NEW PRIMARY CARE POLICY IN THE RUSSIAN FEDERATION

By: Erica Richardson and Igor Sheiman

Summary: The Russian government has introduced a new national project to strengthen primary care that will run from 2019 to until 2024. Over this period, there are ambitious targets to further improve population health as well as sector specific targets to improve the supply of health workers in primary care and modernise primary care facilities. A distinctive feature of primary care policy in the Russian Federation is the inclusion of extensive health checks, which will be expanded to cover the whole population in an attempt to address a high burden of non-communicable diseases.

Keywords: Primary Care, Public Health, Universal Health Checks, Russian Federation

Introduction

Primary care in the Russian Federation has retained the polyclinic system, and as a result the boundaries between primary care and specialist outpatient care overlap. This is known as the ‘extended model’ of primary care. In urban areas, polyclinics are still staffed by internists [terapevty] and paediatricians and a standard mix of 5–20 specialists who work at the primary care level (most commonly: gynaecologist, general surgeon, ENT specialist, ophthalmologist, neurologist, urologist and dentist). These specialists monitor conditions and might provide an initial diagnosis but confirmed diagnoses are provided mostly at the secondary level. These services cover the adult population – parallel primary care services cover children through dedicated polyclinics and paediatric departments in primary care facilities, which are staffed by primary care paediatricians and sometimes a team of paediatric specialists.

Doctors for children and adults at the primary care level have a list of patients they are responsible for. They refer patients to specialists, but their gatekeeping role is frequently undermined.

Contrary to most other post-communist countries, the Russian Federation has not developed general practice and retained a model based on internists with a limited curative capacity (task profile). This generates demand for specialists. Their number in urban polyclinics is much higher than internists. The latter don’t play a central role in primary care provision.

In 2017, officially one in five primary care facilities were short-staffed, although other estimates which look at the number of patients a primary care doctor covers put the level of short staffing much higher at 32%. There are many challenges facing primary care which complicate the recruitment and retention of staff and which also make it harder for primary care to fulfil its full potential in tackling non-communicable diseases. Working in primary care is not considered prestigious.
The overall aim of the National Project “Health” [Zdorov’e] (2019–2024) is to increase the size of the Russian population and to increase overall life expectancy to 78 years by 2024 and 80 years by 2030. To achieve this, the Project sets ambitious goals for improving population health, including reducing the mortality rate for the working age population to 350 per 100,000 population, reducing the cardiovascular mortality rate to 450 per 100,000 population, the cancer mortality rate to 185 per 100,000 population, and the infant mortality rate to 4.5 per 1000 births (see Table 1).

Table 1: Selected target indicators for the National Project “Health”, 2019–24

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2017</th>
<th>Targets 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality rate at working age (per 100,000 population)</td>
<td>484.5 455</td>
<td>350</td>
</tr>
<tr>
<td>Mortality from cardiovascular disease (per 100,000 population)</td>
<td>587.6 565</td>
<td>450</td>
</tr>
<tr>
<td>Cancer mortality rate (per 100,000 population)</td>
<td>200.6 199.9</td>
<td>185</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 births)</td>
<td>5.6 5.5</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Source: Eurohealth

and has fewer opportunities for career development than working in hospitals. This can make it harder to recruit and retain clinical staff in primary care. Patients prefer to self-refer to specialists who are generally perceived as offering better quality care and there are few disincentives for bypassing primary care doctors. Hospitals have to compensate for weak primary care and the mistrust patients have of primary care doctors. The result is an over-utilisation of inpatient care. All of this contributes to the weakness of primary care in the Russian Federation.

The health of the Russian population has improved over the past decade

Overall, the health of the Russian population has improved over the past decade as tobacco and alcohol control policies have borne fruit. Per capita alcohol consumption fell by 40% between 2003 and 2016, and adult daily smoking rates fell from 35% in 2000 to 23% in 2015. Life expectancy at birth for men is the highest it has ever been at almost 68 years in 2018 – for women it reached 78 years. This means Russian men are expected to live a decade longer than in 1994 when life expectancy fell to just under 58 years. However, despite clear improvements, working age mortality is still very high and much of it is attributable to cardiovascular disease. In response to these specific population health problems, the Russian government focused resources on improving the accessibility and quality of cardiovascular care nationwide. This has involved the rolling out of a universal screening programme (see Box 1) and the modernisation of cardiovascular care – particularly in terms of ensuring people had access to the latest technologies and surgical techniques.

The Federal Project “Supply of qualified staff for medical organisations in the health care system” [Obespechenie meditsinskikh organizatsii sistemy zdravookhraneniya kvalifitsirovannymi kadrami] seeks to address health workforce shortages in primary care by increasing the supply of health workers by around 10%. The target is to increase the proportion of primary care facilities which are fully staffed by doctors from a baseline of 79.7% in 2017 to 95% by 2024 and rural paramedics (feldshers) from a baseline of 88.8% in 2017 to 95% in 2024. This project also seeks to increase the number of specialists enrolled in continuing professional development (including distance learning) from 109,000 in 2017 to 1,880,000 in 2024. This is part of efforts to improve the quality of care and adherence to agreed clinical recommendations on optimal care but it is also a means of improving productivity and the distribution of staff across specialisations.

Investing in basic and IT infrastructure to improve the quality and accessibility of primary health care also features prominently. One target is for the rolling out of a ‘New Model’ of primary care provision nationwide. The New Model
seeks to improve the patient experience by upgrading primary care facilities to give them open and welcoming reception areas, comfortable surroundings in the waiting areas, and clear signage. Developing IT infrastructure, should allow for the introduction of bookable doctors’ appointments to reduce waiting times as well as reducing the volume of paperwork that patients and health workers deal with. Previously, appointments were not bookable so a patient had to attend the polyclinic in person and queue up to see an available doctor. Improving the logistics of patient movement through polyclinics is another area for increasing productivity of service provision.

The Project (“Health”) also aims to increase coverage of universal health checks (see Box 1), by ensuring all eligible people are made aware of their right to access this service (dispanserisation). The ambitious target is to increase coverage of the adult population in annual health checks, which links to the target of reducing working age mortality. However, there are also explicitly pronatalist targets for ensuring 80% of young people aged 15–17 are given detailed reproductive health checks (in 2017 this programme reached 38.7% of the target population) which are linked to other policies to strengthen maternity and child health services.

Box 1: Universal health checks

Universal health checks and dispanserisation (i.e. preventive activity on the population level) are not unique to the Russian Federation, they are also a feature of primary care in Belarus, for example, and have their roots in the Soviet era where universal health checks for the working age population were a prominent feature of occupational health and “dynamic dispensary surveillance” was in place for all detected cases of particular diseases.

The Dispanserisation programme is conceived as a two-staged process that is coordinated by the local primary care provider. Firstly, a comprehensive ‘screening’ check based on a questionnaire and basic medical examination is used to identify people at increased risk of ill-health or those with undiagnosed conditions and as an opportunity to provide general health advice. This stage can be conducted by a primary care doctor, a feldsher or a mobile medical team for remote rural areas. The second stage is for the identified risk groups and covers a suite of diagnostic checks with further referrals for treatment if necessary; this stage is performed by the internists and polyclinic specialists where indicated.

There is a general requirement that all serious cases detected should be managed with special attention [dispanseryi uchet]. However, this requirement is not usually followed due to the overburden of primary care physicians and the lack of resources in polyclinics.

While a dispanserisation programme has clear intuitive appeal, its efficacy and cost efficiency have not been demonstrated. The full dispanserisation of the adult population entails a huge amount of clinical time per patient – given the requirements for completing questionnaires, provision of health advice, blood tests and full physical examinations, and other screenings. Dispanserisation is also reimbursed by the mandatory health insurance fund only for “completed dispanserisation cases”, that is for a full standard set of services irrespective of patient need. Primary care doctors have no discretion on the scope of preventive services provided at this first stage of dispanserisation. Second stage services are reimbursed on a fee-for-service basis, consequently utilisation has increased substantially but with unclear health outcomes.

It is also hard to capture the target population through dispanserisation; in 2017, only 39.7% of adults were screened – the target for 2024 is 70%. Those who are not screened are often the ones most at risk of ill health. The people most likely to miss out on health checks are vulnerable groups such as the homeless, people with alcohol problems and people in insecure employment.

There are no obvious targets for secondary prevention of cardiovascular disease and this could limit the full potential of the programme for reducing cardiovascular mortality. To include targets such as improving not just the detection but also the control of hypertension, for example, the programme would also need to ensure access to outpatient pharmaceuticals as an essential part of primary care services. However, the coverage of outpatient drugs is very limited, and they often must be purchased out of pocket. There are, however, plans to expand coverage of essential drugs needed by cardiology patients.

This programmatic or project-based approach to policymaking and implementation, with annual targets and monitoring, is standard in the Russian context. The national projects link together to echo the overarching policy goals of ensuring the security and prosperity of the Russian Federation. The first was the ‘National Priority Project – Health’, 2012–2015, and subsequent plans have sought to build on the achievements of this first plan while acknowledging and addressing the outstanding challenges. The approach is centralised and ‘top down’ with regional leaders expected to do what they can to ensure the federal targets are met. This programmatic approach is a good way of focusing attention on a particular issue and can be a good way of rapidly developing or upgrading the necessary infrastructure. However, the concern is always that such capital investment is seen as a one-off ‘fix’ for the
health system, which will be insufficient to maintain facilities over the longer term – particularly as health in general, and primary care in particular, have historically been very underfunded. The project also does not cover many important issues such as integration of care or quality assurance. Moreover, given the noted staffing shortages, the extra burden of dispensarsisation with limited follow-up activities is likely to overstretch services.

**Conclusion**

Russian population health has improved greatly over the past 20 years – largely in response to concerted health policy efforts to reduce tobacco and alcohol consumption; increasing investment in the health system is also part of the policy response. After a lengthy period of focusing on strengthening specialist services, health policy is increasingly targeting primary care services and universal health checks. Ensuring access to high quality primary care services is of central importance in providing adequate care for people with chronic conditions but ensuring access to essential medicines for secondary prevention is a key factor that will also need to be addressed to improve care and maximise population health outcomes.

**References**


**WHO Barcelona Course on Health Financing for Universal Health Coverage**

**16–20 March 2020, Barcelona, Spain**

The WHO Regional Office for Europe is pleased to announce the next annual WHO Barcelona Course on Health Financing for Universal Health Coverage to be held from 16 to 20 March 2020 in Barcelona, Spain. This week-long intensive course is offered by the Division of Health Systems and Public Health of the WHO Regional Office for Europe through the WHO Barcelona Office for Health Systems Strengthening. We invite you and your colleagues to participate in this exclusive training event.

The course will review policy instruments to improve health systems performance through better health financing policy focusing on revenue collection, pooling, purchasing and benefit design. It will explore themes related to universal coverage and place emphasis on policy instruments to achieve efficiency gains. The course will offer many examples and practical experiences from Europe.

The deadline for applications is **16 January 2020**.

This course is exclusively for participants countries from the WHO European Region. The course is delivered in English. Apply at: [https://extranet.who.int/datacol/survey.asp?survey_id=4100](https://extranet.who.int/datacol/survey.asp?survey_id=4100), with **Barcelona2020** as the user name and password.

For any queries, please contact: eubar@who.int