money, have failed to make the necessary payments, arguing in some instances that the existence of the insurance funds provided enough resources and that they had other "priority" areas to support. At the same time, the enterprises do not always remit the funds they must to the funds, this for a variety of reasons including the fact that a great deal of the economy now operates on barter rather than money. In some instances the regional or municipal authorities have been able to dip into the insurance funds for other purposes than health, thereby repeating the same problem that plagued socialized medicine earlier. In addition, there is a constant turf battle between the Health Ministry that would like to reinstitute the kind of command authority it enjoyed in the past, and the regional insurance funds determined to retain and expand their turf.

This creates a very complicated and uncertain situation for the individual. Thus the law on obligatory health insurance is, according to Judyth Twigg, "...being explicitly broken in many cases, bent substantially in many others, and ignored completely by a few" (26) reflecting the unsettled nature of the transition period. The upshot is that this creates a polarization between the majority of the population for whom health care becomes problematic, and often unaffordable, and a minority (the New Russians) who can afford high medical costs, or can go abroad for treatment, thus creating in essence the same problems that socialized medicine initially was supposed to remedy. For many the lack of money represents the difference between life and death. This leads to a nostalgia for the certainties, however meager, of the Soviet period that has obvious political implications.

It should also be noted that the employees are not required to make any direct payments, nor are there matching payments by employees and employer, as is customary in most insurance schemes based on employment, and as has been introduced in most countries that had a Soviet style system of socialized medicine. In Hungary, for instance, the proposed contributed amount is 22%, 4% from the employees, and 18% from the employer. Several commentators in Russia have also noted that the 3.6% contribution is absolutely insufficient to meet the costs of health care, with at least 10% being the required amount. In 1991, a 10.8% contribution was proposed (covering both worker and family members) but that was rejected (Notes of Judyth L. Twigg, Trip Report Moscow 1998, unpublished, p. 18). As was the case in the Soviet period, health care retains its low priority status, and is consistently underfunded.

The transition to this new system has been difficult for the population to understand and to accept (27). The insurance system was supposed to introduce the efficiency of the market system, to decrease the involvement and the responsibility of the state in the provision (and financing) of health services, to increase competition, to foster the growth of privatization, to encourage the individual's responsibility for his/her own health, to foster the growth of general practice and to reduce the Soviet-style of training mostly specialists and to decrease the amount of hospitalization, and eventually obtain a better match between the demands of the population and the supply of health services. This could be called the transition from the “assurance” of the Soviet model of socialized medicine to the “insurance” of a market-oriented health service, or some would have it from Beveridge to Bismarck.
This would also mean that the perverse incentives or disincentives of socialized medicine would be toned down. It would mean that hospitals would become more efficient, improve the quality of services, and reduce the number of costly unnecessary beds. Very little of these changes has taken place. In the same way they did in the Soviet period, medical institutions are performing a lot of treatment in order to earn more money, this time not from the budget but from the insurance companies (Notes of Judyth L. Twigg, Trip Report Moscow 1998, unpublished, p. 18). As one respondent interviewed by Twigg in 1996 said: “We rejected the British and the Canadian models because we did not want to do something that resembled the old Soviet system… there was an enormous anti-governmental sentiment… there was a desire to move everything to the market, including health care” (Notes of Judyth L. Twigg, Trip Report Moscow 1998, unpublished p. 13). Thus perhaps the greatest delusion was the belief that market forces could do it all. This was understandably part of a revulsion against the omnipresent role of the state as noted above. And yet, as John Gray has noted (cf. 28). “The contemporary cult of the free market is just as radical an exercise in social engineering as many experiments in economic planning tried in this century.” But more precisely, as pointed out recently by David Landes (cf. 28), the market must operate within a culture, and it operates best in the contest of strong government and the enforcement of contracts. Thus markets cannot work with a malfunctioning government. It requires “respect for property rights and the rule of law, a regime that helps the very poor and regulates business judiciously” (cf. 28, p. 23).

But these pre-requisites are precisely the elements that are lacking in Russia today, in a society on the verge of collapse economically and politically, a society that is corrupt and criminalized, and in which the government is largely bankrupt and impotent. In essence the insurance principle in the funding of health services was premature, and was adopted in a system that was, for a variety of reasons noted, not prepared nor equipped to support it. Most citizens are confused about the nature of the benefits of the new system, about their entitlements, and often see the new system as a kind of scam in which they are triply penalized by having to bear the cost (indirectly) of insurance payments, paying taxes that feed the budget, and disbursing money personally to pay physicians and hospitals for services. No wonder that the former Health Minister, Tatyana Dmitrievna remarked, in 1996, that “not everything about socialism was bad” (29).

At the same time, many of the features of Soviet socialized medicine, honed over a 70-year period, simply could not be abandoned or changed overnight and have been retained. As noted earlier concerning over-treatment. As Michael Specter wrote, commenting on the wasteful aspects of Russian medicine, “the money from Moscow may be gone, but the network designed by the Soviet government-grand, cumbersome, repetitive and blind to the perverse and often baffling economics of medicine still lives on.” For instance, the treatment of tuberculosis, which is becoming a major threat to the population (30,31), follows the lines developed in the Soviet period: long hospitalizations rather than the use of antibiotics as recommended by WHO, a practice that costs five times more than using drugs on an outpatient basis. And unfortunately, as time goes by, even drug treatment becomes problematic because of resistant strains (32). In the city of Tomsk, one heart center is open only five days a week. “Don't have a heart attack on the week-end”, counsels the chief doctor of the Tomsk Institute of Cardiology! (30) Thus, many aspects of the Soviet system remain intact. This resistance to change could be called, with due obeisance to Dali, the “persistence of institutional memory”. This memory includes, as we have seen, clinical practices now considered obsolete in the West, perhaps the result of many years of isolation from world medicine and a kind of reactive nationalism about being told what to do by outsiders.

But perhaps more essential in understanding the nature of the transition in the financing and provision of health care, is the perceived incompatibility between the concept of the market and that of health care, particularly in the context of Soviet and Russian culture. While it is true that patients “consume” health care, it is not accurate to portray them as “consumers,” “customers” or “clients” operating in a market economy, and capable of making rational choices between “services,” of comparing costs and judging quality. In addition, their ability to pay “market prices” is usually limited to those few for whom such costs are marginal. Ideologically, the strength of the appeal of socialized medicine was that it was to be immune from market, income, and other considerations, and that only needs would determine availability of services, and that such services should be insulated from the ability to pay, particularly in an area of such emotional significance as disease and death. With the increased collapse of the Russian health system, the inadequate functioning of the insurance scheme, the need on the part of patients to pay considerable sums of money which many cannot afford, there is indeed nostalgia for the assurance of socialized medicine even with all its faults and deficiencies. And in addition to the often exorbitant charges made by formerly state-owned medical centers, some diagnostic procedures and pharmaceuticals have become unavailable at any price. As mentioned
earlier this leads to an increased polarization between those few who can afford to pay, or who can go abroad, and the great majority for whom health care is often out of reach. This also leads to the perception of "state desertion", of the breaking of a social contract by the polity, of a sense of betrayal and abandonment by the government that in the past felt responsible, or at least proclaimed its concern for the welfare of the people. This has its baleful political implications.

Some Conclusions
The transition from socialized to insurance medicine in the post-Soviet period has been tortuous, problematic, and confusing. To some degree one can attribute these problems to the growing pains of a new system struggling to be born. To an important degree such a transition has also been affected all along, by the macroscopic transformations taking place at all levels of the society as it tries to metamorphose itself from a totalitarian, centralized, command system to a democratic, decentralized, market economy. Reforming the health care system has been a difficult process, marked often by failures, and blocked by those who fear and resist change and whose interests are often vested in the previous system. And it is clear that no reform can ever start de novo, since the reform process must utilize existing elements, forged in the past, and attempt to change them. This means not only re-shaping institutions but also changing mentalities, so that according to Volkov in 1997 "...the field of medicine must be adapted to the free market – that is the goal of the government-approved concept for public health reform" (33). This will be a difficult goal to achieve under the best of circumstances.

The case of post-communist Russia thus has universal and didactic elements, but also its own particularistic features. Of special significance is not only the polarization between those who have and the have-nots, but also the perception, on the part of the population, of having been abandoned by the state, including the promise of free medical care. Furthermore, health insurance is not health care: it is only a financial scheme, and one that is flawed. In theory, the availability of a demand for health care fueled by insurance-provided funds should lead in good capitalistic fashion to the emergence of an appropriate supply of health and related services. For the moment the reality is something else again.

In retrospect, Russia has gone through a two-phase crisis and transition: the first one was long-drawn out, lasting about thirty years, from the 1960's to 1991, the period of the Cold War with a gradual impoverishment of the population because of the heavy emphasis on defense expenditures in a country that could hardly afford them. The second phase, from early 1992 to the present is, in fact, a "post (Cold) War" situation, reflecting the fact that the war was lost, and reminiscent in some aspects of the Weimar Republic: the sense of the loss of national might and prestige, the humiliation of moving from world power to international beggar, the lack of direction and predictability, the hyperinflation that wiped out the savings of most of the population and the loss of the Soviet safety nets that, however meager and flawed they were, could still be counted on. And add to this the shock therapy that was more shock than therapy!

But it should also be noted that in that second phase, while adult mortality went up (particularly male mortality) infant and geriatric mortality remained constant, and in some cases actually declined. It was therefore not so much impoverishment, or poor nutrition that were the major causes, but the traumatic and rapid transition from a normal to an abnormal situation, it was the change itself that, in the Durkheimian sense that was the really traumatic factor (34). The increase in mortality and the consequent decrease in life expectancy resulted mainly from an augmentation of external causes such as homicide, suicide, alcohol poisonings, alcohol related traffic accidents, and cardiovascular morbidity exacerbated by alcohol consumption, all manifestations of disorientation, confusion and despair. And, again following Durkheim, as the population slowly gets accustomed to the new situation, the impact of the change may slowly diminish as a new equilibrium of adaptation is reached.

Between 1994 and 1997, male life expectancy that had dropped to a low of 57.4 years regained about three years to 61 years. For women the gain in life expectancy was also positive though smaller, from 72.5 to 73.1 years and thus of the years of life expectancy that had been lost between 1991 and 1994, men regained more than half, women two-thirds (35). It is too early to determine whether this is a trend, particularly in the light of the financial crisis of August 1998, but it is one of the few rays of light in an otherwise bleak situation.

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References
29 Interview with Health Minister T.D. Dmitrieva, "Health care must live, not [only] survive" [in Russian]. Meditsinskaia Gazeta 1997 August Nr. 50; 2:1 and 3.
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