STRIKE WHILE THE IRON IS HOT:
POST-SOVIEIT HEALTHCARE REFORMS AND
THE CRITICAL JUNCTURE OF THE 1990S

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Abstract

With the rise of international public health standards over the last century, many governments have embarked on health system reform to address inefficiencies in financing and provision of care. Yet even similar initiatives within geopolitical regions have produced significantly different healthcare system designs across countries. Despite sharing the historical legacy of the Soviet Union and similar health challenges, the post-Soviet states have followed a wide variety of reform trajectories. Countries as poor as Moldova and Kyrgyzstan and as wealthy as Russia have introduced insurance mechanisms and private provision of care. Countries as wealthy as Kazakhstan and as poor as Ukraine and Uzbekistan have maintained state-financed healthcare systems with state provision of care.

My dissertation tests several explanations for these patterns in the post-Soviet states since 1991. I demonstrate the importance of both timing and incentive for major structural reforms, arguing that the long-term trajectories observed in the post-Soviet healthcare systems can be traced back to a critical juncture for major healthcare system reforms in the 1990s. I contend that decisions made at that time led to the institutionalization of reform trajectories through the development of legal (de jure) and practical (de facto) state responsibility for financing and provision, contradictions between these two concepts of state responsibility, and resulting patterns of political rhetoric, public opinion, and outcomes surrounding reform efforts. Utilizing historical institutional analysis and process tracing methods, I show that the decisions in the 1990s were significantly shaped by the prioritization of long-term state-building efforts, and
that, because of the dual nature of healthcare as a policy area – connected both to the economic sphere and the human rights sphere – threats to state stability were the most pressing concern for decision makers in considering reform designs. When national cleavages aligned with divisions of economic ideologies in regions, state leaders avoided introducing major reforms, instead preferring to maintain consistency in the state’s role as they sought to build legitimacy for the system. These findings contribute to our understanding of institutional change in the post-Soviet states and of the politics surrounding healthcare reforms in middle- and lower-income countries.
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Yet, here it is, a completed dissertation. Something that, though it may not be anywhere near perfect, I can be proud to have finished. Something that – though I am sure several years from now when I am older and wiser, I will look back and be annoyed at all of its flaws – is a product of an enormous amount of hard work and time.

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Chapter 1
Introduction:
Reforming Institutions in the
Post-Soviet World

1.1 The Question

At a May 2015 roundtable discussion entitled “Healthcare Reform in Ukraine: Lessons Learned and the Way Forward,” held at the Ministry of Health in Kyiv, the Health Minister at the time, Alexander Kvitashvili, looked about the room. Gazing at the many representatives from international and non-governmental organizations, he was clearly somewhat stressed. For several hours, he and fellow healthcare leaders responded to questions on the lack of major reforms in Ukraine. While answering one question about how to change people’s perceptions of hospitals and their purpose, he suddenly declared, “We still have the legacy of the Soviet Union in the infrastructure…I can’t believe we are still talking about this this many years after!” (MoH Ukraine 2015).

Yet Ukraine’s experience, despite sharing the Soviet legacies with the other fourteen successor states, has differed from some post-Soviet states where major healthcare restructuring has occurred, with many pursuing those reforms in the midst of the crises in the 1990s. Countries as poor as Moldova and Kyrgyzstan and as wealthy as Russia have pursued reforms, instituting insurance mechanisms and a level of private provision of care. Countries as wealthy as Kazakhstan and as poor as Ukraine and Uzbekistan still maintain institutions of the Soviet state-financed and state-provided healthcare system. If the Soviet legacy cannot fully explain these trajectories as now
former Minister Kvitashvili claimed, and wealth and economic constraints are not clearly
connected to reform efforts, then what can explain how and why these states sought to
maintain or reduce state responsibility (both legal – de jure – and practical – de facto) for
health during economic and political turmoil?

This raises a broader question: when a healthcare system fails to support desired
health outcomes, what shapes the political will to boost performance through major
structural reforms, and what determines decision makers’ views of the feasible options in
this process? How do decision makers determine the level of the state’s responsibility for
financing and provision in a reformed system? Leaders of countries across the world,
varying in economic, political, and cultural characteristics, have been confronted with
this dilemma. Some have faced it when their healthcare systems began to crumble, while
others had to determine the state’s role during a time of economic or political transition.
The main normative question during these times becomes one of burden and ideas about
health as a human right: Who should bear the greatest responsibility for health protection
– the individual or the state?

This leads to questions of how to address health challenges most effectively. There is only so much that the healthcare system can do, as studies have shown that
socio-economic and environmental factors also significantly affect health outcomes.¹

¹ See, for example, Bruce G. Link and Jo Phelan (1995), “Social Conditions as Fundamental
Causes of Disease,” *Journal of Health and Social Behavior*, pgs. 80-94; Lisa F. Berkman,
Durkheim in the New Millennium,” *Social Science & Medicine* 51 (6): 843-857; Richard Rose
*Social Science & Medicine* 51 (9): 1421-1435; David R. Williams and Chiquita Collins (2001),
“Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health,” *Public
“Socioeconomic Disparities in Health: Pathways and Policies,” *Health Affairs* 21 (2): 60-76;
Nancy E. Adler and David H. Rehkopf (2008), “U.S. Disparities in Health: Descriptions, Causes,
This complicates the answer to health challenges, raising the question of whether the healthcare system is the best point of focus for those hoping to improve those outcomes, or whether living conditions, income, and education are key to addressing these issues. With this complexity in mind, then, how do decision makers determine what role the state should play when redesigning a healthcare system – that is, how do they answer the questions “Who should pay?” and “Who should provide?” And why, when they make the decision about the extent to which the state will be provider, financier, regulator, or some combination of those three, do far-reaching healthcare system reforms still prove to be so difficult to successfully pass? Finally, what does this say about broader patterns of institutional change?

This dissertation explores these dynamics within the context of the post-Soviet transition. Each of the fifteen newly independent states following the Soviet Union’s fall faced the challenge of a “transition” process – whether that was simply a stabilizing period or one of true transition to a new system. In all of the cases, the leaders of these countries had to make decisions about how to move forward after a significant political


2 In this dissertation, I will be referring to the period following the fall of the Soviet Union as a “transition” and to the states that went through this process as “transitioning states.” This does not mean that I believe that there was some end that these states were moving toward. Instead, I am referring to it with this terminology to emphasize the fact that the systems were being reevaluated and reshaped during this time. This could mean that the same structures were kept and just refined, or it could mean that they chose to completely restructure institutions. The argument that the period following the fall of the Soviet Union constituted a democratic “transition” (implying some end goal) has been the subject of a heated debate in the literature about the values of and differences and similarities between “transitology” and area studies. See, for example, Valerie Bunce (1995), “Should Transitologists Be Grounded?” Slavic Review 54 (1): 111-127; and Thomas Carothers (2002). “The End of the Transition Paradigm,” Journal of Democracy 13 (1): 5-21.
and economic revolution. I explore here how those decisions were made, whether there was opportunity for choice or whether they were limited by their circumstances, why, in the case of an opportunity for choice, varying institutional trajectories were followed across the region, and what the consequences of those decisions have been.

1.2 The Empirical Puzzle

Healthcare in the post-Soviet states has been the subject of much criticism for nearly three decades. With low levels of funding, creeping demographic decline, and mortality rates that continue to rival those of low-income countries in other regions – even in states that fall into the lower-middle- or upper-middle-income ranges – many of the post-Soviet states leave much to be desired. Despite what one might expect with these shared characteristics throughout most of the region, the structures of the healthcare systems differ significantly across countries. In some states, including the Baltics, Russia, Kyrgyzstan, and Moldova, new insurance models have been introduced, established a standard of mixed responsibility for health – some of which falls on the state, and some on individuals. These systems tend to align most closely with European models. In other states, including Armenia, Azerbaijan, Belarus, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan, there have been no major structural changes since the fall of the Soviet Union, leaving the state with the majority of responsibility for health.\(^3\) Finally, in two states – Georgia and Kazakhstan – there were early initial reform efforts that were

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\(^3\) Ukraine recently passed a healthcare reform plan at the end of 2017, which set forth a strategy for establishing a national health service model. This has not yet been fully implemented at the time of this dissertation.
reversed with a few years, leaving Kazakhstan with a more state-run system and Georgia with a largely privatized system financed with out-of-pocket payments.⁴

These significant differences across the Soviet states do not appear to follow any clear patterns of wealth, culture, or health burdens. Countries share similarities in disease burdens, both wealthy and poor countries have introduced reforms, and countries with similar religious and ethnic identities have followed very different trajectories. This raises an interesting empirical puzzle – if healthcare systems are not being designed to adequately address poor health outcomes or low spending, then what exactly is happening during that reform process? If corruption, private interests, and economic constraints are playing a significant role in the states of this region as some have argued, then why do they produce such varying institutional structures? These structural variations across the post-Soviet space provide an opportunity to explore how institutional change occurs, as well as how the dynamics of healthcare reform unfold in policy-making environments.

Figure 1 below shows the reform trajectories that will be examined in this dissertation, along with my proposed explanations resulting from this dissertation research for the divergence we see, first in the initial designing of reforms, then in the maintenance of those initial reform efforts. Further explanation of my theory on these reform trajectories follows in the next section.

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⁴Kazakhstan, like Ukraine, also recently attempted to introduce a plan to restructure its system toward a mandatory insurance model. However, at the time of this dissertation, these reforms had been delayed. This is discussed further in Section 7.2.1 of this dissertation.
Figure 1: Reform Trajectories

<table>
<thead>
<tr>
<th>Soviet Union</th>
<th>1990s</th>
<th>2010s</th>
</tr>
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<tbody>
<tr>
<td>Pass Legislation</td>
<td>Implement Legislation</td>
<td>Public</td>
</tr>
<tr>
<td>Revised Semashko</td>
<td></td>
<td>State Budget (Informally OOP)</td>
</tr>
<tr>
<td>Armenia</td>
<td>Azerbaijan</td>
<td>Armenia</td>
</tr>
<tr>
<td>Belarus</td>
<td>Tajikistan</td>
<td>Azerbaijan</td>
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<tr>
<td>Turkmenistan</td>
<td>Ukraine</td>
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<tr>
<td>Uzbekistan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Botched Implementation</td>
<td>State Budget</td>
</tr>
<tr>
<td>Georgia</td>
<td>Kazakhstan</td>
<td>Belarus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kazakhstan (1999)</td>
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<td></td>
<td></td>
<td>Turkmenistan</td>
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<td></td>
<td></td>
<td>Ukraine</td>
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<td></td>
<td></td>
<td>Uzbekistan</td>
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<tr>
<td></td>
<td>Mixed (Public and Private)</td>
<td>Private</td>
</tr>
<tr>
<td>New System</td>
<td>Managed Implementation</td>
<td>OOP</td>
</tr>
<tr>
<td>Georgia</td>
<td>Estonia</td>
<td>Georgia (2004)</td>
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<td>Estonia</td>
<td>Kyrgyzstan</td>
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<td>Kazakhstan</td>
<td>Latvia</td>
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<td>Kyrgyzstan</td>
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<td>Latvia</td>
<td>Moldova</td>
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<td>Lithuania</td>
<td>Russia</td>
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<tr>
<td>Moldova</td>
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<tr>
<td></td>
<td>National Health System</td>
<td></td>
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<tr>
<td></td>
<td>Latvia (1993)</td>
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</tbody>
</table>

Legend
(Year) = Year in which the current system was introduced
1.3 Theories of Institutional Change and Healthcare Reform

While debates about healthcare can often be found in the news, the study of healthcare decision making as a political phenomenon is far less prominent, particularly outside of the advanced industrial countries. Much of the scholarly focus on changes in healthcare have focused on the economics behind healthcare and on its successful implementation on the ground, with a focus on levels of financing and health outcomes. While there have been some welfare state studies that include health amongst several issue areas examined (Glatzer and Rueschemeyer, eds. 2005; Cook 2007; Haggard and Kaufman 2008; Cammett and MacLean, eds. 2014), studies focused on health reform decision making in advanced democracies (Alford 1975, Immergut 1992, Skocpol 1996, Kingdom 2011), and studies of political decision making and the sociological aspects of specific health issue areas, such as HIV or women’s health (Rivkin-Fish 2005; Lieberman 2009; Halfmann 2011), the literature on comparative political decision making about healthcare systems in lower-income and more authoritarian states has been sparse.

Much of the literature on the politics of healthcare system design focuses on the role of external actors, such as international financial institutions, in low-income countries and on the central role for political parties and organized interests in high-income democracies. These works often consider healthcare reforms within a limited timeframe, with a focus on short time horizons of the decision makers. Little has been said about the remaking of healthcare systems in transitioning countries with established institutions but weak civil societies, or about healthcare system design as part of state and market building processes. Despite the emphasis on the “opportunity windows” and increasing returns of institutional changes in studies of welfare reform, the effects of
transition contexts on decision making – including the impact on decision makers’ time horizons – have been underexplored. One is therefore left to ask: Do patterns of healthcare reform – and, in a broader sense, institutional change – differ in lower-income and transitioning states? Furthermore, as a policy area mixing both market and the state, how do healthcare reforms in transitioning states reflect state- and market-building efforts? What can they tell us about the way in which state responsibility is shaped, both in transitioning and established states?

Studying variation in healthcare reforms in the former Soviet Union provides an opportunity to examine institutional change in states facing structural uncertainties, weak civil societies, and underdeveloped party systems. Unlike in the case of high-income democracies, we might expect healthcare reforms in these countries to be less influenced by party ideologies or pressures from the public, and more influenced by economic constraints and international actors. Furthermore, studying healthcare reforms in the former Soviet Union at this point in time – over 25 years after the USSR’s dissolution – allows for an examination of the longer-term impact of reform decisions and the testing of critical juncture explanations of institutional change. The puzzle of these institutional trajectories and the impact of these possible explanatory factors can thus be broken down into two questions for the broader literature: (1) Timing: Why did the institutional designs change and diverge at certain points in time? and (2) Type: Why do we see a reduction in the state’s responsibility for healthcare through privatization and more market-oriented mandatory health insurance-based models in some states, and not in others? In order to understand the trajectories of reforms, we have to be able to address
both of these questions. The institutional change, policy processes, state building, and economic reform literatures all provide possible hypotheses.

1.3.1 Timing: When and Why Do Institutions Change?

The comparative politics literature has a long history of works seeking to explain institutional change. The first aspect of timing to examine is its consistency. Some scholars, such as Thelen (2004) and Hacker (2004), argue for a nuanced picture of institutional change emphasizing gradual adjustments over time that eventually change the core nature of the institution. Others, including Collier and Collier (1991) and Capoccia and Kelemen (2007), suggest that there are moments at which major long-lasting changes occur, with the latter arguing that these can be understood as “openings” during which decisions made have a greater impact on the long-term trajectory of the institutions. Both approaches allow for the primacy of structural conditions or the agency of decision makers; instead of focusing on how the change occurs, the frameworks of gradual change and critical junctures are ways to understand the difference between an institution at point A and point B in time.

This second aspect of timing – the question of why institutions change at certain times and not at others – lies in the structural analyses of change, where the differences between decision makers with agency and those without come to the fore. Before considering the specific programmatic aspects of change (for example, the push for liberalization or privatization), we can look at the characteristics of the institutions, actors, and context of reforms in order to determine what forces might lead to institutional change.
Many works looking at public policy and agenda setting have emphasized the role of political “openings” or “windows” as suggested by the critical juncture frameworks. Kingdon (2011) showed, using healthcare policy in the United States as one of his cases, that the importance of “political streams” – including problems, politics, and policies – aligning in order to get an issue on the decision agenda was key to explaining changes in institutions. This provides one way that the critical juncture framework has potential explanatory power. When a crisis arises, it pushes the issue onto the agenda. This can explain why, with healthcare, political will brought on by traumatic events or characteristics of the executive can play an important role; for example, President Truman’s signing of the National Heart Act of 1948 followed closely behind President Roosevelt’s death connected to high blood pressure in 1945. Baumgartner and Jones’ (2009) punctuated equilibrium model too supports this idea that there are “moments” of change that interrupt periods of stability, showing how mobilization can push decision makers to policy changes when new ideas influence thinking about issue areas. Finally, Pierson (1993, 2000) further develops the implications of these theories that institutions normally seem “sticky” outside of crisis periods, arguing that patterns of increasing returns explain why major structural change remains difficult most of the time, perhaps encouraging leaders to move toward the smaller, more gradual changes during periods of “normal” politics. “Policy feedback loops,” therefore, determine the way in which interests converge and diverge to support and oppose policies.

The ideas of “winners” and “losers” of policy fighting for and against change and subsequently determining the timing of reforms, similarly influences studies of international institutions. Hétier (2007), examining changes in the institutions of the
European Union, argues that different types of theories must be applied to institutional changes set in different contexts. For healthcare reforms, this would mean that the redistributive nature of the institutions would shape the type of change that would occur – which, according to Hértier (2007), would be either no change because “losers” of the change, if empowered design actors, will block the legislation, or change that occurs only because the “losers” are compensated in other areas.

In all of these explanations of (lack of) reform, decision makers are pushed by various forces (civil society, special interests, economic developments, external actors) to pursue reforms at a certain time, and they respond to those forces by either complying or reneging, depending on their assessment of what would be in their own self-interest, defined most often as the retention of office and power. This leads to the next, related question of type of reforms: when a decision maker decides to reform, why does she or he choose to pursue a certain design over others? This is a question of how or in what way institutions change.

1.3.2 Type: How/In What Way Do Institutions Change?

The second aspect of reform trajectories lies in the type of policies that are pursued, or the direction of the policies overall and during given segments of time. This question considers the specific programmatic changes and their underlying philosophies that drive reform and institutional change. With healthcare reform, we might expect to find correlations with patterns of larger economic reforms – that is, those countries that took more drastic liberalization and privatization measures would also be more likely to liberalize and privatize their healthcare systems. This is because the mechanisms of healthcare financing and provision – and what I term throughout the dissertation as “state
responsibility,” or the state’s role in providing services and protecting human rights – are tied to economic and philosophical beliefs underlying political ideologies.

If healthcare is so closely tied to economic preferences, then we would expect the same explanations of trajectories to apply as in the broader economic reform sphere. Much like with wider economic reforms, we might expect similar reforms across post-Soviet states due to the neoliberal consensus amongst international financial institutions of the time (Pop-Eleches 2009), and yet there is variation. While some states implemented mandatory health insurance schemes and privatized (some) provision, others only attempted rationalization efforts such as cutting the number of hospital beds and facilities, never changing the central responsibility of the state to provide “free” (at the point of service) universal healthcare. Previous works would have explained this divide between reformers and non-reformers as one determined by geography and the spread of ideas and incentives (Kopstein and Reilly 2000; Frye 2003; Orenstein and Haas 2005), the type of regime (Przeworski 1991; Huntington 1991; Offe 1991), elections and polarization (Fish 1997; Frye and Mansfield 2004; Frye 2010), or the dominance of specific interest groups, or “constellations of power,” and their ability to influence policymakers (Alford 1975; Hellman 1998; Immergut 1992; Cook 2007; Roberts 2009).

Two important divisions in the literature arise from these works. First, there is a division between those who argue for the influence of exogenous international factors in shaping the post-Soviet reform trajectories and those who argue that domestic factors overwhelmed external incentives or actions. Second, there is a division between those who argue for the agency and strategic calculations of decision makers and those who
point to structural conditions, such as economic constraints, that ultimately lead to certain types of reforms.

The first of these – the division over the primacy of international forces and domestic pressures over reforms – reflects the ever-increasing globalization of ideas, values, and resources. This has been particularly true in recent decades and a more nuanced understanding of the interaction of these two factors has been argued to have had an important impact on the economic reforms in the post-communist region (Pop-Eleches 2009). Therefore, examinations of the way in which global trends or pressures from international organizations shape decision making, and the opposing causal pathway – the way in which domestic factors shape decision makers’ interpretations of and cooperation with those international pressures – should not be oversimplified, with some arguing that reform efforts, rather than resulting from either international or domestic pressures, instead has amounted to “a convergence of determinations” (Greskovits 1998, pg. 60; Cook 2005, pg. 160). The exact impact of globalization, then, must be considered carefully, and all possible mechanisms, such as differences in how globalization affects spending versus institutional design, must be examined (Cook 2005).

Second, there are those who argue for the agency of political decision makers and those who point to factors that pushed these decision makers to their decisions, with little room for choice. For those allowing political decision makers agency in their reform decisions, a consideration of the decision makers’ analyses of the context and future of their policies has arisen. Frye’s (2010) work suggested that elite concerns about staying in power and their uncertainty about the future of their policies after the next election – due to the level of polarization – drove reform decision making. Jones Luong (2002)
similarly found that elite perceptions of their relative power, and the subsequent bargaining strategies, played a role in reforms shaping the design of electoral systems in Central Asia. The importance of these decision makers, particularly in the context of the chaotic post-Soviet transition period, cannot be denied. With little development of civil society (Howard 2003; Rose, Mishler, Haerpfer 1998) and nascent economic interests (Kubicek 2002), there were few obstacles to the influence of those at the center of political decision making.

In considering the agency of decision makers, we must theorize as to how they make their decisions and why they might decide that certain reforms are more beneficial than others. This question of strategic decision making is particularly important in the case of explaining “risky” reforms, like those of major structural changes to welfare institutions. The welfare state literature has therefore explored this question extensively. Because much of this literature has defined “risky” as “electorally risky,” works have often focused on the costs and gains to politicians in the polling booth as predicted by the voters’ support for or opposition to reforms. This idea of being concerned about the uncertainty of the future of policies coincides with those broader works focusing on partisanship, uncertainty, and broader economic reforms (Frye 2010).

Theories of blame avoidance and credit claiming have dominated these analyses of strategic calculations (Weaver 1986). However, it remains unclear how the decision makers calculate their possible costs and benefits to determine their preferred strategies, with some arguing that the widely used expected utility calculation is less useful than a prospect theory approach, in which the psychological aspects of gains versus losses for
the decision makers can be taken into account (Vis and van Kersbergen 2007). It also remains unclear how these calculations of “riskiness” would translate to countries with less developed civil societies, transitioning states and economies, and more authoritarian-leaning leaders, where “riskiness” may have more to do with maintaining power and a legacy in the long term than concern with the next electoral outcomes.

1.3.3 Combining the Effects of Timing with Strategic Calculations

In this dissertation, I argue for a combination of a prospect theory-inspired analysis of strategy and critical juncture framing for understanding major structural reforms in the healthcare systems of the former Soviet states. I point to the importance not only of critical junctures, but specifically in the way in which a political decision maker’s – in particular, the executive’s – understanding of the effects of critical junctures on long term costs and benefits for the state shapes his or her strategy in introducing or not introducing major structural reforms. I propose that the recognition that one is at a critical juncture magnifies the possible costs and gains as observed by the decision maker, as they become more focused on long time horizons relative to their focus on short time horizons at times outside of critical junctures. The difference between attempting reforms in a world where there are long-term losses, rather than just a maintenance of the status quo, if reforms are not pursued, is consistent with prospect theory’s framework of states of “losses” and “gains” and the differences in decision making when faced with one over the other.

5 Prospect theory was first suggested in 1979 by Daniel Kahneman and Amos Tversky. This category of decision theory in behavioral economics seeks to explain why it is that people will often take the “second-best” outcome over the best outcome. They explain this phenomenon with an explanation about the way in which people approach possible gains versus possible losses, as well as their “reference points.” See Kahneman and Tversky (1979). “Prospect Theory: An Analysis of Decision under Risk.” Econometrica 47 (2): 263-292.
Ultimately, I argue for three main theoretical points: (1) Decision making during critical junctures will differ from that during “normal” periods of politics; (2) Critical junctures serve as points in time at which decision making has a greater influence on long-term trajectories, and decision makers are aware of these patterns; (3) Healthcare reform decision making at critical junctures will follow patterns connected primarily to state-building processes – that is, because healthcare is connected to both economic and human rights frameworks, the alignment of national cleavages and divisions of economic ideologies in regions will shape the possible consequences of reform, and, therefore, the riskiness of pursuing reform. I outline my theory in the next section.

1.4 Critical Uncertainty: A Theory of Healthcare Reform, Critical Junctures, and Political Decision Making

1.4.1 Healthcare Reform as a Political and Economic Process

With the collapse of the Soviet Union, fifteen newly independent countries found themselves facing the dilemma that many new states face: how best to govern and develop a state and economy with limited resources or experience. From political institutions to economic laws to welfare benefits, the newly autonomous governments were faced with setting plans for the future trajectories of their countries’ political and economic systems. Among the challenges facing these leaders were the failing centrally financed and administered system of healthcare left behind from the Soviet era. With price liberalization and privatization, inequalities rose quickly, and many people found themselves unemployed and nearly penniless. Health indicators dropped dramatically as disease spread and self-inflicted death rates rose due to poor economic conditions
Political leaders scrambled to save their citizens as the shock of both major political and economic transitions took hold.

1.4.1.1 Two Major Questions of Healthcare Reform Design

Post-Soviet political leaders in the 1990s faced a number of decisions regarding the administration and financing of their healthcare systems. Like in healthcare reform processes across the world, these choices raised debates pitting long-standing ideas about responsibility for healthcare against the interests of numerous stakeholders, which in turn faced both exogenous and endogenous institutional constraints. Decision makers, through this process, had to somehow manage to answer two major questions: “Who will pay?” and “Who will provide?” Only with answers to these questions could major healthcare reforms be designed, let alone passed; and in the immediate aftermath of the dissolution of the Soviet Union, these questions carried increased significance.

First, when post-Soviet decision makers addressed the question, “Who will pay?” they faced a time when the average household income was falling dramatically. The average monthly income for adult workers in Russia had plummeted from 537.10 (in US dollars) to 36.9 (in US dollars) from 1988 to 1992 (Oostendorp 2013). With such extreme conditions, it seemed almost inconceivable to put the burden on citizens. Ideas about the definition of “good” healthcare versus “bad” healthcare, as well as views of the government’s level of responsibility in providing healthcare to its citizens – whether healthcare is a human right or simply a luxury and to what extent care is a human right or

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6 The study of suicide as it relates to social and cultural conditions dates back to Émile Durkheim’s *Suicide: A Study in Sociology*, first published in 1897. Since that time, many researchers have looked at the effects of economic crises and social factors on suicide rates and, in particular, the way that suicide rates capture an element of economic and social conditions that is not often caught in other mortality data: mental health.
a luxury – were not only relevant as they are in any healthcare reform debate, but were indeed questions of life and death during a time of economic collapse, political upheaval, and organizational crisis within the healthcare system itself. The structure of the Soviet healthcare system had developed entrenched beliefs in the government’s responsibility to provide free care to everyone (Lipsmeyer 2000, 2003).

The institutional landscape provided further obstacles beyond the immediate economic collapse. Government tax revenues at this time were cut, limiting the financial resources available for continuing to pay for comprehensive coverage as in the Soviet era. This exacerbated the burden of a healthcare system prioritizing in-patient care – an outdated characteristic in terms of global healthcare trends that had begun to reveal its shortcomings even before the collapse of the USSR. Additionally, there existed little to no third-party institutions, such as insurance companies, to serve as purchasers for healthcare who could optimize the trade-offs between and separate the interests of those paying for care, those providing care, and those receiving care, something that social insurance systems rely upon heavily.

Second, state leaders had to decide “Who will provide?” That is, they had to determine whether the state could continue taking on the responsibility of administration of the healthcare system or whether other entities, such as private companies or insurance providers, should be involved. This decision was complicated by the economic context and the need to ensure that care remained accessible to all citizens, regardless of their ability to pay.

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7 The ideas debate is not only relevant in the post-Soviet case, but constitutes a major theme in the discussions for any healthcare reforms around the world. Recent examples close to home of these “ideas” debates include the discussions of American healthcare in the past few years, as individuals and companies argue that certain medications or procedures (birth control pills or plastic surgery, for instance) are owed to citizens due to their right to care, or whether they are “optional” and therefore the cost must be borne by the person choosing to utilize that care. Other relevant examples are the arguments that arise whenever the price of a drug that is key in the care of certain potentially life-threatening ailments and diseases is increased, such as the overnight increase of the drug Daraprim, used to treat a life-threatening parasitic infection, (see http://www.nytimes.com/2015/09/21/business/a-huge-overnight-increase-in-a-drugs-price-raises-protests.html?_r=0 ), the increase of the price of EpiPens, used to treat severe allergic reactions (http://www.nytimes.com/2016/08/24/upshot/the-epipen-a-case-study-in-health-care-system-dysfunction.html).
and provision of care, with medical personnel serving directly as employees of the state, or whether the government’s role was simply one of regulator of private practice. The medical personnel of the Soviet Union had long been underpaid and overworked, a trend that continued into the transition years. State-guaranteed salaries had removed incentives to provide greater quality care or perform difficult procedures (Rowland and Telyukov 1991, Feshbach 1984). The medical community as a whole remained largely unorganized as an interest group. The Soviet government’s lack of investment in more advanced education for medical personnel, as well as the continued reliance on expert opinions more often than evidence-based medicine, meant that the usual incentive structures for improving care through provider-side mechanisms were undeveloped or non-existent (Frieden 1981, Lekhan et al 2010). The asymmetrical nature of information in the medical field – that is, the greater amount of information on diagnoses and treatments held by medical personnel than by patients or political decision makers – further exacerbated the challenges presented by this question.

Post-Soviet leaders, then, had to contend with many obstacles when attempting to design healthcare reforms and revamp the innerworkings and incentive structures within their healthcare systems. In answering these major structural questions, they often considered prototypical answers as frameworks; that is, much of the conversations on restructuring the systems in the Ministries of health drew on already developed healthcare system models. These included five primary “competing solutions,” all of which differ on how they divided responsibility for payment and provision of care (White 1995): 1. A social insurance model based on not-for-profit sickness funds that pool and then distribute payments, and in which there are both public and private providers – the
“Bismarck” model, such as the systems in Germany and France; 2. A government-provided insurance model, in which the state runs the insurance program within a system of mostly private providers, as that in Canada, Australia, and South Korea; 3. A national health service model – the “Beveridge” model – in which healthcare is state-financed, and there are many government-owned health institutions, as well as private practices, like that of the United Kingdom and Scandinavia; 4. A market-oriented, largely privatized, model, such as that of the United States; and 5. A completely government-controlled system, like that of the Semashko model of the Soviet Union, in which the government both paid for and provided care through funds from the central budget and a state-owned hospital system (without opportunities for the development of private practice). Figure 2 below shows these five types of healthcare systems along a spectrum of the state’s de jure responsibility for healthcare. This does not consider the de facto role of the state in implementation of healthcare, which can differ significantly from the

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8 While Joseph White (1995) was examining the options for reform in the American healthcare system, his categorization of the major three models as the national health service model and the two types of social insurance models holds true for many countries reforming during that time period. Here, I have modified those solutions to include the Semashko system (which White did not consider seriously for the U.S. system at the time due to its apparently defunct condition and the lack of legacy of such a system in the U.S.), as well as the U.S. system (which he was arguing for reforming away from and therefore did not include as an option). Thus, my list of solutions here reflects the models that were available to most countries in the 1990s and, in fact, are all largely still considered possibilities today, though there are some arguments for an expanded typology based on other significant characteristics of the systems. This includes some calls for the current post-Soviet states to have their welfare-state conditions recognized as unique from those of the traditional Western healthcare systems (see, for example, Fenger (2007), “Welfare regimes in Central and Eastern Europe: Incorporating post-communist countries in a welfare regime typology”). While the evidence does demonstrate that they differ significantly in their level of funding from other systems, I would argue that this is not necessarily the development of a significantly new model in terms of healthcare, but instead a variation on the existing models. Furthermore, I find that the evidence does not support an argument for the unique creation of such a model of systems – instead, I find that in the design process, existing models are the main consideration, and the variations largely come from more minor adjustments made in order to successfully implement that model on the ground.
state’s de jure responsibility. As this figure shows, there is no system model where the government does not play (in official terms) at least some role in healthcare, but there are significant differences in the degree to which the government is responsible for financing, provision, and regulation. While most of the world has a significant share of responsibility spread between both the public and private spheres, there is one model—that followed by the United States—that gives significantly less responsibility to public funding and provision.

Figure 2 De Jure State Responsibility for Healthcare Across System Designs

The institutional design process, when looking at these models of healthcare systems, had to include considerations of the existing structures and the costs and advantages of dismantling and replacing those structures. As discussed above, the
pressures of ideas about the “right” approach to healthcare, the interests of stakeholders in either maintaining or reforming the system, and the institutional structure within which these forces interacted all had some role to play in the post-Soviet reform process. However, as I argue, the time was right in those first years of the transition if decision makers truly wanted to pass significant institutional reforms. This was a result of the expansion of decision makers’ agency over the institutional trajectories at the time, particularly due to the legitimized need for reform – that is, conditions that created a consensus across diverse groups that some type of change was necessary – and the lack of development of interest groups that typically would resist such reforms at that time.

1.4.1.2 Stakeholders in Healthcare Reform

Who are the stakeholders or interest groups mentioned above that influence healthcare reform? Because it is an extremely complex policy area, there are many stakeholders that play a role in the political process. This changes from system to system, depending on the political institutions in place. In democracies, for instance, medical interest groups, such as the American Medical Association, can play a significant role in shaping health policy (Halfmann 2011). In more authoritarian systems, political and economic elites are more likely to carry the greatest amount of agency in determining the shape of healthcare reforms due to the underdevelopment of civil society or their exclusion from the political decision-making process.

In general, however, there are four main groups of stakeholders that should be considered when examining healthcare: political decision makers (the regulators and, at times, financiers), medical workers and members of the healthcare industry (the providers – this does not only include doctors and nurses, but also medical technology companies,
pharmaceutical companies, and insurance providers), citizens (the users of healthcare), and international and non-governmental organizations (external actors supplementing provision and financing). These groups are not necessarily unitary actors – for example, the pharmaceutical industry and insurance providers rarely agree with doctors and nurses, but all are a part of the on-the-ground, day-to-day provision of care.⁹

Given the very undeveloped civil society in the former Soviet Union, it is not surprising that, in my research, I found that citizen preferences have not played a significant direct role in the reform process in terms of determining which types of reforms (those involving the state more extensively or those eliminating much of the state’s responsibility) would be pursued. Yet, while their preferences have not had a direct influence on the design, the rights of citizens – as the consumers of the healthcare system policies and the proclaimed reason for the reforms in the first place – have played an important role in giving the search for legitimacy and stability meaning. Without citizens to protect as part of the state-building process, there would be no reason for the connection to the human rights framework. Thus, the political decision makers and, over time, the development of interest groups within the healthcare system as a result of the transition to democracy and market economies, shaped the trajectory, but always within the context of what would preserve their interests in the long term.

⁹ This typology differs significantly from Alford’s (1975) analysis of the structure of interests that shape healthcare reforms, as his examination specifically focused on the dynamic between those who wanted to maintain the status quo and those who wanted to change it, regardless of the policy direction. The power structure amongst these groups certainly plays a role in whether healthcare reform occurs, but it cannot explain why, in the case of the former Soviet Union, it occurred in different ways across different countries. I am instead looking to examine which groups supported which policy directions and how the dynamics between these groups impacts the ultimate trajectories of healthcare system reforms.
1.4.2 Explaining Change in Healthcare Systems: The Importance of Timing and Strategy

Major structural reforms, particularly those involving institutions that reflect strong societal values connected to human rights frameworks, will often prove difficult to successfully pass. Leaders in the position to make decisions about these reforms are driven by a variety of interests and incentives, including short-term considerations, such as their continuing hold on power and influence, and long-term concerns about their legacy and the continuation of their preferred policies. The institutions themselves, on the other hand, are often the focus of support from constituencies or interest groups that most benefit from their functions. This is particularly true for welfare institutions, which often have a direct effect on the everyday lives of citizens in very recognizable ways.

Building on the literature discussed above, I argue that healthcare system reforms in the post-Soviet region can best be explained through a critical juncture framework utilizing the “openings” definition, and that the decisions made at the critical juncture were shaped by the political decision makers’ uncertainty regarding the state’s ability to weather such changes in the long term. Major structural reforms were most appealing in those countries with middling uncertainty. That is, where improvements provided some potential legitimation of the state during a challenging transition, but whose implementation did not significantly threaten the future of the state by favoring certain populations over others, leaders were more likely to attempt to restructure the healthcare system such that responsibility was spread across both the public and private sectors. The first aspect of this argument – the existence of critical junctures as moments in time in which major healthcare reforms can be implemented – is rooted in my theory that welfare institutions, which often directly impact citizens and are seen to reflect social values of
the regime and population, will be more readily changed if the values upon which they were established have been uprooted by crisis, either economic or political. The establishment of new institutional structures, then, also creates new standards for those social values, thus re-interpreting the state’s responsibility in the system. This sends a signal to key actors about the trajectory for not only the institution, but the state as a whole, thus leading some actors to take advantage of the future trajectory while it is first being established. This creates even greater resistance to reforms in later years.

The second aspect of my argument – that the critical juncture is an “opening” during which decisions have greater impact, thus implying that leaders have a choice whether or not to reform at those moments – builds on the literature mentioned above about the importance of the decisions made during the early years of state building in the post-Soviet space. I expand upon the more narrowly-focused time horizons of studies looking at election outcomes, however, and argue that policymakers are also interested in the long-term continuation of their legacies on institutions. They are aware that, at certain points in time (critical junctures), the benefits to them of a long-term legacy on the institutions are greater – but the possible costs of failing to reform (either by trying and failing or simply not taking action) are greater as well.

During a time of state and nation building, there is a particular uncertainty rooted in the existence of threats to territorial integrity and alignments of both national and ideological cleavages. Therefore, for those states in which national and ideological cleavages aligned along concentrated territorial boundaries, few long-term major reforms were made as the leaders sought to preserve the state’s existence and their own legacy. In states where there was little territorial instability and old regime communist leaders were
able to adopt more nationalistic rhetoric, there were again few long-term reforms made, as leaders felt no incentive to risk their grip on power. Finally, in those states where leaders either did not face a significant territorial threat or were able to mitigate nationalist sentiment such that it did not align with economic preferences, there existed greater incentive for reforms as the states moved to become more closely integrated with high-income states.

Finally, I note that the pressure to reform from the Soviet centralized healthcare system in the first place lies within the context of international trends in health and human rights, as well as the historical trajectory of the Soviet system itself. If the Soviet system had not been struggling, or if the international healthcare standards had not moved toward more liberal values focused on the patient, quality of care, and human rights, then the opening for reform may not have occurred. It is therefore only within the temporal and spatial context of institutions and ideas that these trajectories can be understood.

Empirically, the differences in the alignment of these prohibitive conditions – the threats of national and ideological cleavages and territorial instability – are difficult to pinpoint at first glance. It is perhaps because of this, and because of the difficulty of understanding complex healthcare reforms, that studies of these dynamics between the short- and long-term time horizons and the impact of the international pressures as well as the domestic context have been simplified to ones of party politics or interest group dynamics. This dissertation seeks to build a more detailed picture of how exactly these various key actors influence healthcare reform and to understand more clearly how decision making at defining moments compares to that under “normal” circumstances.
1.4.3 Competing Explanations

Possible competing explanations for healthcare reform trajectories lie both in historical and more contemporary influences, with the 1990s serving as a piece, but not a more significant piece, within the larger puzzle. These explanations largely revolve around the crucial division in the institutionalism school of thought on the patterns of reform – that is, that reform trajectories are defined by “constant causes,” rather than the effects of punctuated equilibria.

First, it could be argued that the legacies of the Soviet era play the most significant role in shaping reform trajectories. Variations in the extent to which the Soviet healthcare system was entrenched and the resources distributed by union republic could be argued to have led to the reform trajectories we see today. That is, if this competing explanation were true, we might see similarities in the variations across union republics as we see across today’s independent healthcare systems. This theory would make the decisions of the 1990s far less important in their impact on the trajectory.

Second, one could argue that, rather than the 1990s acting as a critical juncture, healthcare reforms are an ongoing process which occur slowly over time as resources are available, or when particular events create the political will. Therefore, more immediate factors, such as aid levels, natural resources, the state’s ability to effectively collect taxes, or the executive in office could explain why reforms take certain shapes at certain times. For example, some might argue that Armenia and Azerbaijan did not reform in the 1990s because of conflict conditions but that this fact does not in any way influence whether they could reform today if they had the resources and political will. In other words, it
may be that the 1990s were only one part of a larger trajectory, with no part more important than another.

In this dissertation, I show that, while both the antecedent conditions set by the Soviet experience and immediate factors did have some influence on decision making during the 1990s, healthcare trajectories today are best understood as legacies of the decisions made during the first decade of the transition. I discuss the antecedent conditions in Chapter 3 and the 1990s and my argument for the critical juncture interpretation in Chapter 4.

1.5 Data and Methods

In order to answer these questions on institutional change and closely examine the mechanism of the critical juncture, I follow a qualitative research agenda utilizing both historical and contemporary sources. I did not want to simply find significant correlations between the conditions and healthcare reform, but to provide an in-depth analysis of how institutional change occurred and did not occur during a time of crisis, as well as explain why it is that the conditions can seem opportunistic for reform, and yet the chance is still not taken. Therefore, I chose historical institutional analysis and process tracing methods to reveal the details of the cases at hand and the innerworkings of the reform process, including decisions of those leaders involved and the consequences of those decisions.

In doing this, I first examine the structure of the Soviet healthcare system through firsthand accounts by both domestic and foreign workers, government and international organization reports, publications by government officials (including Nikolai Semashko himself) about the history of the system, and academic research from the time period.
Second, for the case studies, I utilize archival, interview, and observational research conducted in Russia and Ukraine from 2014-2015. Archival sources for Russia were found in the State Archive of the Russian Federation (GARF), as well as through interviews with members of academic institutions and international organizations and foreign leaders, including the World Health Organization and the United States Embassy (focusing on the U.S.-Russia Bilateral Presidential Commission’s work in the healthcare field), who have been involved in the healthcare reform process. These were collected over several months, from July 2014 to March 2015. Interviews were only conducted in cases that responses were received while in Russia during those months. I was also able to gather data on doctors’ preferences at doctors’ protests in Moscow in the fall of 2014. Online archival sources through the Yeltsin Center and reports from the Gaidar Institute for Economic Policy provided further insight into the Russian case. Archival sources for the Ukraine case were found in the Central State Archives of the Supreme Bodies of Power and Government of Ukraine (TsDAVO). These documents consisted of the meeting minutes from the Ukrainian SSR Ministry of Health and the Ukrainian Ministry of Health after independence, as well as the correspondences between the Ministry of Health, constituents, and other union-, regional-, and local-level government and party officials. They also included decrees and other documents set forth by the USSR Ministry of Health and discussed within the Ukrainian Ministry of Health meetings. Interviews with current leaders in healthcare, such as World Bank, CDC, USAID, and Kyiv-Mohyla project directors and researchers, supplemented the findings. The interviewees were chosen based on their participation in advising the Ministry of Health on reforms and were only conducted in cases that responses were received while in Kyiv from April to
June 2015. Attendance at a roundtable at the Ministry of Health of Ukraine that was meant to identify and discuss the plan for reforms further added to the insight into the innerworkings of the system. Finally, I was able to gather further data on legal cases, business connections, and Ministry orders through online archives and databases.

In choosing Russia and Ukraine as case studies, I followed a most similar systems design, examining cases in which conditions, under the assumptions of the current literature, would a priori predict similar outcomes, and yet varying outcomes are found. Ukraine and Russia are particularly fit for this type of study, not only because they began from the same type of healthcare system (the Semashko system), but also because their health and demographic characteristics match – they face similar problems in terms of most threatening causes of death and increases in HIV prevalence, as well as in terms of other demographic factors that may affect approaches toward health (religion, ethnicity, history of healthcare practices, etc.). Therefore, apart from an examination of political factors, it is difficult to see why they would vary so significantly in their healthcare reform trajectories. The differences in wealth and resources provided an interesting starting point in explaining the two different trajectories, but, as I will show, the analysis demonstrates that economic constraints were not the driving factor of Ukraine’s hesitancy or Russia’s push for structural reforms. The opportunity to analyze in detail why this was the case gave the qualitative data even more value.

While a qualitative research agenda focused on two case studies is often considered to limit the external validity of the findings, there are ways to maximize the leverage through case study choices. Following the most similar systems design allows for me to develop more abstract concepts within the political process to explain the
varying outcomes, without running into the problem of unique circumstances that may have somehow produced either the same or different outcomes. Furthermore, looking at these cases, which are relatively prototypical choices for post-communist countries, I am able to generalize to a wider post-communist universe of cases. The obstacles created through the institutional entrenchment and legacies of those types of systems are largely similar when given the same set of institutional arrangements and priorities (this is considering, for example, that the Yugoslavian experience with communism differed significantly from that of the Soviet space). Additionally, my theory can be generalized across political systems based on the arrangements of the healthcare systems themselves – that is, reform away from tax-funded, government-controlled systems often face very similar obstacles, even apart from the political ideology driving the system.

1.6 Theoretical Contributions

The theory I have briefly outlined above provides greater insight into the politics of healthcare as a welfare policy area, as well as the dynamics of international and domestic pressures on welfare policies. This helps us to better understand the politics of welfare reform and institutional change in a few ways.

First, while previous studies have focused on healthcare as just one example of several policies within the welfare state, my dissertation seeks to understand the unique dynamics of healthcare as a policy area. In particular, the high levels of information asymmetries and the connection to both the economic sphere and human rights frameworks are a central part of healthcare rhetoric and design. Differences in such characteristics of policy areas provide a better understanding of why states may liberalize some welfare institutions while keeping a tighter control on others. It can also provide
insight into why it is easier to reform certain welfare institutions over others, and why healthcare especially has proven difficult for governments across the world, including the United States.

Second, my theory contributes a better understanding of decision makers’ incentives at critical junctures. While previous works have considered the self-interested motivations of remaining in power, they have often ignored the longer-term considerations that become the focus at moments of crisis. My argument points to how the differences in context at critical junctures, versus in moments when it is “politics as usual,” can shape decision makers’ willingness to attempt risky reforms.

Third, my dissertation gives some insight into how threats to state stability and the state- and nation-building processes can shape leaders’ decisions about welfare. Few have looked at the politics of providing welfare to populations threatening independence movements and the way in which leaders, if seeking greater unification (either for a selfless interest in the good of the people or a selfish interest in maintaining influence) can manage the distribution of resources while building state legitimacy through welfare institutions. This is particularly true for healthcare, which has been the focus of human rights movements for the past few decades.

Finally, my dissertation provides some suggestions on how tensions between international standards and the reality of limited domestic resources can impact institutional trajectories. In particular, studying healthcare provides an idea of how global frameworks of human rights and expectations of standards within those frameworks can shape the rhetoric used while looking to redesign a system and build state legitimacy.
1.7 Overview of the Dissertation

The dissertation is divided into eight chapters in total, including this Introduction.

In Chapter 2, I outline my argument, giving detailed explanations of what constitutes a critical juncture and why they occur, as well as the factors that impact decision making during times of crisis and state building. I discuss the ways in which the stakeholders in healthcare reform in lower-income countries differ from those in high-income countries, and the impact this can have on the decision-making process during these times.

The next four chapters detail the empirical research at the core of this dissertation. Chapter 3 gives a history of the Soviet healthcare system, both in its structure and function, as well as its trajectory to the end of the Soviet era. Chapter 4 moves to the next chronological point in the healthcare reform process – the fall of the Soviet Union and the crises of the 1990s. It is in this chapter that I identify the way in which this served as a critical juncture for all of the countries of the post-Soviet states, one at which key decisions were made about the future of the states’ healthcare systems. I provide a detailed analysis of the critical juncture in my two cases, Ukraine and Russia, and how elites reacted to the crises and the pressures from both domestic and international sources. Chapters 5 and 6 then follow the legacies of those decisions made in the 1990s in Russia and Ukraine, outlining how they sent signals to the population and key stakeholders about the direction of the state, and that the result of the attitudes and networks developed around those first decisions still impact healthcare reforms today.

The last two chapters seek to extend this argument beyond the two cases explored previously and conclude with some broader thoughts on the dissertation’s findings.
Chapter 7 explores how the theory carries to other post-Soviet states, outlining the pattern of reluctance for reforms in countries where economic, national, and territorial cleavages aligned and in countries where no incentive to modernize and empower a greater number of actors existed. Only in those countries where the national, economic, and territorial cleavages did not fully align yet there still remained incentive to pursue greater stabilization were reforms pursued seriously and maintained in the long term. This suggests that the focus on political decision makers’ uncertainty about the future of the state, rather than limitations of economic resources or political alliances, best explains the decisions made during the state-building opportunities of the 1990s. Finally, in Chapter 8, I conclude with some thoughts on the theoretical and policy implications of these findings.
Chapter 2
Critical Uncertainty:
A Theory of Healthcare Reform, Critical
Junctures, and Political Decision Making

Answering the core questions about healthcare – “Who will pay?” and “Who will provide?” – proves to be a complex and difficult process in many countries, and the post-Soviet states are no exception. While healthcare is understood to be difficult to reform – consider for a moment the recent struggles in the United States – the connection between the unique aspects of healthcare as a policy area and larger patterns of institutional change has been understudied. Instead, healthcare is often seen either as unique in its complexity, especially when considering the information asymmetry as compared to other welfare areas (Arrow 1963), or it is over-simplified to just an example of welfare state reform equivalent to those of pensions, housing, and unemployment. While I do contend that these complexities are part of the significant obstacles facing reformers, I argue in this dissertation that the process of healthcare reform can be considered an example of more general institutional change patterns once we consider the particular institutional characteristics of healthcare as a policy area, including its relationship to both economic and human rights frameworks and the levels of asymmetrical information involved in medical care. It is therefore possible to move up the ladder of abstraction (Sartori 1970) to theorize about how institutional change in healthcare systems represent patterns in policy areas that connect economic and social values, as well as areas that involve principal-agent problems rife with information asymmetries. In doing so, I argue,
we can understand healthcare reform as a microcosm of broader state- and market-
building patterns.

In this chapter, I outline my argument of the dissertation. I first lay out in detail
the theory of the critical juncture and my propositions for identifying \textit{a priori} (as opposed
to after the legacies have become institutionalized) when a critical juncture occurs. It is
this recognition of the contextual characteristics of a critical juncture that I will argue
drives political elites to recognize when they might be making decisions at a critical
moment. In doing so, I develop a definition of the characteristics of critical junctures
drawn from the literature, outlining the role of antecedent conditions, legacies, and
mechanisms of production and reproduction, as well as the importance of understanding
critical junctures as “windows of opportunity.” I will be using these definitions as the
framework for my argument throughout the dissertation.

Second, I discuss the critical juncture for post-Soviet healthcare reforms occurring
in the 1990s, which I argue shaped the trajectory for reforms today. I describe how, when
governments decided whether or not to pursue major reforms, they set the course for the
de jure state responsibility framework – that is, what the state’s role in healthcare is
legally, and how it relates to international standards. The decision at this juncture, I
contend, was significantly influenced by threats to state stability, the way in which they
aligned along national and ideological cleavages, and the implications this had for the
possible consequences of major reform efforts. I then describe the aftermath of these
decisions and how they served as a signal for the state’s trajectory regarding the state’s
role in healthcare for the longer term. I argue that as states either successfully
implemented reforms or ineffectively implemented reforms, the state’s de facto
responsibility was developed and institutionalized through the actions of economic elites in response to the signal sent by the design plans for the new healthcare system. This, combined with de jure state responsibility, helped to formulate the legacies we see in the healthcare systems today and the entrenchment of the institutions designed at that time.

Next, I outline the outcome of the critical juncture – state responsibility for healthcare – and my framework for understanding its relationship to the legacies of the junctures. Finally, I discuss the assumptions and limitations of the argument and competing explanations.

2.1 Identifying a Critical Juncture

What is a “critical juncture”? I assert that critical junctures can be defined as points at which actors’ choices have a greater impact on institutional change, without necessitating that major modifications are made (Capoccia and Kelemen 2007). I argue that the reason there is an increased level of agency at a critical juncture is because political, economic, and organizational crises provide increased legitimacy for calls for significant reforms. The necessary crises for a critical juncture for welfare state institutions will differ than those necessary for other types of institutions because of the connection of welfare institutions with both the economic and human rights spheres. This is particularly true for healthcare reforms. Furthermore, following Collier and Collier’s (1991) framework, a critical juncture will establish recognizable patterns that can be traced to the core decision-making moment. However, while I demonstrate in this dissertation that these patterns can be identified in the post-Soviet healthcare systems, I also contend that we can recognize the existence of a critical juncture early on for healthcare institutions because the crisis leading to that juncture will have involved an
opening of expectations and a possible “loosening” of social values attached to those institutions.

In order to elucidate this framework fully, I describe here the antecedent conditions, and then move to a discussion of the legacies, including the mechanisms of production and reproduction, of a critical juncture. I emphasize that in examining critical junctures’ importance for institutional change, the emphasis should be put on how they impact decision making in the moment, rather than only on their outcomes, as in the case in most of the literature. This is because the opportunity for change – which will define when change can occur – will not necessarily produce significant differences in institutional designs. It could, in fact, be a moment when the existing designs become further entrenched. This does not lessen the importance of critical junctures in institutional change, but rather modifies it, formulating it as a necessary, but not a sufficient, condition for change, and puts emphasis on the way in which the context of the critical juncture will emphasize or lessen the impact of variables that we might otherwise hypothesize would have a significant impact.

2.1.1 Antecedent Conditions and Crises Preceding of Critical Junctures

Why do critical junctures occur when they do? The literature has little to say about this. While historical antecedents are often examined as causes for the choices and outcomes of critical junctures, few works argue why, at a particular point in time, a critical juncture occurred in the first place. Instead, it is often assumed away as an “alignment of the stars” and the result of a cleavage or crisis, but with no standard explanation of why or how that crisis or cleavage produces a critical juncture for institutional change, how to recognize what will lead some crises or cleavages to produce
critical junctures while others do not, or, if all crises or cleavages produce a critical juncture, why we should believe that the conditions across these are equivalent.

The antecedent conditions, or the “‘base line’ against which the critical juncture and the legacy are assessed,” (Collier and Collier, pg. 30), provide both the setting for the critical juncture, as well as the potential explanations for competing hypotheses. While these conditions can play a role in the instance of a critical juncture, they also pose a challenge to the critical juncture theory. These hypotheses suggest that “important attributes of the legacy may in fact involve considerable continuity and/or direct causal links with the preexisting system that are not mediated by the critical juncture” (Collier and Collier, pg. 30). It is therefore a priority for the researcher to demonstrate that the critical juncture interposes some sort of mediating factor in this connection.

The legacy of the Soviet healthcare system in the case of post-Soviet reforms does appear to provide a very strong challenge to the critical juncture argument. The characteristics of the Soviet healthcare system that I discuss in Chapter 3 are, in many ways, still considered to be undeniably relevant in analyzing post-Soviet health. An overwhelmingly bloated infrastructure for inpatient and specialist care with very little emphasis on general or preventive medicine, as well as strong citizen support for access to free care, are just a few characteristics that scholars continue to see patterns of today. However, while there are consistencies across the states in the challenges they face due to this legacy, their responses have been varied, indicating that the legacy does not specifically shape the way in which regimes have approached reforms to the system.

In this dissertation, I argue that the existence of three types of crises – organizational, political, and economic – led to the critical juncture by legitimizing the
idea of change to the system. The characteristics of Soviet medicine, including the infrastructure challenges and the low level of financing, led to the organizational crisis that preceded the critical juncture. Table 1 below outlines the definitions of each of the three crises that I hypothesize played a role. I argue that, in examining healthcare reform more broadly, at least one of these crises is needed for a critical juncture to be reached because healthcare is tied so closely to both the economic system and social values regarding human rights. The crisis or crises provide the framework within which reforms are communicated and legitimized. In the case of the post-Soviet states, I point to a disconnect between social values (the continued belief in the importance of universal access), economic conditions (declining wealth and increasing unemployment), and the values promoted by the new political systems that helped to legitimize considerations of reform for what had been one of the more popular aspects of the Soviet system.

In the case of healthcare in the post-Soviet states, all three crises were necessary to create the conditions of the critical juncture due to the entrenchment and popularity of the healthcare system in the USSR. This does not mean that all three types are necessary for any critical juncture. Instead, the necessity of the crises to set the stage for a critical juncture depends upon the type of institutional change that one is examining. With healthcare reforms in a communist country, all three conditions were necessary to support the legitimacy of reforms. However, in countries where the healthcare system is not

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10 There is a large literature on the use of necessary and sufficient conditions in political science, and the strengths and weaknesses of this approach. The main advantages of this approach lie in its clarity and applicability. Weaknesses include the difficulty in explaining why a condition is sufficient, necessary, or both, as well as understanding what role necessary or sufficient conditions play in the political process (i.e., how the mechanism works). Gary Goertz discusses these issues at length, including the challenge of determining how important necessary and sufficient conditions are for an outcome. See, for example, Bear F. Braumoeller and Gary Goertz (2000), “The Methodology of Necessary Conditions,” *American Journal of Political Science* 44 (4): 844-858.
inherently tied to the political regime, such as more privatized systems like that of the United States, it may be that only a significant organizational crisis, in which the healthcare system is not addressing the problems that it was built to address, is necessary for a critical juncture in the healthcare system. However, I would argue that, for all healthcare reforms, any crisis that leads to the critical juncture will have to involve a challenge to social values surrounding the state and individuals’ responsibilities for health due to the human rights nature of healthcare.

**Table 1 The Crises Preceding the Critical Juncture**

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<table>
<thead>
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<tbody>
<tr>
<td><strong>Political</strong></td>
<td>The ability of political decision makers to pursue major reforms for institutions is increased, either by changes in power structures or institutional rules</td>
</tr>
<tr>
<td><strong>Economic</strong></td>
<td>The economic conditions provide an incentive to consider changing the institutions, either by a lack of resources to continue the current institutional structure or by an inflow of resources that allow for change that previously had not been possible</td>
</tr>
<tr>
<td><strong>Organizational</strong></td>
<td>The conditions of the problem addressed by the institution (in the case of this dissertation, health) change to the point that the legitimacy of the existing institutional structures can be questioned</td>
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2.1.2 **Legacies of Critical Junctures**

The second and crucial characteristic of critical junctures is the outcome or legacy that these moments produce. If the change can just as easily be made at any time, erasing the effects of previous institutions, then that moment in time, by definition, is not a critical juncture. After the legacy has come to light through “mechanisms of production” (Collier and Collier 1991), there are two resulting processes outlined in the literature by
which the outcomes of critical junctures make a difference. These processes are “institutional reproduction,” or what Collier and Collier originally called “mechanisms of reproduction,” and “reactive” processes (Collier and Collier 1991; Mahoney 2001). The first of these is a positive feedback process, while the second is negative and can be understood more as the building up of forces toward another critical juncture.

The first – institutional reproduction or entrenchment – describes a process by which the decision made at a critical juncture becomes increasingly difficult to change. This is because of various mechanisms, such as learning, coordination, and adaptation, all of which develop a system around the institutional structures in place after the choice is made (Pierson 2000). Mahoney (2001) describes this process as a narrowing of possible paths – that is, critical junctures only exist at “those choice points that close off important future outcomes” (pg. 113). Collier and Collier (1991) similarly emphasized the importance of these “mechanisms of reproduction,” as well as the “stability of the core attributes of the legacy” in the process of identifying and confirming the existence of a critical juncture. This key quality of critical juncture legacies, the institutionalization of a new trajectory, highlights the discontinuous change process.

The second process involves actor reactions and procedural consequences to the choice. Mahoney (2001) outlines how, once a choice is made, the “reactive” processes, or creation of groups for and against that particular institution, begin to build and challenge the strengths and weaknesses of the institutional design. The groups who are the “losers” of the design will attempt to change or adapt to the institutions in a way that they achieve the best result possible. At the same time, the “winners” of the choice will be incentivized
to do everything they can to maximize their benefits from the decision, as Hellman (1998) described with the economic transitions in the former Soviet Union.

An important note to emphasize again about my definition of critical junctures and their legacies in this dissertation is that they may produce significant structural change – but they also may not. The key to a critical juncture is that there exists the opportunity for change, a greater opportunity than is usual the majority of the time. Much like Lukes’ (2005) definitions of power – in which he argues that power may or may not be utilized, and yet, regardless, still exists – the definition of a critical juncture depends upon the capabilities for change and the reinforcement of the choice that is made, rather than whether significant change away from the antecedent conditions actually happens (Capoccia and Kelemen 2007). Instead, a critical juncture may entrench existing characteristics in a way that is deeper or more complex than under earlier conditions.

The argument that a critical juncture can in fact entail a choice between a new path and further entrenchment of an existing path is a critical element of my theory in this dissertation. I propose that all of the post-Soviet states experienced a critical juncture in the 1990s in terms of healthcare system reform. While some governments took that opportunity for change, others did not, but all faced the critical juncture to the same extent. The legacy lies in the entrenchment of the state’s responsibility for healthcare. This dissertation looks at the cases of Russia and Ukraine; in the first, political actors take the opportunity for change, and in the latter, there was little change pursued. As I will show, however, in both cases, there was an increased chance for change – a critical juncture – during the early to mid-1990s. The legacies of the critical junctures, then, are
recognizable through the patterns produced by the promises of the reforms and the restructuring or maintenance of the state’s responsibility in the healthcare system.

2.2 The Decisions:
Preserving the State, Addressing Uncertainty

As I outlined in Chapter 1 in the review of the economic reform literature, scholars have provided many possible factors that influence decision making in terms of “direction” of reforms. However, few have explored in-depth the causal mechanisms connecting the context of a critical juncture to the decision-making process. One prominent exception is Frye’s (2010) theory, which provides a clear connection between the political environment and reform decisions, based on the assumption that elites in the post-communist states are rational, self-interested actors, focused on preserving both their power and their political legacy. Many theories looking at self-interested decision makers, however, assumed that elites in the post-communist states in the 1990s would act similarly to those in other regions or times. I instead argue that the context of the critical juncture impacts the priorities of the political decision makers, who, in coming to power, hold preferences for policy and for their own political legacies. Specifically, the conditions of a critical juncture amplify the impact of decisions, which in turn increases considerations of their longer-term legacy of state building. This changes time horizons of decision makers in ways that do not happen during periods of “normal” politics, and significantly heightens the influence of the level of uncertainty on reform decisions.

2.2.1 Time Horizons and Threatened State Stability

The critical juncture for healthcare reforms involved a time period during which officials determined whether to pursue major reforms in healthcare, or whether to make
minor adjustments to the already existing system. The crisis of healthcare put decision makers into a difficult position: either condemn their populations to acute, though hopefully short-lived, chaos of a major system overhaul, or put off any major reforms in favor of stability, but with dwindling resources that could not maintain the level of care needed to provide for the citizens as they struggled through a major economic transition, resulting in restricted access to care and low-level corruption as citizens and medical personnel alike attempted to adjust to the harsh conditions. Furthermore, they faced a crucial question about the role of the state in healthcare in the long term: Is it the state’s responsibility in the newly independent country to guarantee a certain level of healthcare? This meant determining whether it was up to the state to provide access to a certain level of free medical care for everyone, and who exactly would fund such a system. The outline of the process surrounding this critical juncture can be found in Figure 3.
What were the mechanisms behind the decisions in the critical juncture? While governments faced a transition in both the state and market, they prioritized state building to maintain their legacy on the newfound sovereignty – an independent state, after all, can exist without a market economy, but a market economy would be meaningless without the existence of an independent state by which to define it and through which it can be promoted and protected. Therefore, as the patterns of economic reform decisions show, the top priority of decision makers in the 1990s was state stability. This prioritization of course encompassed other interests, such as remaining in office and economic prosperity, both at the individual and group level. As a result, state stability and possible threats to
that stability in the wake of the Soviet Union’s dissolution shaped leaders’ approach toward reforms, particularly those that might threaten large segments of society.

The greatest threats to state stability at the time of the critical juncture in the 1990s rested in nationalist movements, which, while having propelled these countries to their newfound independence, often threatened the very boundaries that had just become those of the fifteen new states. These movements, however, were not necessarily a direct threat in terms of consequences of healthcare reform decision making. Instead, it was when bounded nationalist movements (those concentrated in certain regions or areas of the country connected to specific territory) aligned with ideological cleavages that threats to state stability were most heightened by healthcare reform decisions, as well as other policy decisions closely connected to economic preferences and human rights.

The threats of these alignments were salient due to these characteristics of the type of policy area. That is, while the trade-offs paralleled similar circumstances with broader economic reform considerations, there was one significant difference: healthcare, along with other welfare institutions like education, was believed to be one of the core responsibilities of the state to its people, particularly in times of crisis. Whereas the state’s responsibilities concerning capitalist institutions of welfare, such as unemployment benefits, had not yet been defined, those regarding these long-standing institutions, and especially in-kind benefits, were well established, and many citizens did not believe such responsibilities changed with the transition to capitalism (Lipsmeyer 2003). Furthermore, these welfare institutions stood as one of the key points of pride of the now-defunct Soviet state, serving as something that had challenged and shaped new norms for human rights and universal access. As opposed to other states where the
mindset of economics and insurance had set the stage for benefits prior to the rights framework (Clegg 2010), the Soviet welfare system had been designed around the ideas of universal rights and equality, with insurance structures and incentives introduced only at the end of the Soviet era.

Considering threats to state stability, rather than a measure of state capacity, creates an important difference between my theory and other examinations of reform decision making at the time. While the literature often relies on the concept of state capacity as one with an objective measure, there is no clear definition of “state capacity” that has proven to be the most reliable in terms of strength in the face of reforms – instead, different measures can often give very different pictures (Fortin 2010). Showing that threats to the state’s stability threatened the future of the state, and in turn, impacted reform decisions gets around the difficult task of arguing whether the state could “handle” those threats (that is, the state’s capacity). Instead, the important factor in this explanation is the fact that there was a threat connected to issue areas about which the reform decisions would send a direct signal, thus impacting possible threats in the long term to the state’s stability.

The decision to pass or not to pass reform legislation during the crisis years, then, signaled to both domestic and international audiences the values of the state in the healthcare sphere and the role it intended to have in reforms going forward. Furthermore, it set the stage for the fitting of the state’s definition of responsibility and human rights within the international frameworks, such as that defined by the World Health Organization or International Monetary Fund, and therefore, the relationship that the state would have with those organizations and the international system. The political decision
makers were aware of these consequences of their reforms and showed concern for their longer-term legacy on the state-building process.

2.2.2 The Aftermath of Reform Decisions and the Creation of the Legacy

The “signal” sent by the reform decisions about the responsibility of the state in the future healthcare system led to actions by domestic stakeholders to capture opportunities, particularly economically, in the reformed system or to maintain their advantages in a system that was not reformed – the “reactive” processes, or mechanisms of production, of the critical juncture framework. The less responsibility the state maintained over healthcare, the greater the opportunities were for the rise of private interests. In states where insurance systems were designed, opportunities in the insurance industry became an important factor for economic elites seeking to control the market. The privatization of the pharmaceutical market and pushes for the introduction of innovative technology further advanced possibilities for economic elites. The consequences of actions taken by economic elites at this time helped to solidify the way in which state responsibility would play out in the implementation of reforms, creating a separate “de facto state responsibility” that often clashed with the legal structures of the state’s responsibility, or de jure state responsibility, producing a contradiction in the state’s role in healthcare system.

These mechanisms – de jure state responsibility and de facto state responsibility, and the contradiction between the two – in turn influenced core attributes of the legacy of the critical juncture. Specifically, de jure state responsibility produced a framework through which government officials continue to speak about the healthcare system and about human rights (an interpretation of the state’s responsibility) in healthcare. De facto
state responsibility, or the reality of state responsibility on the ground, directly influences health outcomes. Finally, the contradiction between these two conceptions of state responsibility impact the public’s opinions on healthcare reforms, affecting the population’s confidence in planned and attempted reform efforts, as well as their support for those efforts. These three core attributes of the legacy – the rhetoric, public opinion, and health outcomes – in turn influence the success and failure at attempts to change the institutions (both de jure and de facto), perpetuating the legacy. The relationships between these various aspects of the legacy are shown in Figure 4.

**Figure 4 The Legacy**

**Mechanisms of Reproduction**

![Diagram showing the relationships between de jure and de facto state responsibility, official rhetoric, public expectations, and health outcomes.]

The patterns of actions taken after the reform decisions – whether they further entrenched the structural changes made or challenged the new framework in such a way that political decision makers quickly reversed or halted the reforms, setting the stage for
the long-term legacy – depended upon the way in which the economic and political elite networks related to the designers of the new system.

In states with fragmented elite networks – like those in Georgia and Kazakhstan – the decision makers in power rushed to implement the reforms as they saw fit due to a lack of coordination between those making the design decisions and those seeking to take advantage of the new system. The rushed effort gave rise to corruption and inadequate planning, causing the reforms to be halted or reversed, and institutionalizing the existing distribution of resources.

In states with cohesive elite networks – those that had some dissent but were either largely dominated by one group or had strong cooperation across groups – pursued implementation more deliberately. Shared visions of the possible advantages of the design led to this gradual approach, which allowed the necessary institutions to develop over time, resulting in (relatively) successful attempts at institutional change during that period, creating legacies around those newly formed structures. While there are certainly still problems in all of these healthcare systems, the elite’s decisions led them to a position of relative prosperity with regard to the healthcare system as compared to those who either did not reform or reformed too quickly.

2.3 Outcome of the Critical Juncture: State Responsibility in Healthcare

The institutional legacies of the critical juncture, commitment to a de jure state responsibility framework and, as a secondary outcome, its comparisons and contradictions with de facto state responsibility, form the overall structure of state responsibility in healthcare. I define the final outcome, state responsibility for healthcare,
as the role of the state, legally and financially, in the maintenance and provision of healthcare. This responsibility, which is balanced with societal responsibility (individual and community responsibility for health) and non-state responsibility (responsibility given to actors beyond the state, such as non-governmental organizations and international finance organizations), is one part of the larger picture of responsibility for healthcare in a given country. Figure 5 shows a basic visualization of the relationship between these various aspects.\textsuperscript{11}

\textsuperscript{11}The idea of “responsibility” for healthcare, as opposed to the concept of “commitment” often used in studies of the welfare state (see, for example, Haggard and Kaufman 2008) is meant to capture the broader picture of the ideas and values encapsulated in the politics of health. “Commitment” is defined by the Oxford English Dictionary as either the “state or quality of being dedicated to a cause, activity, etc.,” “a pledge or undertaking,” or an “engagement or obligation that restricts freedom of action” (For all forms of the definition, see the OED site: \url{https://en.oxforddictionaries.com/definition/commitment}). This implies a direct constraint on the committed. “Responsibility,” on the other hand, is defined as the “state or fact of having a duty to deal with something or of having control over someone,” the “state or fact of being accountable or to blame for something,” the “opportunity or ability to act independently and take decisions without authorization” (See \url{https://en.oxforddictionaries.com/definition/responsibility}. There is one more definition – “a thing which one is required to do as part of a job, role, or legal obligation” – which I have not listed here, as it applies to the count noun form of the word, rather than to the mass noun, which I am using here). That is, while “commitment” implies the restraining of actions and an obligation to one course of action, “responsibility” focuses on the idea of having control over an institution, person, or situation. It implies an obligation to make a decision or play a role but does not necessitate a specific action.
The concept of state responsibility can be most directly compared to ideas of privatization in the welfare state literature, and particularly Esping-Anderson’s (1990) liberal, conservative, and social democratic ideal types. These three types fall along a spectrum of state responsibility as I suggest for healthcare system models in this dissertation (see Figure 2 in Section 1.4.1), with liberal close to no state responsibility, conservative somewhere in the middle, and social democratic close to the full state responsibility end of the spectrum. I argue, however, that using this spectrum, rather than “types,” for healthcare systems allows for a more useful conceptualization of the values upon which these healthcare systems are designed. Healthcare systems that share 50-50 responsibility between state and private enterprises, for example, will differ significantly in their conception of state responsibility than will those systems that divide the
responsibility 75-25 or 25-75. Allowing for these differences in a spectrum conceptualization makes it easier to pinpoint the impact of the critical juncture and its legacy on the healthcare systems today.

In examining responsibility, rather than commitment, to healthcare, I hope to achieve two things. First, I hope to develop a broader picture of the role of the state in healthcare beyond the pedantic measures of commitment, such as public spending per capita. In doing so, I seek to include within the examination the ideas and expectations behind the state’s role. This should help to more clearly reveal the underlying characteristics of healthcare reform trajectories. Second, in looking specifically at the former Soviet states, I hope that by looking at state responsibility, I am capturing the transformation of the state’s role in healthcare, and in the broader welfare context, from the ideals of communism to those of capitalism.

In the next chapter, I turn to the antecedent conditions of the critical juncture as established by the Soviet healthcare system.
Chapter 3
Healthcare in the Soviet Union

3.1 Introduction: Soviet Healthcare as a New Model

When first introduced in 1918, the Soviet healthcare system embodied the communist ideals of equality and universality. Its goal was simple: provide healthcare, free of charge, to all citizens uniformly across the entire Soviet Union. Government officials often expressed the belief that these goals of equality and universality were imperative more than other aspects of healthcare (including quality). This was a relatively new concept in the history of healthcare systems, and the history of healthcare system “models” of which we think today was only in its infancy in the beginning of the 20th century. Just a few decades earlier, in 1883, Bismarck had first introduced the idea of statutory health insurance (Gesetzliche Krankenversicherung) in the newly unified Germany, and it was not until after World War II (1948) that the British National Health Service would be established.

The Soviet model, meant to be an even more ideal structure of benefits denying not one man, woman, or child his or her right to free medical care, sought to develop new standards for global health beginning in the early 1920s. It was, in fact, “the first country in the world to make a constitutional guarantee of a universal, though not necessarily equal, entitlement to free medical care to the entire population at the expense of society”

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12 While the first guarantees only covered the Russian Soviet Federative Socialist Republic (RSFSR), the system was expanded over time to include all the republics of the newly established union as well as the territories acquired over time.
13 See, for instance, Ryan’s (1978) discussion of these issues and government reactions (pg. 9-10), as well as many reports from Meditsinskaya Gazeta.
(Field 2002, pg. 161). And in many ways, it succeeded. However, the implementation for such a goal proved to be much more difficult than had been hoped by the founders of the new USSR, and slowly the idealism of the early years of the revolution faltered in the face of new health challenges.

In this chapter, I discuss the main characteristics, both positive and negative, of the Soviet healthcare system and how the landscape of Soviet health changed over the decades of the USSR’s existence. I do this by first discussing the establishment of the system and its initial outcomes before moving to the effects of the perestroika era and the reasons for the ultimate unsustainability of the system. I demonstrate that the structural characteristics of the state-run healthcare system proved too inflexible for health needs, which are constantly morphing over time due to societal, economic, and environmental changes. The institutional “stickiness” of the system, as well as the entrenched values it established amongst the Soviet populations, resulted in both the unsustainability of the system and a difficult path to reform after the collapse of the Soviet Union. The legacies of the state-run Semashko health system significantly shaped the challenges of the health systems and reform efforts seen in the post-Soviet countries today.

3.2 Main Characteristics of Soviet Healthcare

3.2.1 Establishment of the System

Shortly after the end of the Russian Revolution, the People’s Commissar of Health, Nikolai Aleksandrovich Semashko, helped to found a new healthcare system. This new system, based on the communist principles of equality and universality, established institutional legacies that not only lasted through the rest of the 20th century, but continue to do so even today.
The first move towards reform took place as the October Revolution turned into civil war between the Red and White Armies. On December 1, 1917, the Supreme Council of the National Economy was organized, which led to the nationalization of banks (27 December), land (19 February 1918), foreign trade (22 April), and large-scale industry and commerce (28 June) (Sigerist 1937, pg. 45). Pharmacies too were nationalized beginning in December 1917, after a failed effort by Mensheviks to push a policy of “municipalization” (putting workers and cities in charge) of the institutions (Conroy 2006, pg. 51). Under the same umbrella of economic reform, the Council of Medical Departments, a combination of health departments from various Commissariats (War, Education, Interior, etc.), was established in February 1918. The Council sought to coordinate the work of medical services across the departments in order to create a more unified and organized system.

However, the task of coordination proved to be more difficult than expected. Due to a lack of detailed information across the system – which made it nearly impossible to unify services under one plan – and due to the obstacles created during war, the Bolsheviks faced seemingly insurmountable challenges. During the years of civil war (between 1918 and 1922), it is estimated that morbidity from typhus reached 20 to 30 million, and mortality from typhus approached 3 million. In 1921 alone, official records showed 83,016 cases of small pox, 308,548 cases of typhoid, and 205,553 cases of cholera. Epidemics were the officially recorded cause of death for an estimated 8 to 10 million people from 1916 to 1922 (Gantt 1928, pg. 15). The fast dwindling of medicine produced by fighting in the civil war and the continued Allied blockade of World War I (which Russia officially pulled out of on 3 March 1918 with the signing of the Treaty of
Brest-Litovsk) added to the terrible conditions facing the healthcare system (Semashko 1934, pg. 36-37). The Bolsheviks decided at that time that more drastic measures had to be taken to create a more effective healthcare system.

The People’s Commissariat of Health Protection, founded by the Bolshevik government of the Russian Soviet Federative Socialist Republic (RSFSR) on 11 July 1918, was one of the first major government institutions of the newly founded Soviet Union. Establishing new principles of healthcare organization in light of extreme food shortages, epidemics, and wartime casualties that accompanied World War I and the Russian Revolution and Civil War, the Bolsheviks faced significant hurdles in solidifying the authority and control of the new system. In addition to the rampant epidemics that plagued the country, conditions in hospitals at the time did not help the Soviet government in consolidating control. During the civil war, the number of hospital beds did not meet the demand, with a handful of people at times required to share a single bed. It was often necessary for patients to provide their own food while in the hospital, with the few hospital rations given within the institution provided by outside actors such as the American Relief Administration (Gantt 1928, pg. 17-18). The American Relief Administration, British Mission, and German Red Cross all helped to run hospitals or provide medical supplies. Gantt reported that in 1922, 75 to 100% of the most important medicines and surgical supplies in the four largest hospitals in Leningrad were provided by the American Relief Administration (Gantt 1928, pg. 24-25). Adding to the chaotic conditions, many doctors openly opposed the new government and its reworking of the system and resisted change (Semashko 1934, pg. 38-41; Sigerist 1937, pg. 118; Field 1957).
Institutionally and economically, the Soviets faced a daunting task in healthcare reform, but they understood there to be no choice – reform had to happen if the Soviet Union were to reach its communist ideal. Therefore, while still relying on the few resources were left from tsarist healthcare, they built the state-run Semashko system nearly from scratch after the 1922 establishment of the Union of Soviet Socialist Republics (USSR) (Ryan 1978, pg. 7). 14

The core ideology of the Soviet healthcare system, like that in other policy areas of the Soviet Union, revolved around the central tenets of communism as described by Karl Marx and Friedrich Engels. The assumptions of the communist ideology – that all working-age adults should be making some contribution to society and its general welfare and that any aspects of life affecting a person’s ability to do so are state, rather than private, business – resulted in a state-run health system, with little room for patient choice or variation in treatment. The state needed to address citizens’ health because “disease [was] seen to be harmful, not only to the person suffering from it, but to the state of which he [was] an economic and social unit” (Haines 1928, pg. 13). In particular, Engels’s 1845 work, The Condition of the Working Class in England, laid out the fundamental beliefs of communist ideology regarding healthcare. In it, he detailed the living conditions of the working class in England in the 1840s, arguing that a major cause of disease lies rooted in the poor conditions created by capitalism, such as poverty and poor hygiene (Engels 1845). In theory, in a socialist society those conditions would be eliminated, in turn eliminating many diseases connected to capitalist societies.

14 Particularly devastating during the civil war was the typhus epidemic, which is believed to have affected tens of millions, though there is a paucity of accurate statistics from the time to verify this (Semashko 1934, pg. 37).
Healthcare, like all aspects of life in the Soviet Union, focused on the superiority of a unified, socialist society over the failings of its capitalist rival.

While governments had for years treated the curing and prevention of infectious diseases, such as diphtheria and yellow fever, as state business, the Soviet Union took this one step further in regarding *all health affecting a person’s ability to work* as the state’s and society’s responsibility. Mark Field wrote in his detailed analysis of the innerworkings of the system in 1967 that it could be described as:

“a socialist system of governmental and community or collective measures having as their principal purpose the prevention and treatment of illness, the provision of healthy working and living conditions, and the achievement of a high level of work capacity and long life expectancy for the individual (to be gained primarily through a reduction of the mortality rate).” (pg. 43)

Field further defined the main operational characteristics of the system, including state responsibility, centralization of planning and administration, the free provision of services, the focus on prevention, and the union between medical practice and research, the need for public support of the system, and the prioritization of care for workers responsible for more critical tasks in the national economic and political framework (Field 1967, pgs. 42-48). These main characteristics, like those of other policy areas in the Soviet Union, prioritized the national economy and the role of community in the USSR’s success.

The State Planning Commission (Gosplan), whose prioritizations and reorganization of the Soviet economy determined the direction of healthcare reform, was established on 22 February 1921. Originally bound by the New Economic Policy (initiated by Lenin in March 1921), which allowed for more private enterprise and
introduced “an amalgam of market practices and government control,” the Plan slowly turned to full government control and nationalization of trade (Conroy 2006, pg. 76). By 1928, the first Five-Year Plan was launched under Stalin’s leadership, with the second Plan following in 1933. Each of these plans set forth specific quotas and priorities for every area of the national economy, including healthcare. All goals were meant to very quickly modernize the country for the good of the workers so as to reach the ideal communist state, in which the good of the society, rather than money, drives people’s contributions, as opposed to what Marx and Engels argued was the case in capitalist societies. The Constitutions of 1924 and 1936 established society and the state’s (and, specifically mentioned in the 1936 Constitution, the Communist Party’s) authority over all property, including all medical practices, hospitals, and health resorts. The entire healthcare system, then, was subject to the authority of the Gosplan. Furthermore, Article 120 of the 1936 Constitution guaranteed every Soviet citizen “the right to maintenance in old age and also in the case of sickness or loss of capacity to work.” Along with its guarantees of employment and free education, the Soviet government revolutionized healthcare through its guarantees of free medical care for all citizens (Sigerist 1937, pg. 52-53). All guarantees were based in the Soviet leaders’ interpretations of communist ideology.

Unlike other areas of Soviet policy, however, the main goals of the healthcare system did not change significantly based on the interpretation of individual leaders within the Communist Party. Short-term flexibility drove variations in other areas, such as, most prominently, in foreign policy. Significant differences in diplomacy and approaches to the communist idea could be seen from Stalin to Khrushchev, and even
from Khrushchev to Brezhnev (Bauer, Inkeles, and Kluckhohn 1957, pg. 82-85). However, the central characteristics and operations of the healthcare system largely remained unchanged and tied to the long-term rigidity of communist ideology until Gorbachev’s attempts at major reform during the perestroika era. The healthcare system throughout the existence of the Soviet Union focused on the free provision of basic healthcare to all citizens, with access to healthcare understood as a basic human right to which all were entitled.

Though the central tenets remained stable throughout the history of the Soviet Union, individual initiatives and programs changed over time. These changes were often subject to global conditions. World War II led to a redirection of resources toward the war effort, as it did in many countries. There were also slow changes throughout Soviet history of research programs, which were aimed to address the most pressing problems of the day. As Judyth Twigg has emphasized in her reports on possible cooperation in healthcare research between the United States and Russia today, some of the Soviet research programs involved close cooperation with the United States, even during the height of the Cold War. The creation of the polio vaccine provided a perfect example of the potential for Soviet medical research, as Dr. Mikhail Chumakov, a Soviet scientist, successfully perfected a version of American Dr. Albert Sabin’s vaccine so that it could be delivered orally. Similarly, it was collaboration between American and Soviet scientists that helped to eradicate smallpox (Twigg 2009, pg. 8). The achievements of the research arm of Soviet medical care seemed to demonstrate a clear potential for effective and groundbreaking healthcare in the Soviet Union, especially when considering the

15 An impressive, but sadly, short-lived, example of this cooperation can be found in the volumes and mission of the American Review of Soviet Medicine, published from 1943-1948.
Soviet health system’s encouragement of uniting medical practice with research.\textsuperscript{16} However, that flexibility proved to be constrained to areas of medical research, rather than practice.

Despite the Soviets’ scientific achievements in health, the daily implementation and administration of healthcare to its own citizens resisted change, both ideologically and institutionally. As with the greater ideology of the Soviet Union itself – and perhaps even more stringent than it – the political-ideological framework driving the health system, rather than providing a guiding light subject to interpretation within changing political and social contexts, gave an unbending structure within which health personnel were forced to solve a myriad of problems with the same small set of tools. This limited capacity for adjustments over time proved to be a key component of the slow demise of the Soviet healthcare system. The simultaneous nationalization of industry and subsequent push for rapid industrialization would, over time, require an even more extensive healthcare system than had been provided under the tsarist regime or even during the early years of Bolshevik control (Kaser 1976, pgs. 38-40).

In December 1969 the system was officially extended across all of the republics that had fallen under Soviet control since World War II. This law, titled “The Principles of Legislation of the USSR and Union Republics about Health Care,” outlined the roles of the various levels of government and party institutions, as well as the priorities and

\textsuperscript{16} Field (1967) shows that this approach of encouraging both research and practice was taken seriously, with “most Soviet health officials working at the Health Ministry USSR insist[ing] that they either practice medicine or do research or both, in addition to their administrative responsibilities” (pg. 46). While many doctors both researched and practiced daily, however, there was no structured way to bring research to the forefront when it came to patient-visits. Instead, the research focused on groundbreaking vaccines and other major prevention issues, following the Soviet’s prioritization of infectious diseases over longer-term healthy lifestyle problems.
norms to be followed across all republics. It was in this piece of legislation that it was officially designated that all citizens of the USSR had a right to free access to medical care provided by the state (Supreme Soviet of the USSR 1969). While there had been earlier guarantees, many of these had been formally or informally set aside when priorities shifted during World War II, and initially had only included the original republics, to be expanded slowly over time (Kaser 1976, pg.38-39).

Healthcare reform in the 1960s and 70s fit into the larger economic picture of the Soviet Union consisting of what Millar (1985) dubbed Brezhnev’s “Little Deal.” During this time, petty market activities – activities that were considered illegal or questionably legal, or nalevo activities – were tolerated (Millar 1985). Unlike in the Stalin era, when fear of violence shaped incentives for or against illegal activities, the attitudes under the Brezhnev era appeared strict but tolerable. Most of the services offered filled gaps that were insufficient in the Soviet economy as it stood. Private medical care on a small scale sprung up at this time, along with other services offered in petty marketing activity (Millar 1985, pg. 699-700). Unlike the corruption or side private practice amongst doctors that had happened for decades – for example, the demand by some medical personnel for extra fees, thought to be motivated by their very poor pay (Sigerist 1937, pg. 119) – these marketeering efforts were on the edge of legality; the strict stipulation was that people could not be openly acting as capitalists and making a profit. This is not to say, however, that they were legal and clear. It was, instead, Brezhnev’s political decision to not concern himself with these small activities. However, the Central Committee’s lack of attention to these issues and preoccupation with defense led not to
better outcomes, but rather to dramatically deteriorating health conditions (Field 2002, pg. 167).

By the 1980s, the efforts of the Soviet healthcare system had been realized in many ways. Most of the union republics in the USSR were comparable in terms of healthcare statistics (access and outcomes), though some variation still existed. Mezentseva and Rimachevskaya (1990) reported that birth and death rates were largely converging over the last two decades of the Soviet era, with the exception of one or two republics.\footnote{One consistent outlier republic in the statistics is today’s Turkmenistan, which is likely because of the extreme poverty of the area and its very low level of development, as well as the lack of reliable information coming from its government. This trend in unreliable reporting still continues with Turkmenistan today.} This demonstrates that the Soviet system’s goal of equality was, on a macro level, achievable. However, there are questions on how reliable the information was, as there was no well-developed information system. Instead, as will be discussed more below, the central Soviet government and Communist Party officials relied upon the reports of local officials to understand the health conditions across such a vast and diverse area.

### 3.2.2 Structure and Administration

Like much of the Soviet Union, the administration of health services fell mainly under Communist Party control. While the Supreme Soviet – and the Presidium when the Supreme Soviet was not in session – was technically the highest state power in the USSR, and therefore, according to the Constitution, held the greatest authority over the Soviet healthcare system (Field 1967, pg. 76), it was the Communist Party’s directives, and, in particular, the Plan, that determined the workings of the state-run healthcare system. As in all of the Soviet Union, the Communist Party was the true center of power in
healthcare. The Party’s role within the healthcare system involved, but was not limited to, the spreading of communist ideology through the workings of the system, including through the encouragement of fighting diseases for the purpose of creating a greater USSR, the training of doctors to embody the communist ideals, and the establishment of the system’s goals through the Five-Year Plans (Semashko 1934; Sigerist 1937; Field 1957).

Though there existed more decentralization on a day-to-day basis than in other policy areas, the healthcare system of the Soviet Union remained, for the most part, very highly centralized, both administratively and financially. Health authorities created the central plan for the healthcare system in coordination with the general economic plan of the Soviet Union. The Council of People’s Commissars of the USSR (Sovnarkom until 1946) had the legal authority for the approval of the full plan across the entire healthcare system, though their decisions largely fell under, and indeed, were never independent of, the influence of the Politburo, the highest policy-making organ of the Communist Party. The design of the plan involved all levels of party and government officials. After each health department locally and regionally gathered statistical data on the mortality and morbidity rates, as well as on the industries – especially the important factories and collective farms – in their areas, they would devise the plan based on how to best reach the central economic plan’s goals within their jurisdiction. This included both prophylactic and curative goals, as well as budgets for the financing of the system. Finally, after the writing of each locality’s plan, factory meetings were held in order to confirm the plan’s coordination with the interests and needs of the workers before
sending the findings to the Council for the coordination and approval of the central plan (Semashko 1934, pg. 44-46).

While the federal party organs established the ideology, health outcome goals, and budgetary limits that guided the health system as an institution and directed it through the Five-Year Plans, regional otdeli (departments) and local soviets oversaw the day-to-day administrative tasks of implementing the central directives and providing healthcare to Soviet citizens. Union republic ministries were responsible for the supervision of those tasks and especially the fulfillment of the plan. The Soviet health system was structured in a more decentralized manner than other economic institutions, as the Ministry of Health was part of a collection of “union-republic ministries,” which administered policies through a ladder of state organs down to the local level (Field 1967, pg. 77). Each union republic had its own Ministry of Health (with the Minister being a member of the republic’s Council of Ministers) that was then responsible for the relaying of the Council of People’s Commissars of the USSR’s directives on planning and financing quotas and initiatives to the regional and local levels, as well as for writing republic-level health legislation. Finally, regional and local officials oversaw the implementation of those policies on the ground and communicated information back to the union republic Ministry of Health about results and problems that needed to be addressed. This system gave the union republics relatively more independence in policy administration than was seen in systems under the control of all-union ministries, such as

18 The other category of ministries was comprised of the “all-union” ministries, which were directly involved in the administration of their policies throughout the Soviet Union (rather than simply handing down directives). The Ministry of Defense was one example of this type of ministry. See Field 1967, pg. 77, for a brief discussion of these two distinct categories.
those involving international trade, diplomacy, or defense. However, the system remained extremely centralized under Communist Party control.

Most of the finances for the healthcare system came from tax-funded local budgets, but central authorities determined the specific percentage of those budgets allowed to be put toward healthcare. The state budget provided financing as well, focusing especially on the funds for the institutions understood as important beyond the local context, such as hospitals, sanitorii (health resorts), and research centers. Financing for the central actors of the Soviet system according to communist ideology – the workers – came from what were called “social insurance” funds, the majority of which was turned over to the state to be added to the general financial plan and, in turn, administered by the state-run trade unions (Sigerist 1937, pg. 84-85). This was meant to help equalize services across the urban-rural, developed-underdeveloped divides across the USSR. Employers paid a specific amount per employee into these funds, with that amount being pre-determined by the central authorities based on the importance and danger of the work in that institution in terms of the USSR’s central economic plan. These funds were then used to pay both for basic medical services and for other general welfare needs, such as pensions, housing, and education. In 1931 and 1932, the amount spent on medical services equaled 479.2 and 701.5 million rubles, from a total social insurance fund of 2,614 and 4,120 million rubles, respectively – amounts equal to 18.33% and 17.03% of

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19 It should be clarified and emphasized that the “social insurance” of the Soviet Union was not organized in the same way that we might think of social insurance today. Today, most social (medical) insurance institutions are separate entities from other state-run institutions, meaning that the funds are not redistributed to other areas of welfare or to the general budget. Furthermore, the distribution of the funds is not centrally determined as it was under the Gosplan in the Soviet Union. However, “social insurance” in both the Soviet Union and today is created as a way of guaranteeing healthcare to citizens so that there is no question when one falls ill as to whether medical services can be attained.
the social insurance funds. These funds were in addition to the general budgetary funds provided by state and local budgets for medical treatment, with the social insurance funds only being provided for employed working-age adults. They made up 48.1% of the general healthcare budget in 1932 (Semashko 1934, pg. 134-137). The percentage of GDP committed to healthcare, however, decreased over time dramatically, moving from 6-6.5% in the 1960s to approximately 2-3% at the time of the collapse (Field 2002, pg. 167). This demonstrated that the state’s concerns, in the long term, were not focused on health.

The communication between the union republic ministries of health and the local and regional government officials implementing the policies consisted mainly of letter writing and testimonials at the union republic Ministry of Health meetings. Every year at one of the first meetings of a union republic’s Ministry of Health, the members would discuss major concerns conveyed in letters from the previous year. Many of these letters included complaints about the quality of service and, most often, access to primary care, which government officials blamed on a lack of information about services given to citizens by the health departments (MoH Ukrainian SSR 1987a, pg. 15). However, many of these discussions resulted in no significant action taken to change those conditions, as the overall political-ideological single-plan framework continued to determine the priorities of healthcare institutions.

Discussed more below, statements from doctors invited to the Ministry of Health meetings, while officially recorded, did not play significant roles in the shaping of the healthcare framework. Instead, they served as reporting mechanisms for the Ministry, which collected the information in meeting minutes so as to communicate policy
outcomes to the USSR Ministry of Health if and when needed. Like in other professions, doctors were seen as a possible threat to Soviet power and therefore were refused the freedom to create self-governing institutions (Bauer, Inkeles, and Kluckhohn 1957, pg. 65; Field 1957). Considered a remnant of the old class system of the tsarist era, even the taking of the Hippocratic Oath was abolished in post-revolutionary Russia, as it “symbolized bourgeois medicine and was considered incompatible with the spirit of Soviet medicine” (Field 1957, pg. 174).

Though doctors and healthcare personnel held few formal legislative powers or even social power, they were often entrusted with the relaying of information on major health patterns and for providing guiding expertise to the regional and local state officials. The republic Ministry of Health meetings very often included statements given by doctors on outbreaks, hospital conditions, and the results of policy implementation. The system significantly relied upon this expertise rather than on the results of evidence-based medicine, which started to take the place of expertise-driven advising in the rest of the world in the 1970s and 80s. Though these statements by doctors at Ministry of Health meetings rarely changed legislation or the overall health framework, they were treated as justification for the actions taken by medical personnel in certain regions or institutions. While technical expertise can provide important insights into possible courses of action, the Soviet Union’s heavy reliance on it for the daily administration of its healthcare left the system even more vulnerable to manipulation by individual and group interests.

3.2.3 Access and Health Outcomes

The state-run Semashko system significantly improved access to healthcare throughout the Soviet Union. Based on either a person’s residence (the majority of the
population) or occupation (certain ministries and administrations – mainly those considered most important to the national economy), each citizen was assigned to an outpatient polyclinic. These polyclinics both had specialists and were connected to specific hospitals. Therefore, a rationalized plan determined each person’s nearest point of care, eliminating questions of access to services (Field 2002, pg. 164-167). Free access to healthcare remained one of the aspects of the Soviet system that even those immigrating to the United States continued to support (Inkeles and Bauer 1959).

The distribution of resources throughout the Soviet healthcare system, like the fundamental ideology, was centrally planned and monitored based solely on quantitative goals. The number of doctors per 10,000 people and the number of hospital beds per 10,000 people were the main statistics by which Soviet officials measured success. The number of doctors increased dramatically throughout the Soviet era, bringing the numbers from a dismal 1.5 doctors per 10,000 patients in 1913 Russia to a world-leading 42.8 doctors per 10,000 people in the USSR by 1986 (Ryan 1989, pgs. 2-3). The Communist Party and Soviet government put significant efforts into the equalization of access to services, especially in the late 1960s and early 1970s. Hough (1977) demonstrated the significant differences in numbers of hospital beds per 10,000 people that could be calculated using the officially published figures (pgs. 160-169). As he emphasizes, the dynamics of the rural-urban divide changed somewhat with the full introduction of a truly USSR-wide health system in 1969 and the apparent decentralization of healthcare authority in the late 1960s and early 1970s. Before this, the

20 With these statistics, the reporting strategies can make a difference. Ryan (1989) discusses briefly the slight distinctions in counting, particularly with regard to dentists, which may have resulted in small differences between the Soviet numbers and those of other countries (pgs. 2-5).
distribution of resources in the Soviet health system remained similar to the distribution under tsarist rule, with rural medical care neglected by state authorities (Kaser 1976, pg. 36-37). After the move to unify the system under one structure but decentralize the administrative decision making, the differences between regions became less of a result of the rural-urban divide and more subject to political factors.

Like with education, under Soviet rule many of the important basic health outcomes improved, particularly those regarding infectious diseases and vaccination rates. For example, in 1959, 15,200,000 people received the new orally administered polio vaccine in the Soviet Union, and in 1960, an estimated 77,478,800 people did so (Chumakov et al 1961). These impressive mass immunization efforts not only improved the rates of such diseases in the Soviet Union, but they demonstrated the effectiveness of such vaccines and vaccination drives.

Immediately following World War II, the crude death rate (number of deaths per 1,000 people with no controls for age) and life expectancy at birth (the number of years one can expect to live from the moment of birth) in the Soviet Union reached their all-time low and high, respectively. The crude death rate stood at 6.9 per 1,000 people in 1964, and by the late 1960s, life expectancy at birth for males reached about 66 and appeared, at the time, to be climbing. The rates of infectious diseases decreased significantly under Soviet rule, though deaths from cardiovascular and cancer-related deaths continued to increase at rates higher than those in other industrialized countries and, most concerning, continued to increase even for more treatable forms of the diseases (Feshbach 1984).
While the overall statistics of healthcare in the Soviet Union would seem positive, there were growing concerns about the priorities of the system over time. While the number of doctors per 10,000 people does indicate the very basic level of accessibility in a country, it does not take into account the distribution of those doctors or to which specialties those doctors belong. Many medical personnel worked in terrible conditions, and doctors were not given any higher status based on their level of education or specialty, which led to many disincentives to perform at the highest standards (Field 1957, Field 2002). These conditions are discussed more in Section 3.3.1.2 below.

Unfortunately, even the changes in the late 1960s and early 1970s did not improve dramatically the obstacles of getting doctors and nurses to work at a higher standard despite poor conditions or of transporting medicine and medical equipment to very rural villages, with much time in Ministry of Health meetings devoted to the discussion of doctor assignments and the distribution of resources. The USSR’s overall drive for numbers of doctors, stemming from the early years of Bolshevik rule when doctors were needed to help support the military and political struggles taking place throughout the country, continued to dominate the agenda for healthcare officials. And during times of war, numbers often matter. The Soviet Union’s approach to medical care, therefore, worked well during war and crisis, such as World War II or the push for the polio vaccine. However, this “numbers drive” continued even during times of peace and relative prosperity. The emphasis of quantity over quality, as a result, developed over time into the basis of dysfunctionality of the Soviet healthcare system (Ryan 1989).

Basic health indicators slowly declined over time. After reaching that all-time high in the 1960s, life expectancy steadily decreased until the late 1980s. Infant mortality
increased even when controlled for geographic region and ethnicity. During much of this time (1974-1986), the Soviet government forbid the publication of mortality data, forcing scholars to construct and re-construct the data from various available sources (Shkolnikov and Meslé 1996). While studies have pointed to the role of alcohol and the significant improvement in health indicators under Gorbachev’s anti-alcohol campaign in the 1980s – highlighting the importance of health lifestyles in affecting mortality rates, particularly in Russia – these behavioral factors do not completely account for the significant drop in life expectancy and rise in mortality rates, particularly infant mortality, over the long term, as the failure of the healthcare system to address the rise of noncommunicable diseases and to introduce a stronger focus on preventative care over time became apparent (Feshbach 1984; Ellman 1994; Shkolnikov and Meslé 1996).

3.3 Perestroika and the Collapse of the Soviet Union: The Unsustainability of the Semashko System

Beginning in the 1960s, Soviet health indicators began to show signs of significant problems within the healthcare system. Despite efforts to fight these trends, the healthcare system continued to decline. By the mid-1970s, the government ceased official publication of many of the main health indicators, including infant mortality, life expectancy, death rates by gender and age group, the urban-rural distribution of doctors, and more (Feshbach 1984, pg. 80). While the leading cause of death – coronary diseases – matched patterns seen in other industrialized countries, its increase rather than decrease over time indicated larger structural problems. By the 1980s, “[p]erhaps the greatest damage to the state mythology was inflicted by the gradually divulged enormity of the healthcare crisis in a country where free medicine had from the very beginning served as
a key legitimizing symbol” (Aron 2000, pg. 282). The need for significant change had become undeniably clear as the Soviet Union entered its last decade of existence.

With Gorbachev’s introduction of *perestroika* in the 1980s, the Soviet government also introduced a new norm of questioning existing institutional structures. Already subject to a more decentralized structure than other economic areas, the ministries of health of the union republics were often left to interpret this new concept of “restructuring” (especially in tandem with the concept of *glasnost*, or “opening”) for their own populations. The central government’s directions on the matter were vague and far from instructive for how this new idea should be applied in various fields and at different levels of government. Long discussions on the matter took place even in the union republic Ministries of Health, where the difficulties of introducing new technologies, techniques, and planning strategies clashed with the inflexibility of the communist guarantee of free healthcare for all (MoH Ukrainian SSR 1987b). Government officials and doctors alike were confused about whether this meant a full change of the system or whether it simply meant minor adjustments to the everyday running of medical institutions – but they were also still more concerned in their discussions about adequately addressing local problems within the communist framework.

### 3.3.1 Three Major Challenges

What were the characteristics that made the Semashko system unsustainable in the long run? Why were there not minor adjustments made, adapting the institutions to the changing health landscape? Three major issue areas explain this unsustainability: financing problems, principal-agent problems, and effectiveness and provision problems.

#### 3.3.1.1 Financing Problems
The Soviet healthcare system centered on a tax-funded allocation of resources. This meant that no specific healthcare fund existed, but rather that each year, the central government determined what proportion of the general budget should be distributed as healthcare financing. As a result of this financing structure, two main problems arose: the over-commitment of government finances and the competition of healthcare funds with other state concerns.

The first financial problem, that of the over-commitment of government funds, stemmed from the inability of the Soviet government to keep up both its commitment to keeping medical care free to all citizens and rising costs of both medical equipment and pharmaceuticals. While the Soviet government sought to create a relatively self-sufficient medical system, with the best equipment and drugs being produced domestically so as to avoid the pressures of market pricing, it failed to consider the pressure of global medical trends and innovations. With only a small percentage of GDP going toward medical care – only between 3 and 4% in the last years of the Soviet Union, with some estimates as low as 2% at the time of collapse – there was simply not enough funding allocated to the medical field to both serve the population adequately and continue to innovate at the same rates as other middle-income and high-income countries (Field 2002, pg. 166-167).21 Over time, this burden on the government grew exponentially, as innovations and pricing in other industrialized countries continued to grow and put the Soviet Union further and further behind in its approach (Desai 2006, pg. 310-314; White 1995).

The second challenge in financing, that of the competition of healthcare funds with other state concerns, was rooted in the budgetary nature of resource allocation. Because there were no specific taxes or health funds toward which resources could be distributed, healthcare had to compete with other important government departments – defense and security and trade, for example – for prioritization. While Soviet officials recognized the importance of healthcare as a fundamental need to sustain even those areas with which it was competing (for example, without healthy individuals, how could factories be run or wars be fought?), there was tremendous pressure for the government to focus on security and economic issues above social welfare problems. The urgency of those issues far outshone the slowly deteriorating health patterns that were taking place during the last few decades of the Soviet Union’s existence. Therefore, healthcare funding was based on a “residual principle” – that is, first resources were allocated to what seemed to be more pressing areas, and healthcare was distributed what could be spared afterward (Mezentseva and Rimachevskaya 1990). This tendency of the Soviet government to relegate healthcare to a lesser tier of concern – despite speeches and calls for attention to health by high-ranking officials (Kaser 1976, Feshbach 1984) – in combination with the growing gap between Soviet and global trends in medical care, left the Semashko system desperately wanting by the end of the 1980s.

3.3.1.2 Principal-Agent Problems

The second area of major trouble for the Soviet healthcare system was in the obstacle of rogue – or, at least, independently minded – officials at the subnational levels of government. As mentioned above, the communist system of social benefits, including medical care, relied upon the principles of universality and equality to set itself apart
from other, Western, capitalist systems. This assumed a universal obedience by
government officials to the Communist Party and its ideology, as well as to its laws and
decrees, regardless of location or conditions.

However, there were many holes in this structure of subordination, particularly
with regard to medical care. Officials oftentimes took the initiative to address the local
problems as needed, and the administrative structure of the system incentivized such
behavior. As Hough (1977) emphasized in his chapter examining the role of local organs
of power in determining the number of hospital beds in an RSFSR region, the totalitarian
models of power suggested by some of the literature inadequately take into account how
varied the decision-making characteristics may be at subnational levels. A 1969-1971
study of the effects of orders given from regional to local-level health departments, for
example, found that they had very little effect (Kalyu 1975, as cited in Ryan 1978, pg.
13). Hough’s (1977) examination of the patterns of the number of hospital beds similarly
suggested that regional and local actors, rather than objective urban-rural ratios,
determined increases in numbers of hospital beds due to decentralization of
administrative decision-making authority in the late 1960s and early 1970s. These
patterns of local autonomy regarding health issues outside of central government
departments originally stemmed from the tsarist system of healthcare, in which doctors
were often independently working in rural areas (zemstvo physicians), as well as the
heavy reliance in Soviet healthcare on expert opinion, rather than evidence-based
medicine (Frieden 1981, Lekhan et al 2010).22

22 Ryan (1978) similarly notes that even in the tsarist system, the government provided medical
care through various institutions, including its departments of trade, education, armed forces, and
more (pgs. 5-6).
The lack of a strong centralized communication and information system resulted in asymmetrical relations amongst government officials, and the dearth of mechanisms to ensure horizontal, as well as vertical accountability meant that much trust was placed in local health officials and their report on conditions. This contradicted the universal nature of the Semashko system and the Communist Party’s welfare benefit structure. While it may have allowed for some efficiency in addressing local issues, it did not create incentives for developing creative problem-solving skills. Instead, it was left to the regional and local officials to determine the best course of action, often resulting in the least costly course of action being taken.

Furthermore, with the salaries of medical personnel determined by the state regardless of quality or skill – and set at only about 70% of the salary of the average non-farm worker and lower than the wages for most bus drivers by the end of 1991 (Randolph 1991; Rowland and Telyukov 1991) – medical professionals had no economic incentive to perform difficult procedures, to work in more difficult conditions, or to cure patients effectively. Because financing was determined by the number and filling of hospital beds, there were incentives to see as many patients per day and to commit them overnight, rather than to provide quality care based on best outcomes or patient choice. Run ragged by the numerous patients seen every day – Feshbach reported that one polyclinic saw an average of 1,300 patients per day, as opposed to the number that the work norm at the time set at 260 patient-visits per day (1984, pg. 81) – medical personnel had very little incentive to provide quality over quantity in medical care. By the end of 1991, many doctors reported switching to “less depressing and more lucrative” jobs and, for those that
were able, emigrating to the West, where pay for medical professionals was much higher (Randolph 1991, pg. A14).

Once more, as with the financing issues, the Soviet Union’s rigid commitment to measurements of success by numbers and to community-driven, rather than economically driven, motivations, led to development of perverse incentives within the Soviet healthcare structure itself. Despite calls for the better training of doctors (Feshbach 1984) and medical personnel’s demands for higher incomes which the government failed to meet (MoH Ukrainian SSR 1986), the system continued to collapse with little incentive for anyone to save it.

3.3.1.3 Provision and Effectiveness Problems

Beyond financing and administrative issues, the Soviet healthcare system also suffered from performance failures. While there were many advances during the Soviet era in areas of infectious disease research and prevention and while most citizens technically had access to care (though the quality was lacking), the overall report card for the Semashko system by the end of the 1980s was dismal. These performance issues were based in two areas: provision and effectiveness.

First, universal provision of healthcare, while a key feature of the Soviet healthcare system, remained reliant on very specific communist social and political structures, hindering them from adapting over time to demographic, economic, or political changes. Much of Soviet healthcare was distributed through places of employment. Though this seems reasonable in a society in which the employment rate is tagged to be 100%, it leaves no room for any deviation from that economic structure. That is, the homeless and unemployed were left to the whims of government funding to
cover their access, something that did not always provide adequate provision as was imagined. Furthermore, when the transition to capitalism took hold and unemployment rates skyrocketed, access to healthcare fell dramatically, even while employers still provided their own medical systems. Even during the Soviet era, the existence of these parallel systems of medicine through employers challenged the communist principles enshrined in the founding of the Semashko system. The prioritization of better healthcare for “more important” people as defined by their employment continued to serve as a central pillar throughout the Soviet era (Field 1967). As mentioned in subsection 3.3.1.1, the parallel systems across government ministries competed directly with the Ministry of Health for funding, with the military posing the greatest threat. Furthermore, some industry employers were able to provide better healthcare systems than others, meaning that the concept of equality too was challenged. Even today, after the privatization of some of these parallel systems, the legacies of these inequalities still exist; for instance, the healthcare system run by joint-stock company Russian Railways (RZD) ranks far above other systems in quality, and it has even been argued that the managers of the railway’s healthcare institutions should be included in helping to improve the wider state medical system (Atkov and Ulumbekova 2011, pg. 256).

Second, the effectiveness of the Semashko system in its goal of keeping the Soviet populations healthy slowly eroded over time. As discussed in subsection 3.3.1.2, the preference for expert opinion over evidence-based medicine, which was being adopted in much of the rest of the world, led to less rational planning and distribution. Instead, this allowed for principal-agent problems in administration and provided opportunities for interests to creep into what was meant to be a universal, Soviet system.
The rise of non-communicable diseases as the leading cause of death also challenged the structure of provision and the medical approaches prominent in the institutions, as the Semashko system had been built on the basis of fighting infectious disease epidemics and caring for the victims of crises, such as wars and revolutions. It was a system best utilized in urgent war-like conditions, rather than one for the prevention of larger unhealthy lifestyle trends.

The declining health indicators served as important evidence of a slowly developing crisis in the medical structure. As reported by Feshbach (1984), the crude death rate reached its lowest point in 1964, at 6.9, and by 1980, this had increased to 10.3. At the time of writing, Feshbach found that the estimate for male life expectancy at birth was only 61.9 years, down from 64 years (the last officially reported figure in 1971/72), and down even further from the previous rates in the 1960s. By 1990, this number had improved slightly to 63.7 years, but still remained 10.6 years lower than life expectancy at birth for females in the Soviet Union, and both figures remained significantly lower than the increasing life expectancy in other industrialized countries (Popovich et al 2011, pg. 10). While life expectancy is subject to individual behaviors, this alarming trend indicated a deeper structural problem. Similarly, infant mortality, having increased by more than 20% between 1971 and 1974, showed that alcoholism amongst males of middle age was not the sole issue in the declining health indicators (Feshbach 1984, pg. 81).

Immunization efforts also began to decline in the 1980s. In 1980, the Ministry of Health of the USSR adopted a new and more extensive list of accepted contraindications (reasons for not receiving certain medical care) concerning the diphtheria-tetanus
toxoids-pertussis (DTP) vaccine, which is often blamed for the later epidemic of diphtheria among children in Russia in the 1990s (Tatochenko and Mitjushin 2000). Health officials began to re-analyze vaccination efforts, and, while the statistics showing the number of doctors and hospital beds per 10,000 people continued to increase during this time and the rates remained high relative to many other countries, the efforts put toward immunization drives slowly decreased as decentralization was implemented.23

Interestingly, this contradicts the idea that more medical care needed to be provided to fight the downward health trends. As mentioned in the subsection above, salaries were set regardless of skill, and financing of hospitals was determined by quotas set by the state and based on input factors, such as the numbers of patients seen and hospital beds filled, rather than on health outcomes. As was seen in other economic areas of the Soviet Union, the incentive system prioritized quantity over quality, leading to negative outcomes. These counterintuitive statistics reveal the redundancies in a system forcibly following set quotas throughout the Soviet Union. It was not the health legislation or directives that were killing the Soviet people – it was the structure and administration of the system itself.

These three major challenges in the areas of financing, administrative, and implementation made the extremely rigid institutional structure of the Soviet healthcare system inherently unsustainable in the longer term, particularly in light of global trends in the second half of the 20th century.

23 There were reports of shortages of middle medical personnel during this time, but the number of doctors specializing in specific diseases and practices continued to increase (Feshbach 1984, pg. 81).
3.3.2 Toward Today’s Healthcare System Models

There were some attempts during the perestroika era to address the pressing concerns with the Semashko system discussed above. The core approach tested during this time was the further empowerment of local officials. Gorbachev believed that giving local health officials even more power would help to solve the rising demographic concerns of increasing non-communicable disease rates and limited access to more advanced healthcare facilities.

In the latter half of the 1980s, a “New Economic Mechanism” project was piloted in the regions of Kemerovo, Samara, and Leningrad in the RSFSR. These projects looked to introduce new financing mechanisms moved away from tax-based general budgetary funding and toward more specific health funds run through more knowledgeable local and regional officials (MoH RSFSR 1990). While initially successful, these projects collapsed with the failure of perestroika and the collapse of the Soviet Union. The overall reform strategies explored during the perestroika era included

“(1) the elimination of central resource allocation and control by the central Ministry of Health and return of decision-making authority to the individual republics; (2) greater reliance on the “enterprises” to help finance medical care through the workplace, as a prime source of additional revenue to supplement public spending; and (3) experimentation with medical insurance and the use of incentives to improve provider participation, as a way to bring innovation and motivation to the stalled system.” (Rowland and Telyukov 1991, pg. 84)

While these strategies sounded promising, attempts to implement them were often half-hearted and chaotic with under-developed frameworks.

In 1990 and 1991, republic-level Ministries of Health began discussions on how they were planning to reform the system and what type of system to introduce (MoH Ukrainian SSR 1987b; MoH RSFSR 1991). This appears to indicate a widespread
consensus that the tax-based, universal Semashko model was not working and could not be sustained financially. Yet it does not suggest that officials were ready to give up the Soviet ideals of universality and equality. Instead, they believed that a simple change in the financing mechanisms would gather the necessary funds more efficiently. At the meetings, they discussed a change to an independent insurance fund-based model, much like that of Germany (the Bismarckian model), in which contributions from income would be made to sickness funds specifically set aside for healthcare, administered by insurance institutions relatively independent from state control. These systems include freedom for the insurance company to negotiate prices with hospitals, a purchaser-provider split that had not existed in the Soviet system, in which the state both provided and purchased health services.

The initial movement toward this type of model is not completely surprising – there had been a general movement across Europe toward these types of insurance-based models with mixed private-public responsibility. A restructuring along these lines, according to supporters, would have both protected health funding from competition with other ministries, and required contributions directly to health funds, rather than to the general state budget, something that should (in theory) reduce the possibility for corrupt use of the money. Again, these discussions were taking place before the Soviet Union collapsed, and even before the events of August 1991, suggesting that these deliberations did not simply occur in reaction to the dissolution of the USSR. Rather, there were fundamental problems with the Semashko system coming to light over the decades.

However, though these discussions were taking place, there was no real action toward change during this period. Government officials and medical personnel, while
discussing possibilities for changes at Ministry meetings, continued to spend most of the meeting time addressing local or regional medical conditions and took for granted that the Semashko system in its basic features – universality and equality – would continue to exist and that the changes being considered would take place within its larger framework. Both the government and its citizens continued to admire the achievement of “lethal free medical care” under the Soviet regime (Remnick 1994). It was only with the collapse of the Soviet Union, and the development of a critical juncture as a result of that event, that real change could finally take place in the healthcare systems across the former USSR. I discuss this critical moment in the next chapter.
Chapter 4
The Critical Juncture of the 1990s

“[W]e were told [by our American counterparts], ‘Why did you take off her clothes? We understand that you can take off what is torn, but why criticize so much...that nothing is left? It is the fundamentals of health, which you need to reform in the existing conditions. Why abandon it?’”
- Dr. Y.P. Lisitsyn, Head of the Department of Social Hygiene and Health Organization of the 2nd Moscow Order of Lenin Medical Institute [now – RNMU], MoH RSFSR 1991, pg. 108.

4.1 Introduction

On December 25, 1991, at 7:32pm, officials lowered the communist flag over the Kremlin for the last time, with only solemn chimes ringing from the Spasskaya Tower to mark the momentous occasion. The Soviet state had died (Schmemann 1991, pg. A1). In his farewell speech, Mikhail Gorbachev, the last leader of the Soviet state, insisted that:

“As the economy is being steered toward the market format, it is important to remember that the intention behind this reform is the well-being of man, and during this difficult period everything should be done to provide for social security, which particularly concerns old people and children.”
(Reuters 1991, pg. A12)

Whether Gorbachev meant them as words of caution or inspiration, his statement on the importance of social safety nets in the transition period rang true in a far more dramatic fashion over the next few years than anyone could have imagined on that wintery day. Over the next several years, the turmoil of economic and political transitions took its toll on all major welfare institutions; and nowhere was the stress greater than in healthcare.

In this chapter, I explore how the 1990s served as a critical juncture for major healthcare reforms in the former Soviet states. In particular, I discuss the strains on the healthcare system at the time, including the direct impact of the transition on funding and
resources, as well as the indirect impact through rising unemployment, lack of food and basic supplies needed to maintain health, and increasing rates of both mental and physical ailments resulting from the harsh economic conditions. I connect these to the inherited institutional failures of the Soviet healthcare system discussed in the previous chapter, showing that the political, economic, and organizational crises surrounding healthcare constituted a critical juncture at which decision makers made significant choices concerning their healthcare reform paths. I argue that those governments that did not take advantage of the transitional moment for healthcare reforms relegated themselves to progressively more difficult conditions for reform in later years, as the economic and political transitions also created openings for the development of special interests that would soon serve as obstacles to major reform efforts.

The chapter is laid out as follows: First, I discuss critical junctures as they relate to healthcare reforms and why the 1990s in the former Soviet states constituted a clear critical juncture. Second, I discuss the decision making during the 1990s and the various reform trajectories produced by those decisions. Finally, I discuss the Russian and Ukrainian cases in detail, demonstrating that the reforms made by the Yeltsin, Kravchuk, and Kuchma administrations follow the patterns of decision making we would expect when political elites are aware that their decisions will have long term consequences, and when they are discussing a policy area connected to cleavages that threaten the stability of the state.

4.2 Critical Junctures and Healthcare Reform

Critical junctures are, as discussed in Chapter 1, situations “in which the structural (that is, economic, cultural, ideological, organizational) influences on political action are
significantly relaxed for a relatively short period” (Capoccia and Kelemen, pg. 343). Such situations allow for new institutional paths to be pursued, though the decisions made can also cause institutions to miss those same opportunities for change. Elites seeking major institutional changes, which rely on politically dramatic conditions in order to overcome the effects of previous institutional entrenchment, depend upon such moments of opportunity to give them the power to implement reforms.

Healthcare system reforms are just one category of reforms that rely on the opportunities of critical junctures for major restructuring efforts. Two characteristics of the policy area determine this reliance. First, because healthcare is complex and includes many actors with diverse interests, reform in this area depends upon a high level of cooperation or a reduction in the number of conflicting interests in order to both pass and implement significant changes. Information asymmetries create barriers to reform and can significantly hinder efforts that are not coordinated across these groups. Furthermore, like any other types of major political reforms, the reasons for the reform must be perceived as legitimate. For healthcare, there needs to be an understanding that the current system is not meeting the most pressing health needs and a belief that a complete change in the system would address those issues.

The demanding conditions for reform efforts explain why many of the major healthcare system reforms of history have been the result of wartime conditions. They also explain why the collapse of the Soviet Union and the subsequent difficult decade of the 1990s proved to be such a juncture for much of the post-Soviet world. The widespread catastrophic economic conditions and the political opening provided by the withdrawal of communist power and ideology from the state and economy led to health
consequences similar to that of war (Field 1995). These conditions created the opportunity – which had been developing since the 1970s – for the introduction of a new healthcare system, one that would remain robust in the face of both political and economic devastation. The demands of the quickly rising death rates led to the de-legitimization of the Semashko system, which, between its irrational capital investment plans and over-commitment of dwindling government resources, could not both survive the transition and protect the population efficiently. Therefore, if there was a moment to change the system, this was it.

Importantly, the processes of liberalization and privatization, and the choices associated with the speed and depth of their introduction, impacted the healthcare reform process through the introduction of a variety of interests. These groups included pharmaceutical companies, biotechnology companies, medical personnel unions, and even international and non-governmental organizations. Over time as these interest groups developed, the critical juncture or opening during which the government had enough autonomy to legitimately change the system quickly closed. Special interests sprang up and developed with the opening of civil society and the reduction in restrictions on such groups in the region. These special interests over time began to use their leverage – in particular, the useful information they held about local and regional health conditions and institutions on the ground – as a means of pursuing their preferences in policy. The detailed knowledge of how outbreaks of diphtheria – an epidemic in the former Soviet states in the 1990s (Vitek and Wharton 1998) – were affecting a local or regional population and the conditions in which one might better stop
that outbreak suddenly became a greater power as authority was decentralized and once
republic-level elites found themselves at the heads of states.

As more of these interests developed, it became increasingly difficult to push
through significant structural changes. Decision making about healthcare reform became
progressively more chaotic over time as interests crowded into the decision-making
institutions. Major disruptions in economic reform due to government transitions,
changes in funding, or civil war further complicated this process. By the end of the 1990s
and the beginning of economic recovery, the improved opportunity for major structural
change in the former Soviet states due to the transition had passed. From that point
forward, healthcare reforms began to take their most common forms, through the subtler
change processes that do not significantly restructure state responsibility.

In the next subsection, I discuss specifically the different crises that converged in
the former Soviet states to form a critical juncture during this period. Following my
definition of the three-part structure of the critical juncture – political, economic, and
organizational crises – legitimizing reform efforts, I show that the healthcare systems of
the region during the 1990s had a greater opportunity for change than in the years before
or after that decade. A missed opportunity at the time changed the approach to healthcare
reforms that would have to be taken after the turn of the century.

4.2.1 The Collapse of the USSR and the 1990s as a Critical Juncture

4.2.1.1 Economic Crisis

In the aftermath of the collapse of the Soviet Union, the economies of the fifteen
newly independent states suffered significantly. Economic crises, brought on by price and
trade liberalization and privatization, swept through the countries of the former Soviet
Union and the Eastern Bloc for the first half of the 1990s. Unemployment and inequality escalated, inflation gripped currencies, and macroeconomic destabilization took hold in many states, as prices skyrocketed, and industries were introduced to the effects of capitalism and international competition.

Each of the fifteen successor states took one of two main courses for economic reform at that time: the “big bang” approach or the gradualist approach. Experts argued for sound logic behind each – for the “big bang” or shock therapy approach, the idea was to reduce the length of time that the country was drawn downward by transitioning institutions. While the effect may be more brutal at the beginning, the country would recover quickly and, in the end, suffer less. For those who took the gradualist approach, the ability of leaders to introduce reforms slowly over time would allow for the country to remain stable and prevent a state from falling into chaos amidst the battle of competing forces, such as nationalist movements. The choice between these approaches strongly defined the future reform path for the former Soviet states.

The effects on the economy of these policy decisions appear in the slope and duration of changes in key data. Figures 6 and 7 below show the inflation rate as an annual percentage and the change in GDP as an annual percentage for the countries of the former USSR, excluding the Baltic states.24 As the charts clearly show, the economic crisis of the 1990s took the greatest toll on the Caucasus region. The Central Asian states, on the other hand, did not experience as drastic of a financial crisis as the states in the Caucasus region. However, the volatility created by the crisis lasted longer than it did in the Eastern European countries or Russia.

24 The Baltic states were not included due to the lack of data for the first six years (1990-1995).
Figure 6 Inflation, GDP Deflator (annual percentage)

Figure 7 Change in GDP (annual percentage)

These inflation indicators highlight the same patterns across groups outlined by Hellman (1998) in his examination of the extent of liberalizing reforms and the political causes of different economic agendas. Like other economic indicators such as unemployment (see Hellman 1998, pg. 210-211), the countries appear to fall neatly into his categories ranging from countries in war (chaotic conditions that did not allow for reforms) and slow reformers, up to high intermediate and advanced reformers, based on the speed of the introduction and implementation of economic reforms. These categories align in many ways with the pathways seen for healthcare reform trajectories, indicating a close relationship between economic reform and healthcare reform. It is unclear from this correlation, however, whether the decision making about economic and healthcare reforms were driven by the same explanatory factors, or whether healthcare reform decision making was made in response to the effects of the initial economic reform decisions.

The effects of these choices and the economic collapse on healthcare systems at that time, however, are undeniable. In the countries of the former Soviet Union, the healthcare system, a very entrenched institution, soon came under tremendous pressure to quickly adapt to the risks and rapidly increasing death rates that accompanied the transition to market economies, a phenomenon A. Zinoviev termed ‘katastroika’ during the perestroika (restructuring) years (Ellman 1994; Field 1995, 2000; Popovich et al 2011; Lekhan, Rudiy, and Richardson 2010). During the last years of the Soviet Union, spending on health constituted only about 3.4% of GDP (Cockerham 1999, pg. 36) until the rise in funding during the perestroika reforms and move toward new economic
mechanisms in the late 1980s. The heavy militarization of the Soviet Union was so extreme in the years leading up to perestroika that it had drawn resources away from the maintenance of population health, turning the Cold War into a very real experience for citizens on the ground (Field 2000).

Throughout the 1990s, spending on health failed to keep up with the needs of the population (Twigg 2000). Suicide rates skyrocketed, linked to macroeconomic conditions and high alcohol consumption (Brainerd 2001). Citizens of the former Soviet states demonstrated signs of feeling a loss of control and instability due to economic conditions, which, in addition to declining funding for health, led to increasing death rates and declining birth rates (Bobak et al 2000; Field 2000). A diphtheria epidemic raged through the region, demonstrating that such diseases could reemerge in industrialized countries (Vitek and Wharton 1998). Governments scrambled to find ways to fund healthcare and address these issues, but with state income dramatically decreasing and no existing market institutions to take its place, the picture remained bleak. The economic crisis took a toll on the healthcare system beyond what any elites could have predicted.

4.2.1.2 Political Crisis

Politics constituted a second important factor of the critical juncture. Closely related in the case of post-communist states to the opening of the economy, the political transition provided a platform for the questioning of the way in which the state functioned in the past. That is, a crisis of legitimacy developed in terms of the political design of healthcare institutions and the role of state responsibility in health.

25 It should be noted that this calculation is based on the funding designated for “healthcare and physical culture” in the state budget (Goskomstat 1991).
In the case of the post-communist states, the crisis was two-fold. First, the state’s capacity and responsibility for the financing of the system came into question because of the economic strains weighing down on the countries, as discussed in the subsection above. Second, the state’s responsibility as a decision maker for the good of the people lost its legitimacy as the economy collapsed and the community-minded sacrifice of the individual for the whole came to be less and less valued in the face of survival needs. Communism as an ideology, in connection with these struggles, faltered. The questioning of political institutions became possible, and a push in many of the countries for more effective political institutions, particularly in terms of social policies, took hold. It was this political opening that allowed the changing of the guard in some cases and a greater voice for citizens in most countries. As a result, significant reforms were made possible.

The political currents pushing the loss of legitimacy fell under two categories. First, some argue that a transition in the healthcare strategy had already been developing for several decades, as global trends moved toward greater population activism in the promotion of healthy lifestyles while non-communicable diseases became the predominant killers. Anatoly Vishnevsky, a Russian expert demographer, for example, argues that the Soviet Union’s healthcare system, by the 1980s, already lagged significantly behind its peer industrialized states in terms of its approach (Desai 2006, pgs. 312-313). This argument highlights the role that the suppression of civil society under communist rule played in both worsening the health situation in the country and in reducing the legitimacy of the system as it stood. The politics of the system – the communist ideology itself – then helped create the critical juncture in the 1990s.
Second, the decentralization of political authority to the fifteen successor states and, in many cases, the further decentralization to regional and local levels of government, challenged the existence of a highly centralized healthcare structure. The increased authority of local officials led to a significant rise in the demand for the implementation of unique policies pertaining to the health issues facing specific populations, rather than blanket health policies, which had been a key characteristic of the Soviet healthcare system (Tragakas and Lessof 2003).

The critical juncture of the 1990s, then, paralleled the collapse of the Soviet Union and the possibility for democratization in terms of political openings. However, there is no clear correlation between democratization (or lack thereof) and healthcare reform choices. Instead, changes in healthcare systems in the region remain closely tied to the patterns of economic reform and development, at least in the initial years of the 1990s. However, the importance of crises in both the economic and political spheres remained significant – the pressures of the political crisis affected the decisions in the economic crisis, and vice versa. These first two crises, then, were necessary in the occurrence of the critical juncture for post-Soviet healthcare.

4.2.1.3 Organizational Crisis

The final sphere in crisis was that of the healthcare system itself. A de-legitimization of the state-run healthcare system soon overwhelmed the over-crowded, poorly run and insufficiently funded institutions. The ability of the Semashko system to address new healthcare issues had slowly been fading for several decades, causing the legitimacy of the system’s structure to be questioned, even in elite circles (Tragakes and Lessof 2003). By the late 1980s, the union republic ministries of health were discussing
possible restructuring techniques for a failing system (MoH Ukrainian SSR 1987b; MoH RSFSR 1991). The collapse of the Soviet Union in 1991, then, exacerbated an already existing challenge. It introduced new factors into the health equation: market mechanisms for determining medical and pharmaceutical pricing (leading to significant increases due to competition from abroad), the rise in the number and variety of stakeholders in the healthcare system, and a collapse in population welfare due to the larger economic transition leading to a significant increase in mortality rates. These new factors, added on top of an already struggling Soviet model of healthcare, further de-legitimized the existing structure and called into question the communist approach to health.

This does not ignore the fact that the Soviet system of social benefits had many positive traits. While the system was inefficient and the quality of care poor, the public has generally looked to equality of access as their main characteristic for judgment of healthcare systems. Indeed, even at the beginning of the transition, medical experts were holding up statements by Western doctors on the merits of the Semashko system in terms of its ability to provide a basic level of healthcare to all citizens (MoH RSFSR 1991, pg. 108 – see quote at the beginning of this chapter). Recent studies have shown that post-Soviet populations have continued to think highly of the Soviet structure for the healthcare system (Twigg 1998; Lipsmeyer 2000, 2003).

However, despite the continued legacy of welfare expectations amongst the post-Soviet public, the 1990s served as a possible critical juncture for changing those attitudes. As mentioned in the previous subsection, the global trends for healthcare strategies had moved away from paternalistic approaches to more civil society-centered plans (Vishnevsky, quoted in Desai 2006, pg. 312-313). This put the Soviet system, which was
rigidly paternalistic in its structure, under pressure. The top-down, highly centralized organizational and financial structure meant that unique local problems could not be addressed adequately. The rise of non-communicable diseases as a leading cause of morality challenged the healthcare system, which had been built during a time when the focus remained on the prevention of infectious disease epidemics and the management of the adverse effects of violent military and political events (World War I, the Russian Revolution, World War II).

The combination of these three crises – political, economic, and organizational – increased the legitimacy of reform efforts among both the public and elites, creating the opportunity for reform efforts that during “normal” periods of politics could be seen as unnecessary, irresponsible, or even corrupt. This opening set the stage for the decision-making challenges discussed in the next section.

4.3 Political Decision Making and the Critical Juncture

How did political elites decide whether or not to take advantage of the critical juncture? Were they aware that they were at a critical moment? If they were, why might they choose not to reform? Must political elites be aware of a critical juncture for a juncture to exist in the first place? In this section, I discuss why, when a critical juncture – a necessary condition for healthcare reform – structurally exists, elites still might choose varying reform pathways. I first outline the initial decisions made during the critical juncture to pursue or not to pursue major structural reforms for healthcare. I then discuss the mechanisms through which these decisions – acting as signals of the future path for state responsibility in the system – became entrenched through the actions of economic and political elites and medical personnel, who sought to establish themselves
in the most beneficial positions in the new system. In some states, this process was fragmented, with some actors seeing it more beneficial to fight the reforms and reverse them after the initial efforts, while in others, cohesive networks of elites supported the system reforms in which they saw greater future benefits. Finally, I discuss the reform outcomes, or legacies, of this period, and the way in which mechanisms produced and reinforced a long-term trajectory for healthcare reforms.

4.3.1 The Decisions: Choosing a Reform Path Amidst Uncertainty

The critical juncture of the post-Soviet period occurred in the years immediately following the dissolution of the Soviet Union. As elites considered larger economic reforms, they were faced with a similar question for the healthcare sphere: With the introduction of market economies and the resulting increase in unemployment and inequality, as well as the development of the middle class, what would be the state’s responsibility in terms of providing protection from the effects of market forces through healthcare?

While only one of many areas needing to be addressed, healthcare presented an extremely pressing problem. With mortality rates climbing during the last years of the USSR’s existence, the newly independent states faced a problem that would baffle even a high-income country with long-standing government institutions. The existing healthcare structure, the Semashko centralized system, was failing dramatically and, as GDPs collapsed during the early years of the 1990s, the public financing commitment required for such a system to work simply could not be maintained using the same structures as were used during the Soviet era.
Generally reached only after major economic reform decisions were made, the critical juncture constituted one of the most difficult decisions regarding broader welfare reform for the newly independent governments: should the healthcare system be torn down to a significant degree and reconstructed utilizing market mechanisms, or should it simply be adjusted? The initial reform decisions made by the fifteen newly independent countries of the former Soviet Union are illustrated in Figure 8 below. Some states sought to simply revise the Semashko system, reasoning that a cutting of universal access to citizens at such a critical point in time was dangerous and not in standing with the state’s responsibility to provide healthcare. Others sought to create a new system with greater privatization of facilities, financing, and pharmaceuticals so as to optimize the healthcare system, moving it toward greater efficiency, and, thus, protecting the citizens to a greater extent in the long term.

**Figure 8 Initial Reform Trajectories**

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<td>(State-Run, State-Financed)</td>
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<tr>
<th>Revised Semashko</th>
<th>New System (Privatization)</th>
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<tbody>
<tr>
<td>(Armenia, Azerbaijan, Belarus, Tajikistan, Turkmenistan, Ukraine, Uzbekistan)</td>
<td>(Georgia, Estonia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia)</td>
</tr>
</tbody>
</table>

These decisions, like many healthcare reforms efforts around the world, were driven by
the executive office, often with the backing of international financial institutions, and in consultation with expert advisory groups, often consisting of select medical personnel, NGO leaders, and researchers supportive of reforms, and the Ministry of Health. The legislatures played prominent roles through their show of support for or opposition to reforms, shaping the image of the reform communicated to the public. Non-governmental organizations and international financial institutions often provided further advice on the best reform trajectories, though this advice, as will be seen in the rest of the dissertation, was subject to the constraints of political will and interests.

4.3.2 The Mechanisms of Production: Reactions and Interactions

After the decisions were made at the critical juncture, the aftermath of those decisions played out in the actions and reactions of major political and economic actors, as well as medical personnel, the key providers of healthcare on the ground. At this moment, elites in states that sought to lessen the state’s responsibility and introduce greater privatization had already made the decision to reform away from a healthcare system with a dominant role for the state and toward a more balanced system of responsibility, with burden placed on individuals and non-state actors in combination with the role of the state. Once the elites had signaled this intention, groups for and against this move began to form. It was the interaction of these groups as the institutions were designed that then determined the de facto role of the state in the final distribution of the burden.

In the post-Soviet states, the cleavages and the power of groups to either undermine or support this trajectory was largely determined by patterns of elite networks rooted in the old Soviet system. In some countries, the elites had been largely imported,
while in others, the local population was more integrated. Similarly, in some countries, the local elites held more influence than the regional elites. The dissolution of the Soviet Union and the decentralization of resources further exacerbated these differences.

In countries where these elite networks were cohesive – that is, where there was low enough division amongst elites that there existed generally shared beliefs about the benefits and costs of various reforms (making the division between elites and regular citizens to be the major cleavage, rather than a division between elites) – implementation efforts were designed with a broader support than they were in countries with fractured elite networks. In those countries, implementation efforts were thwarted by self-interested groups and individuals in positions of power, who took advantage of the benefits produced by the reforms early on in the process.

4.3.3 Reform Outcomes

The critical juncture led to significant changes in the healthcare systems of some of the successor states, and in others, no significant change was pursued. In Kazakhstan and Georgia, structural reforms were initially pursued, but were then reversed or abandoned in the late 1990s and early 2000s. Figure 9 below shows how each of the country’s long-term reform trajectories fell in terms of the prioritization of state, mixed public-private, or private responsibility for healthcare, as compared to their GDP per capita in 1995.
While there appears to be some correlation between wealth and major structural reforms, there is also significant variation of long-term reform trajectories, particularly amongst poorer countries. These reform patterns fall under three types of long-term trajectories:

4.3.3.1 No Major Structural Reforms: A Focus on Rationalization Efforts

In seven of the countries, no significant changes were implemented during the critical juncture of the 1990s. They still maintain healthcare systems very similar to that of the Soviet Union today, with slight revisions, such as the reduction of the number of hospital beds. Public funding remains predominant legally, making the states’ de jure
responsibility high. That is, the state remains responsible for providing and financing universal healthcare through centralized state budgets, as was the case in the Soviet Union. In some countries, particularly those that experienced war and extreme crisis during the 1990s – including Armenia, Azerbaijan, and Tajikistan – this legal standard remains, but the state’s ability to fund the system has greatly diminished. In these countries, the de jure state-funded healthcare system is a de facto out-of-pocket payment system, with more than 50% of financing coming from such payments.

4.3.3.2 Implemented Mixed Responsibility Reforms

In seven of the countries – Russia, Estonia, Latvia, Lithuania, Moldova, and Kyrgyzstan – reforms were pursued that lessened the state’s de jure responsibility in the system, pushing some of the responsibility onto the population and private actors. These countries generally pursued some combination of Beveridge and Bismarckian models of mixed state responsibility (shared public-private) healthcare systems. Therefore, the state’s responsibility for health has not been completely eliminated, but it has been reduced while the responsibility of other actors, including individuals and non-state actors, has increased. These states have greater privatization of medical care, either in the provision or a combination of the provision and financing. The reforms were attempts to lessen the impact of economic crises on the state budget’s ability to provide healthcare while still maintaining the values of universal access. These states have maintained those commitments to restructured institutions and have adjusted them gradually over time to improve their performance. While none of them are known as the most efficient or effective healthcare systems in the world, they are generally better off than their peers in the post-Soviet region.
4.3.3.3 Reversed Mixed Reforms

Kazakhstan and Georgia’s trajectories differ from the other thirteen states, with both initially implementing insurance fund schemes and later reversing them. In Kazakhstan, where international organizations led the charge in implementing social insurance, reform legislation was passed and implemented quickly. However, that quick implementation, strained by fractured elite networks who did not share a vision of the benefits of the new system, paved the way for corruption, and the necessary new institutions did not have the chance to develop. With support from oil revenues, the government soon canceled a World Bank loan dedicated to the program. Without a necessity for ties to international financial organizations for funding and an interest in avoiding empowering regional actors, the Kazakhstan leadership quickly decided to reverse the reforms and reinstate a state-budget-funded scheme in 1999 (Borowitz and Atun 2006). Later attempts to institute a mixed responsibility scheme have failed, as I will discuss in section 7.2.1.

Georgia also attempted to implement an insurance scheme with mixed responsibility in the mid-1990s. Under Eduard Shevardnadze’s leadership, the government created the state health insurance fund and implemented a payroll tax contribution scheme beginning in 1995-1996. Yet, due to limited funding and inadequate institutionalization of the new scheme, especially under conflict conditions creating a fractured elite and an extreme level of unemployment, the quick implementation of the reforms failed. After the 2003 Rose Revolution, leaders committed to neoliberal principles brought in by outside experts, who decided to address the disastrous attempt at healthcare reform. They officially abolish the insurance system in 2004. Against the
recommendations of international organizations and political leaders, the administration decided to recognize a largely privatized, out-of-pocket payment system (Chanturidze, Ugulava, Durán, Ensor, and Richardson 2009). This led it to a system much like the other countries of the Caucasus region, with much of the burden shifted to individuals and away from the state, but in Georgia’s case, this shift was reflected in both de jure and de facto state responsibility. The system continues to stand out today in the post-Soviet region as privatized to an extent similar to that of the United States.

These three core reform trajectories help to pinpoint where the explanations for the variation lie. In the next section, I detail the course of events during the critical juncture in my two case studies, Russia and Ukraine, which represent two cases where we would expect similar results based on health outcomes, cultural factors, and historical characteristics, but that followed very different paths. I show that, in Russia, where a relatively strong state with domestic resources and very few threats to state stability connected to economic preferences and nationalism prevailed, reform legislation was passed quickly and a gradual reform process implemented. In Ukraine, on the other hand, political decision makers in a state threatened by a nationalist movement that aligned with economic cleavages rejected the quick passing and implementation of reform legislation, instead prioritizing state-building efforts so as to maintain state stability and provide for the possibility of reform in the future. These decisions, made during a critical juncture for healthcare reforms, shaped the outcomes that we still see today.

4.4 The Critical Juncture of the 1990s in Russia and Ukraine

The critical juncture in Russia and Ukraine was a time of dominant political decision makers and social instability. Both elites and citizens faced high levels of
uncertainty. This uncertainty led to decision making based not on economic efficiency or constraints, but rather on a search for stability. Such circumstances were especially clear in decision makers’ approaches toward healthcare reform.

In Russia, a pro-reform executive empowered by initial popular mandate quickly pushed for changes to the healthcare system. Yeltsin’s weakening of power by the end of the 1990s, however, led to much more gradual reform implementation, which, combined with the entrenchment of interests in the newly established structures, ultimately saved his efforts by allowing for the institutionalization of proposed changes. In Ukraine, reform-resistant former Communist Party leaders remained in power. Seeking state stability, however, President Kravchuk worked to slowly lift price controls and enforce trade liberalization. However, the existence of a territorially bounded nationalist threat to state stability that aligned with divisions of economic interests led his regime to seek stability for their power, and they attempted to maintain state legitimacy through the maintenance of the Soviet healthcare structure.

In this section, I discuss these decisions at the critical juncture of the 1990s in Russia and Ukraine. I show that through the mechanisms of (1) elite reactions to uncertainty generated by threats to the state and (2) elite networks, leaders’ decisions about whether to reform and how to reform led to legacies that we see even in today’s healthcare reform trajectories. I show that, in the 1990s, both Russia and Ukraine had the opportunity for major healthcare reform. Russian officials took advantage of that moment, passing legislation committing to structural reforms during the first half of the decade. They then implemented changes gradually, which aided in the institutionalization of those reforms in the long run. Ukraine’s decision makers, on the other hand, chose to
postpone reform due to elite concerns about state stability in the face of both economic and nationalist threats. Delays in passing reform legislation during these time periods, as happened in Ukraine, ultimately led to reforms being overwhelmed in later years by the obstacles – specifically, special interests – that had developed over the transition period. The development of special interests was present in both cases, but in the Russia case, the decision to reform was quick enough that these interests developed around the new institutions, making later changes more difficult, but solidifying what was initially established. I discuss these legacies of these critical juncture more in Chapters 5 and 6.

4.4.1 Setting the Stage: The Crisis of the 1990s in Russia and Ukraine

As in the rest of the post-communist region, the 1990s in Russia and Ukraine were turbulent and tragic years for citizens. Pressures to liberalize and privatize drove the GDPs of both countries into sharp decline. Russia’s GDP fell as low as 55.9% of its 1989 level, and Ukraine’s as low as 36.6% (Fidrmuc 2003), only leveling out in the mid- and late 1990s (Figure 10). As the economic crisis grew, demands for stability and protection of citizens increased.
Addressing the reform challenges brought on by the crisis was difficult. In studies on economic reforms of the transition to market economies, Russia and Ukraine consistently ranked amongst the lowest groups of reformers (de Melo, Denizer, and Gelb 1996). The costs of major reforms – both on a broader economic scale and with regard to healthcare – sharply outweighed the benefits in the short term, with declines in Russia steeper but stabilized by about 1994, and those in Ukraine more gradual and only recovering somewhat around 1996. The economic reforms reflected the broader economic and political crisis, with struggles to introduce democratization similarly

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26 The de Melo, Denizer, and Gelb Cumulative Liberalization Index (CLI) combines three aspects of liberalization – internal markets, external markets, and private sector entry. This measure is the sum of each country’s Liberalization Indices (LI). Each LI was measured annually and combined the three aspects with weights 0.3, 0.3, and 0.4, respectively. As the authors describe it, the CLI “is defined to represent the duration as well as the intensity of reforms from 1989 onward” (pg. 7).
challenging the countries. By 1998, Russia had only one executive turnover on record, and Ukraine two, highlighting a correlation observable across the post-Soviet states between the effort toward economic liberalization and democratization (Hellman 1998). Despite these similarities, Russia managed to institute major structural reforms in its healthcare system during this period, while Ukraine did not.

Russia’s economic transition began immediately after the dissolution of the Soviet Union. During this period, the economic realities on the ground changed drastically. Price liberalization was instituted in January 1992, which led immediately to a 245% inflation rate during the first month. Waves of inflation continued, slowly decreasing in their intensity, until it sharply declined during the later months of 1993, after the Central Bank of Russia and the Ministry of Finance made efforts to slow money growth (OECD 1995). Industries became incentivized to underestimate output in order to reduce taxes; this contrasted sharply with the incentives during the Soviet era, which led industries to overestimate output in order to increase the investment in input by the government (Cook 2005). Because of this, formal records of industrial output halved between 1992 and 1995. Official statistics reported that real disposable income doubled during the first few years, though wage arrears also became increasingly common. Relative prices of food items and non-food items outpaced inflation during the first years. Prices for services increased dramatically beginning in 1993, as the sector grew to catch up after its artificially maintained low levels of development during the Soviet era (OECD 1995).

Ukraine’s crisis proved to be even more devastating than Russia’s, despite efforts to reduce the sting of reforms through less stringent monetary policies (OECD 1995). While authorities moved to liberalize prices, some price controls were at first maintained,
including those on food items. During the first year of the transition, there was concern that the reluctance of politicians to move quickly in stabilizing the financial situation through credit controls, as well as the introduction of a national currency, would significantly disrupt trade in the region without appropriate payment mechanisms and a high degree of convertibility (IMF 1992a, pg. 32).\textsuperscript{27} International organizations early on began encouraging Ukrainian leaders to lift these controls so as to promote the growth of agriculture and other potentially profitable sectors.

Though there was some variation in the intensity of the economic crises in Russia and Ukraine, the crises of the 1990s took a significant toll on the health sphere in Russia and Ukraine equally. With incomes declining and unemployment rising rapidly, the need for social safety nets increased dramatically. After 1992, deaths outnumbered live births in Russia for the first time, and Russia became “the first industrial nation to experience such a sharp decrease in its population for reasons other than war, famine, or disease” (Field 2000, pg. 13). Ukraine too saw life expectancy plummet and mortality rates skyrocket as citizens attempted to cope with the transition. Vital health statistics for Russia and Ukraine during these years are provided in Table 2 below.

\textsuperscript{27} Though it did not become involved in Ukraine until later, the IMF wrote reports on conditions in each of the newly independent post-Soviet states in the years after the collapse.
### Table 2 Vital Health Statistics in Russia and Ukraine, 1990s

<table>
<thead>
<tr>
<th></th>
<th>Average Life Expectancy</th>
<th>Population Growth (annual %)</th>
<th>Death Rate (crude, per 1,000 people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russia</td>
<td>68.5  65.2  66.0</td>
<td>0.2  0.0  -0.3</td>
<td>11.4  15.0  14.6</td>
</tr>
<tr>
<td>Ukraine</td>
<td>68.9  67.1  68.2</td>
<td>0.2  -0.8  -0.9</td>
<td>12.9  15.4  14.8</td>
</tr>
<tr>
<td></td>
<td>Survival to Age 65 (male, % of cohort)</td>
<td>Deaths from Tuberculosis (per 100,000 people)**</td>
<td>Deaths from Alcohol Use Disorders (per 100,000 people)**</td>
</tr>
<tr>
<td>Russia</td>
<td>49.9  46.6  43.9</td>
<td>7.19  14.94  16.08</td>
<td>14.95  32.59  28.62</td>
</tr>
<tr>
<td>Ukraine</td>
<td>56.5  52.2  49.9</td>
<td>6.35  9.92  11.6</td>
<td>17.15  21.16  19.29</td>
</tr>
</tbody>
</table>

**Source: Institute for Health Metrics and Evaluation (2015). As a comparison, in the United States, the rate of death from tuberculosis at this time was: 0.9 (1991), 0.71 (1995), 0.52 (1999) per 100,000 people. The rate of death from alcohol use disorders was: 2.59 (1991), 2.66 (1995), 2.65 (1999) per 100,000 people.

As even these few statistics clearly show, during the transition, there was a massive spike in negative health indicators, such as death rates and alcohol use, and an equally massive drop in positive indicators, such as the population growth, survival rates, and average life expectancy. These effects lessened in the later 1990s, following much of the same pattern as the J-curve of economic indicators and demonstrating some relationship to the effects of economic crisis on substance abuse and mental health.

Not only did overall population growth and death rates show the effects of the transition, but the causes of death also demonstrated how the crises were affecting behaviors. According to data from the Institute for Health Metrics and Evaluation (2015), the most changes in the common causes of death from 1990 to 1995 reflected the impact of the economic and social strains on society. In Russia, the prevalence of diseases such as HIV and tuberculosis, deaths from alcohol and substance abuse – largely considered to
be the effect of widespread depression during economic recession (Brainerd and Cutler 2005) – and the number of deaths due to “war and disaster” increased significantly. While the prominence of causes of death in Ukraine did not change as significantly, the jump in deaths from cirrhosis likely demonstrates the increasing numbers suffering from alcoholism during this time (Institute for Health Metrics and Evaluation 2015). These differences in the effects on health outcomes between the two shows a possible link between the approach taken toward healthcare in the midst of economic and political crises and the short-term costs of major changes to healthcare structures.

How and why did the transition affect healthcare, as opposed to simply health indicators? As I discussed in Chapter 3, the centralized Semashko healthcare system of the Soviet Union left a bloated infrastructure, outdated technology, an imbalance of inpatient care over outpatient and primary care, and a low level of public expenditure on health. Figure 11 below shows the health expenditure per capita and GDP per capita in Russia and Ukraine during the 1990s based on purchasing power parity rates.  

Interestingly, while Russia’s health expenditure patterns largely match those of GDP per capita during those years – with a leveling out around 1995, and even an increase in 1997 – Ukraine’s health expenditures per capita continued to drop, even after the GDP stabilized in the later 1990s.

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28 The World Bank does not have data for the years 1990-1994 on this expenditure. Because of the chaos of the transition, many of these expenditures were unclear for the first several years after the Soviet Union’s collapse and are difficult to find.
The failure of the healthcare system to cope with the increased burden of the transition demonstrated that the declines in health during the last years of the Soviet Union were not going to disappear along with it. If governments wanted to pursue new economic and political paths, they were going to have to find ways to adjust the healthcare system to match the new social and economic structures. New problems and new incentives would arise under those structures, and, like other welfare areas, healthcare required an adjustment to those conditions if it was to continue existing as a system. In other words, the legitimacy of the healthcare system as it stood became challenged during this period due to its close relationship to the values of both the economic and the human rights spheres.

In the following subsection, I outline the reform efforts in Russia and Ukraine during these years. I show that Russia’s early efforts proved to be successful in moving
the system onto a new trajectory, while Ukraine’s efforts – marked only by weak rationalization reforms and decentralization – led it down an increasingly challenging path. The decisions to postpone major structural reforms in Ukraine, particularly after Kuchma’s election, shaped Ukraine’s position in healthcare systems today.

4.4.2 Reforms in Russia and Ukraine

With regard to determining the state’s responsibility in healthcare, the answers to three questions were needed: (1) Is reform necessary? (2) What type of reform is needed? and (3) When is reform needed, and how quickly should it be implemented? These questions are similar to those addressed in economic reform more generally. With the collapse of the Soviet Union, and particularly in the healthcare arena, in which mortality rates skyrocketed, there was a clear need for structural change. For the second question, a popular choice amongst more committed reformers was a mandatory health insurance (MHI) fund scheme, with the inclusion of budget transfers in order to main the universal access so prized in the Soviet era. However, authorities in the post-Soviet and even in the wider post-communist sphere struggled to answer how exactly MHI mechanisms must be adapted to the conditions left by the legacies of communism. Finally, if reform was needed, authorities had to decide when to start and how quickly to implement the full transformation. It is on this third question that the political leaders of Russia and Ukraine differed significantly in their answers. While both Russian and Ukrainian leaders agreed that reform was needed and even discussed similar mixed responsibility systems, they differed drastically on how quickly they believe such mechanisms should be introduced. The basic timeline of their reform efforts in the 1990s is shown in Figure 12.
Figure 12 Reform Timelines, Russia and Ukraine (1990-2000)

In this section, I show that while each country experienced a similar critical juncture in the early to mid-1990s that opened up the possibility for the introduction of a new healthcare scheme, only the Russian government took advantage of that moment to implement major structural reforms. This is because Yeltsin and his administration answered the third question very differently than did Kravchuk, Kuchma, and the Ukrainian government. While Ukrainian officials expressed interest in also implementing a mandatory health insurance system, the move toward reform was slow to take place in the 1990s due to the prioritization of state stability in the interest of state-building efforts and a belief in the superiority of very gradual reforms in the face of aligned nationalist and ideological cleavages. The variations in their prioritization of reforms were rooted in the differences in the threats to state stability that the political elites faced. In Russia, the lack of cohesive nationalist movements that aligned with economic preferences allowed for state-building efforts to address economic grievances without alienating nationalist groups and threatening state stability. In Ukraine, political leaders faced a nationalist movement that significantly aligned with divisions in economic preferences in the country. Faced with possible separatist movements based on major economic restructuring, political decision makers decided that it was necessary and more efficient to distribute scarce resources to the building and consolidation of the state and to maintain any institutions that remained even somewhat popular amongst citizens.

4.4.2.1 Russia: Powerful Elites and a Focus on Reforms

Russia at the time of the fall of the Soviet Union faced a unique dilemma: how is a country to develop itself anew while still being considered the main successor to a now defunct empire? The Soviet Union had been Russian-dominated, and many still
associated the Soviet state and communism with the Russian nation (Lane 2007). However, though Russian authorities did inherit many problems that had faced the Soviet leaders during the last years of the 1980s, they also inherited many Soviet resources. The newly independent Russian government agreed to take on most of the Soviet external debt as long as it also acquired the majority of the USSR’s assets (Aslund 2009). With the end of the ruble zone in the fall of 1993 and the move to a market-driven economy, the balance of power in the country shifted to those who had the advantage of those resources, many of which belonged to the “upper class” that had developed under communism (Lane 2007). Numerous oligarchs were created through the quick selling of state property, driving an increasingly extreme level of inequality between the “haves” and the “have nots.”

The rise of income inequality resulted in a parallel rise in inequality in access to healthcare. While the poor continued to rely on home remedies or the free state hospitals, the rich could afford care in the new private practices, at which could be found newer technologies, better access to pharmaceuticals, and better trained medical personnel (Davidova et al 2009). Prior to the existence of these inequalities, there were already concerning downward trends in the demographic situation. While some researchers argue that these trends had existed since the 1960s, when most of the world moved to evidence-based medicine and away from tax-funded systems, others pinpoint the 1980s as the culprit, when new market mechanisms began to be introduced after the ending of Gorbachev’s two-year anti-alcohol campaign in 1987 (Brainerd and Varavikova 2001). Regardless of when the problematic demographic patterns began, the 1990s exacerbated those issues with the introduction of market-driven reforms without adequate transitional
mechanisms for the decaying safety nets (Field 1995).

4.4.2.1.1 The Critical Juncture: Creating the Mandatory Health Insurance System

During the 1990s, the Russian government successfully passed legislation creating health insurance funds, which were meant to replace the tax-based system of the Soviet Union. In June of 1991, before the final collapse of the USSR, the RSFSR Supreme Soviet passed the Law on Health Insurance of the Citizens of the RSFSR. In its opening statement, the law states that it aims “at strengthening the commitment and responsibility of the public and state enterprises, institutions and organizations in the protection of public health in the new economic environment and ensure the constitutional right of Russian citizens to medical care” (Supreme Soviet of the RSFSR 1991). This constitutional right was maintained in the new Constitution of the Russian Federation two years later.

The 1991 law laid out the structure of a new mandatory health insurance system that was meant to maintain free access to healthcare for all citizens, while also introducing market mechanisms – competition as well as a purchaser-provider split (separating the entity paying for healthcare from that providing the healthcare) – in an effort to improve quality of care. According to the law, the mandatory health insurance would be funded through taxes paid by employers and by state and local budgets for the unemployed and retired. Voluntary insurance – which could provide expanded protection beyond the minimums of the compulsory insurance scheme – was also detailed (art. 1), though this system was doomed not to develop strongly. The law described the freedom

29 «Закон направлен на усиление заинтересованности и ответственности населения и государства, предприятий, учреждений, организаций в охране здоровья граждан в новых экономических условиях и обеспечивают конституционное право граждан Российской Федерации на медицинскую помощь.»
of choice that citizens would have, which included choices of health insurance companies, doctors, and medical institutions (art. 6). As I will describe in later chapters, these guaranteed freedoms have also not come to fruition for most Russian citizens, as there is a severe lack of quality care throughout the country that continues even today.

Finally, the law, in setting out the details of the new system’s financing structure, indicated that funds would be provided primarily through federal, regional, and local budgets, though additional funding would have to be provided by other “economic entities,” loans, charitable contributions, and personal funds of citizens (arts. 10 and 11). This budgetary financing would then be channeled to federal and territorial funds that would function as independent non-profit financial and credit institutions (art. 12). The institutions created by Federal Law No. 1499-1 never developed strongly, however. This led to the 1993 reforms, which I describe in more detail below.

The 1991 legislation on health insurance never received adequate funding and was seen to have “fundamental weaknesses” (Atkov and Ulumbekova 2011, pg. 256; Popovich et al 2011, pg. 16). Therefore, in 1993, the newly independent Russian government introduced revised mandatory health insurance legislation. The first, Act No. 4543-1, “On the procedure for financing of compulsory health insurance for 1993,” officially established the Federal Fund for Mandatory Health Insurance and set the contribution levels for employers per employee – 0.2% to the Federal Compulsory Medical Insurance Fund and 3.4% to the territorial compulsory medical insurance fund (Ross. Gazeta 1993). The second, Federal Law No. 5487-1, was meant to further detail the responsibilities of the government and other healthcare system actors, as well as to outline non-budgetary sources of financing to add further resources to the system (VSND
VSRF 1993; sometimes referred to as the “Health Insurance Law”). This reform paralleled similar stabilization and liberalization efforts pursued by Boris Yeltsin in other social and economic areas; in December of the same year, the full new Russian Constitution, which guaranteed all citizens the right to health and medical care free of charge at the point of delivery (Konstitutsiia RF, art. 41), was passed by national referendum. The country also began the membership process to join the Council of Europe and gained accession status in the World Trade Organization. Furthermore, the reforms to the health insurance system, while not fully effective immediately, did appear to somewhat protect citizens from what seemed like an imminent collapse of the system. This was especially true in the first couple of years, when there was an increase in healthcare revenue despite the growing severe financial constraints (Popovich et al 2011, pg. 19; Shishkin 1998). However, in a presidential ukaz [decree] meant to resolve differences between the new Constitution and past legislation, the power of the Federal Fund for Mandatory Medical Insurance (art. 12, part 3 of the 1991 Federal Law No. 1499-1) was modified by presidential decree in December of 1993 (Ross. Gazeta 1993, Ukaz No. 2288, 24 December 1993). This was only changed once again in 1998 (Ross. Gazeta 1998, Ukaz No. 729, 1 July 1998), followed by the Federal Assembly’s approval of the charter of the Federal Mandatory Health Insurance Fund (Ross. Gazeta 1998, Postanovlenie No. 857, 29 July 1998). This decree set out the main tasks and organization of the health insurance structure that still exists today.

4.4.2.1.2 Challenges to Reform: Nascent Interest Groups and Reform Prioritization

At the time of the fall of the USSR, Boris Yeltsin held significant power through popular mandate, having been the first freely elected leader of the independent Russian
state. Yeltsin took office looking for change, and his inaugural speech marked the first
time that the social sphere (housing, consumer goods, public transport, and healthcare) was discussed prior to the economy (Aron 2000, pg. 197). Pursuing change but valuing experience, a significant number of the elite members in top leadership positions under the Yeltsin cohort had served under the previous regime (22.7% had entered the nomenklatura under Brezhnev, and 36.4% under Gorbachev), with only 10% beginning political careers after the fall of the USSR (Krishtanovskaia and White 1999, pgs. 49-50).

These experienced yet reform-minded leaders of the newly independent government felt pressured to move the state quickly toward democratic ideals, though with this remaining subordinate to the demands of the economic transition (Fish 1995).

However, Yeltsin’s popularity was increasingly challenged as the crisis continued through the 1990s, raising obstacles to his reforms as the decade progressed. Resistance to healthcare reforms had begun weakly before the fall of the USSR, when regional doctors invited to committees and to speak on the issue in the RSFSR Ministry of Health had disagreed on both the ability of the government to successfully implement major structural changes, as well as the true usefulness of such change when at least a tenuous equality in healthcare access had already been achieved under the Soviet system (MoH RSFSR 1991 pgs. 104-108). Doctors throughout the new Russian Federation staged protests in early 1992, demanding higher pay to match the rising inflation after the dissolution of the USSR. Boris Yeltsin gave into these demands by issuing a decree designating increases in pay to be determined as a percentage of salaries, rather than as flat rates. However, this was not an example of responsiveness to civil society pressures with regard to major structural reforms, but rather was a means of paying off challenges
to authority so as to continue the intended reform strategy. Even Deputy Prime Minister Aleksandr Shokhin, who presented the decree at a special plenary session of medical workers’ trade unions, admitted that the increases in pay were meant to ease the social tensions but would not improve the system overall (Manucharova 1992).

Like when the Bolshevik authorities had imposed a new system on doctors of the tsarist era, there was also significant pushback from physicians and other medical personnel on the new standards of practice and organization of responsibility in the post-Soviet Russian healthcare system. In particular, changes in the requirements for doctor-patient relationships and the rights of the patients with regard to information, as established by *Foundations of Legislation of Russian Federation on the Defense of Health of Citizens* (Supreme Soviet of the Russian Federation 1993), challenged the norms of medical practice, as they moved the expectations away from the recommendations of Soviet deontology – including the idea of doctors as working “for the good of the state” and practicing discretion in providing patients with distressing or “inconvenient” information about fatal diseases – and toward more transparent, patient-centered practices that had developed globally in the second half of the 20th century (Cassileth *et al* 1995, pg. 1571).

The resistance but lack of significant coordination of these nascent interest groups meant that healthcare reforms fell under the same concerns as broader state- and market-building efforts, with the focus on developing institutions for longer-term trajectories of the new Russian Federation. Because there was little to no alignment of economic preferences with the major nationalist movements in the Russian regions, there was very low risk to the state’s stability for the Yeltsin administration in implementation of
healthcare reforms, which were connected to both the economic and human rights frameworks that had become central drivers during the transition. Indeed, while the ethnic republics voted overwhelmingly against Yeltsin and his reform efforts in the April 1993 referendum, this disapproval did not fall neatly along national lines. In fact, many majority Russian regions also demonstrated their disapproval, constituting an agriculturally-driven line of regions that became known as the “Red Belt” for many years for its support of the Communist opposition leaders. With no clear territorial threat to the state that aligned with these economic interests, reformers at that time saw opposition in the parliament, rather than nationalist groups, as the biggest obstacle to their efforts, and found that the reforms continued largely due to the moment’s inertia, the support of powerful oligarchs, and the successful “Da-Da-Nyet-Da” campaign (Barabanov 2013).

With little diversity of decision makers and no cohesive challenge from a nationalist and economically aligned group, the political will of the country’s political elites and powerful economic actors played a key role in the pursuit of reforms. The Russian Minister of Health from 1992 to 1995, Eduard Nechayev, famously ignored pressures from various international and nascent domestic healthcare stakeholder groups during his tenure. In 2005, he recalled in an interview for Novaya Gazeta the pressures put on him by the World Bank and international institutions and his resistance to their programs:

“Ten years ago, representatives of the World Bank approached me with a proposal to hold a health care reform experiment in Russia. Then they talked about general practitioner, the new insurance principles, believing that this will make our health system more accessible and democratic. For the realization of their project, they offered to give us a loan at interest. Then we analyzed their program – it was designed for backward country, not a country with well-developed health and universal culture. These are people who practically were not familiar with either our history
or our health care system… I do not understand why we need a World Bank loan ... It's just a humiliation – to borrow at such huge resources. It would be logical to involve local experts and develop a reform project for their money. We have a way in which we should go. Our health has always been aimed precisely at taking care of people, now we may lose this greatest achievement forever.” (Nechayev 2005)

It was this attitude toward reform – one focused on instituting a mandatory health insurance system but insistent on doing so based solely on Russian authority and the particular preferences of the central elite – and the ability of the authorities to resist pressures from outside actors that shaped the reform efforts of the early and mid-1990s.30

Domestic challenges grew slowly over time. Conflict among interest groups within the country began to grow in the mid-1990s, when medical officials and regional authorities started to protest the legislation and attempted to manipulate power over the insurance funds (Tragakes and Lessof 2003). It was around this time that the accusations of corruption and harmful decision making caught up with Minister Nechayev, who was dismissed under unpleasant and vague circumstances at the end of November 1995 (Frolov 1995). However, interest group pressures developing amongst the insurance providers supporting the new system by this time balanced out any rising medical personnel forces, keeping the legislation in place as it was (Popovich et al 2011, pg. 21). The elite-led transition in Russian healthcare headed by Yeltsin and Nechayev at the time of the critical juncture, therefore, set it on a distinct path of institutional development.

Though the implementation has not been as successful as hoped – a result that

30 In the 2005 interview, Nechayev also mentions the unwillingness of the World Bank to listen to the central authorities’ decisions regarding reform and their attempts to reach out to regional authorities, thus undercutting the central institutions. However, while he understood this as an effort to undermine the Ministry of Health’s authority, he also recognized the failure of such efforts to make significant reform take place. This failure to do so further legitimized the Ministry’s decision-making power.
will be discussed in Chapter 5 – the Russian case represents the path of states that chose to implement risky and, in the short-term, costly reforms in order to establish a new trajectory for the healthcare system, building on these reforms in the long term. While the countries that did introduce and implement gradual changes are not identical system-wise, they are closer in institutional design than they are to those countries that did not implement any type of mixed responsibility structure during the 1990s. The variations in the institutional pathways resulting from this decision making will be seen more clearly in the discussion on Ukraine in the next subsection.

4.4.2.3 Ukraine: Threatened State Stability and No Major Reform

While Ukraine experienced the same convergence of opportunities as Russia – the collapse of communism and even a peaceful political transition with the election of Kuchma in 1994, economic liberalization (price liberalization occurred in 1994), and the clear dysfunctionalility of healthcare institutions – political leaders in the country did not take advantage of the critical juncture and reform the healthcare system. Instead, other priorities took precedence, including state building and security and defense initiatives, such as denuclearization. In fact, very little attention was given to healthcare beyond its place on the list of institutions that would be affected by economic reform. During these years, the divided balance of power between nationalists and the hard liners on the left and the alignment of these groups with economic preferences and territorial threats to the state meant that political decision makers saw healthcare reforms as too risky, because they could challenge the new state’s legitimacy in both the economic and human rights spheres if unsuccessful.
4.4.2.3.1 Same Opportunities, Same Advice

Ukraine’s healthcare story in the collapse of the Soviet Union and the subsequent reform environment, like that of Russia, began in the late 1980s. The Ukrainian Soviet Socialist Republic, much like the other union republics of the Soviet Union, had seen an increase in mortality and a decrease in birthrates – an astonishing demographic crisis – begin to build in the late 1980s.31 Much like in Russia, analysts and decision makers rationalized the declining health statistics and unwillingness to reform with various arguments. Some blamed the declining demographic issues on individual health choices, such as alcohol consumption rates, while others saw the slow introduction of some market mechanisms as threatening to the command economy and its dependent welfare state. Unlike in Russia, the Ukrainian SSR remained somewhat removed from the central policymaking, resulting in relatively more local variation in the crisis than was seen in Russia.32

During the final year of the Soviet Union’s existence and into the first post-collapse years, discussions about which type of healthcare reforms should be pursued were taking place in the Ukrainian Ministry of Health. Like in Russia, many policymakers and doctors in the Ministry meetings believed that a mandatory health insurance fund system, similar to that introduced by Bismarck in Germany in the late

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31 As mentioned in the previous subsection, some scholars have argued that this trend extended back to the 1960s (Brainerd and Varavikova 2001).
32 See for example discussions of the Ukrainian SSR Ministry of Health meetings in the TsDAVO archives in files 342-17-4867 (1988), 342-17-5039 through 5043 (1989), and 342-17-5210 through 5214 (1990) [fond-opis-dela]. In these meetings, while at times considering how to implement reforms set in Moscow, most attention is given to doctors from the regions invited to discuss how they are addressing either the quality of care (particularly to rural residents) or specific problems, such as outbreaks of infectious diseases or, in one case, lice, locally. Very little attention is given to system-wide reform throughout the Ukrainian SSR, putting the emphasis on the implementation of Soviet centrally-directed reforms at the regional and local levels. Republic-level authorities largely acted as regulators in this manner.
1800s, would be the best option to accommodate both the slowly collapsing command economy and the rising market forces. However, while the opening of the political system, the consideration of major economic changes, and the critical demographic crisis created the critical juncture for healthcare reform and the opportunity to institute such a system, no reforms were seriously pursued until the late 1990s and early 2000s. Despite support from international institutions such as the International Monetary Fund and the World Bank, authorities continued to debate, rather than to decide, on reform efforts (Lekhan, Rudiy, and Richardson 2010). This missed opportunity to implement significant institutional reform at the critical juncture meant that Ukraine’s healthcare system followed a much different path of institutional development than did Russia’s.

4.4.2.3.2 Threatened State Stability and a Hesitancy to Reform

The sudden appearance of Ukraine as an independent country in the international system necessitated institutionalization in order for relationships with international institutions and other countries to begin to develop (Motyl 1998). During this time, Leonid Kravchuk and other former Soviet elites maintained power. As was the case in most post-communist countries, the Parliament consisted of a collection of factions, with ex-Communist Party leaders, a large centrist group, and the burgeoning pro-reform Rukh movement. While Kravchuk and the former Communist Party leaders remained in control with backing from centrist decision makers, the Rukh movement, connected to many former Ukrainian dissidents of the Soviet era, managed to climb to a position of minority support by the 1998 election, increasing their number of seats held in the Verkhovna
Rada from 15 of 450 in 1991, to 20 in 1994, to 46 in 1998. Their presidential candidate in the 1991 election, Vyacheslav Chornovil, came in second with 23.3% of the vote (to Leonid Kravchuk’s 61.6%). Though he only won the majority in the Lviv, Ternopil, and Ivano-Frankivsk regions of western Ukraine, the Rukh party gave momentum to a national independence movement that would continue to divide Ukrainian political opinions in the years to come.

During the early 1990s in Ukraine, the executive and legislative branches supported similar status quo policies, with the Parliament in particular influencing decisions made within the regime (IMF 1992b). However, like in other post-Soviet states, there remained a significant level of chaos due to a lack of developed institutions and experienced personnel to fill the roles required for independent national decision making. Under the centralized Soviet regime, the Ukrainian leaders had been subordinated to directives coming out of Moscow. After 1991, a decentralized system of local, regional, and republic-level elites faced the daunting task of creating a cohesive and capable national political system. The lack of strong institutional structures, including robust data collection and monitoring systems, posed a considerable obstacle to this (IMF 1992b, pg. 2). In the healthcare system, the establishment of the Center for Medical Statistics in 1992, following the Ukrainian law On Information about the citizens’ rights to official data, was meant to improve the healthcare as well as allow greater transparency. However, the centralization of information faced many obstacles, as was seen in later orders by the Ministry of Health.

33 The Rukh movement began as just that – a movement – in support of perestroika in 1989. At that time, independent political parties were not allowed under the Soviet regime. They officially registered as a political party in February 1990.
There existed little consensus on the changes that needed to be made in healthcare. In fact, very little attention was given to the topic specifically, and Health Minister Yuriy Spizhenko, in office from 1989-1994, was allowed to continue to run the system with idea of stability and continuity at the forefront of policy. With few changes to the financing and provision arrangements in the system, healthcare institutions had to face rising pharmaceutical, facility, and equipment costs brought on by larger market reforms. During this time, the calls for change continued, yet the discussions of the mechanisms best suited to address the crisis were strained. Medical personnel appealed to the Ministry of Health to take action, condemning the market reforms as detrimental to the healthcare system:

“Today under the so-called market relations, healthcare is practically not protected. Healthcare – [is] a *hostage to a market economy*. We recalculate the prices every day, the budget is absent. We are removing the builders from the repairs, the medications are very expensive. Healthcare facilities are often located in rented premises, [and] rent fees, other services are expensive.” (GV Balashov, Head of the health department of the Zaporozhye Regional Executive Committee, MoH Ukraine 1992, pg. 144 (2). Emphasis is my own).

Others noted that new ways of financing when the budget was overstrained were necessary moves forward, with Dr. V.S. Yarovsky of Kharkiv arguing that, “Insurance medicine is the path which we cannot do without,” moving on to emphasize that “[i]n 1992, we expect to raise 15-20% in non-budgetary funds for healthcare.” (MoH Ukraine 1992, pg. 144 (2)). The concerns about the stability of financing, and particularly of wages, stemmed from conversations, like those in the RSFSR, that took place in the 1980s as experiments in insurance models were tested across the USSR (MoH Ukrainian SSR 1986), and, with uncertainty even greater than it had been in the USSR, medical personnel’s worries focused on the maintenance of their positions and the system.
The greatest source of tension in the Ministry of Health meetings, then, could be found in the high level of resistance to uncertainties throughout the system. Like in Russia, medical personnel continuously did not agree on the merits or necessity of major market reforms to healthcare. Given the relatively significant local autonomy that had been given to the hospital managers and head administrators, particularly during the last decade of the USSR’s existence, this group of healthcare information holders had no incentive to agree to major reforms; and because the Soviet Union’s healthcare system had not made the transition to evidence-based medicine, but rather still relied heavily on expert opinion, they had significant power in maintaining the status quo in a country lacking a functioning centralized information system (Lekhan, Rudiy, and Richardson 2010). This lack of centralized power over the system exacerbated the tensions created by the alignment of national identities and economic preferences in the broader state- and market-building efforts. The informational asymmetries between this group and the political decision makers (the Ministry of Health and Verkhovna Rada Committee on Health) made healthcare reforms seem even riskier in the face of the national and ideological cleavages dividing the country’s regions.

The crucial reason that Ukraine did not reform at the time of the critical juncture, then, was the instability of the state as it was threatened by cleavages that aligned along both identity-driven and ideological lines. The Ministry of Health, lacking in power due to information asymmetries between the center, regional authorities, and medical personnel, remained forced to rely on other groups for support in its reform efforts, yet willingly continued to pursue its own preferred agenda of a mandatory health insurance system. At the same time, political decision makers in the Verkhovna Rada became
unwilling to pursue major healthcare reforms due to the uncertainty created by competing interests and nationalist-driven beliefs about best reform strategies in the regions. While nationalists captured agenda-setting powers in much of the government and therefore were able to set the priorities and focus the state’s efforts on nation building, hard liners on the left remained in power with the ability to block any major reforms (Aslund 2009). With policy areas outside of the economic sphere, such as security and defense initiatives – including denuclearization – some common ground could be found between the extremely divided nodes of power, as the threat to the state’s stability within those policy areas remained external. However, with healthcare reforms, which touched on both economic and human rights concerns of the transition, the alignment of economic and nationalist cleavages concentrated along territorial boundaries put the threat to stability over decisions on these issues in the domestic sphere.

Illustrating these divisions, public opinion on the direction of the country diverged during this time across east-west lines, with the western populations showing far more support for neoliberal reforms than the eastern and southern regions (Figure 13). This divide was further intensified by differing views on respect for human rights across regions. The eastern and southern populations, seeing the movements toward less state intervention, interpreted this as a lessening of the protection of human rights, and were far more likely to believe that there was no respect for human rights in the country than were their western counterparts (Figure 14). 34

34 To create these charts with meaningful regional divides, the four categories consisted of the following regions from the original survey: Western (Western and North-Western), Central (Kiev, Northern, and Central), Eastern (Eastern and North-Eastern), and Southern (South-Western, Southern, and Crimean Republic)
**Figure 13 Opinions on Free Market in Ukraine (1993)**

Do you personally feel that the creation of a free market economy, that is one largely free from state control is right or wrong for Ukraine’s future?

Source: Central and Eastern Euro-barometer 4: Political and Economic Change, November 1993 (ICPSR 6466)

**Figure 14 Opinions on Human Rights in Ukraine (1993)**

How much respect is there for human rights nowadays in Ukraine?

Source: Central and Eastern Euro-barometer 4: Political and Economic Change, November 1993 (ICPSR 6466)
Healthcare, straddling the line between economic priority and fundamental human right, represented a state commitment that was not easily addressed by a government seeking to bolster its legitimacy and secure its legacy for the newly independent and very divided country. With economic collapse, funding was quickly drying up, leaving the state without the resources necessary to properly maintain the centralized Semashko healthcare system of the Soviet Union. Yet, the possibility of introducing major neoliberal reforms to the healthcare system, inviting Western businesses to take over facilities and provide insurance, meant that prices for care would increase, and the universal coverage of the population, at least in the short term, could not be guaranteed.

As a member of the World Health Organization as part of the Soviet Union since 1948, Ukraine had long been committed to the increasingly popular global trend of recognizing health as a human right. The Ukrainian Constitution, adopted in 1996, guaranteed all citizens the right to healthcare (Article 49), and the Principles of Legislation on Health Care in Ukraine, in its empowerment of the legislature in health matters, established this sector as one centered around the people. As they sought to unify the nation, Ukrainian officials had to decide whether access to care or quality of care mattered most for a united Ukrainian population at a time of crisis.

With a strong alignment of identity-driven and ideological cleavages threatening the state’s legitimacy, only a shared belief amongst the President and his Cabinet of Ministers that major economic reforms introducing market mechanisms in every sector would threaten the country’s stability could be reached. President Kravchuk described the approach:

“We undertook very correct policies, taking into account that Ukraine historically differs in its eastern and western parts, in its attitudes and in
many factors. We carried out centrist policies in a Ukrainian way which would prevent west and east quarrelling.” (Interview with Taras Kuzio, quoted in Kuzio 1998, p. 172)

This deadlock stemmed from a fear of destabilizing social tensions at a time when the state was still in the process of consolidating power and led to a hesitancy to pursue any type of possibly unpopular reform. As a result, the default reform mode in social policy areas was inaction, with some small rationalization policies allowed only if they were conducive to the development of the Ukrainian national identity and did not threaten the state’s legitimacy in protecting its citizens (Lekhan, Rudiy, and Richardson 2010).

Importantly, the Ukrainian Ministry of Health and Parliamentary Committee on Health did not rule out major structural reforms completely. Instead, they approached this question as a matter of prioritization of the timing of reforms, rather than a question of their structural design. Focusing on rationalization efforts, they sought to improve the efficiency of healthcare without reworking the state’s responsibility in its financing and provision because there existed threats to state stability that aligned along nationalist and ideological preferences connected to the values in healthcare. In considering any types of reforms to healthcare for the future, one aspect of healthcare policy upon which most elites, both on the left and right, agreed was the speed of the reforms and, in particular, the need to slowly introduce any radical reforms, rather than pursue them through a shock therapy program. They sought to find a uniquely Ukrainian model, an idea for which support was intensified by the continual exposure of policymakers to reports on the struggling transitions in Russia and other former communist states (Nordberg 1998, pp. 49-51; Aslund 2009).

A significant moment in the decision making at the critical juncture for healthcare
reforms came with the first official presidential turnover of independent Ukraine. Price liberalization, delayed until 1994 in Ukraine, set the stage for other economic reforms as the former Prime Minister, Leonid Kuchma, ascended to the presidential office. However, despite his calls for a radical change in pace, Kuchma continued the same general pattern of prioritization of state and nation building as had been seen under Kravchuk’s rule (Motyl 1998; Kuzio 1998). Major structural reforms were still delayed as the administration continued to focus on consolidation and legitimization of the central authorities in the face of possible social tensions. Like his predecessor, Kuchma showed hesitation to pursue reforms that might risk the emergence of “two Ukraines” (Garnett 1997, pg. 17).

Only in 1997 was substantial change implemented in the healthcare system, and even then, only within the larger reform process. The Law on Local Self-Government in Ukraine, passed in 1997, was the most significant reform policy that affected healthcare during the 1990s (VVRU 1997). This legislation restructured the power dynamics of the Ukrainian healthcare system, providing local leaders with greater autonomy in decision making, including in healthcare. However, this decentralization merely officially institutionalized the power dynamics of the information asymmetries that had already existed in Ukrainian healthcare by the final years of the Soviet Union. It did not attempt to revamp the financing system, meaning that the state continued to be responsible for the budgeting of tax-generated revenue for healthcare, even during a severe economic crisis. This drove interregional healthcare inequalities, as state funds for healthcare continued to dry up and more and more of the quality of healthcare in the regions depended upon the actions of regional and local leaders. Power in these leaders and special interests
accumulated at greater speeds, increasing the tensions between the members of the Ministry of Health, who worked closely with international organizations and expert advisory panels to design reforms, and the Verkhovna Rada Committee on Health, who depicted their efforts as ones focused on the people, rather than the pressures of international or elite interests. This would prove significant for the later efforts at major structural reform, a topic I will discuss in Chapter 6.

4.4.2.3.3 Ukraine in Conclusion: A Search for Stability

In conclusion, the risk-adverse elite of the new Ukrainian state and their perceptions of how best to promote stability as they focused on state building determined the course of healthcare reforms. The Ukrainian authorities, both under the Kravchuk and Kuchma administrations, feared a rise in tensions driven by the alignment of national and economic cleavages, particularly as these tensions sharply divided territorial boundaries in the new state. The popularity of social policies, and particularly universal access to healthcare, meant that the state’s legitimacy in the economic and human rights spheres depended significantly upon these decisions. When it came to healthcare reforms, authorities prioritized stability for state building efforts over radical market reforms, pushing off certain short-term costs in the face of long-term uncertainty.

The reforms affecting the Ukrainian healthcare system during the 1990s, then, and particularly in the first half of the decade, were driven by the ideologies that were also guiding major state economic reforms, rather than a specific focus on healthcare reforms themselves. These were largely concentrated on decentralization and attempts to maintain a “soft” monetary policy in order to avoid economic crisis and focus on state and nation building. Ukrainian political leaders disapproved of the shock therapy happening in
neighboring Russia and other former communist states. Yet, while the introduction of only small incremental reforms did allow for a more technically “democratic” process to develop and accompany the state’s transition, it also led to a stalemate in terms of changing major political or economic institutions (Aslund 2009). This would make significant reforms to healthcare become only more difficult over time as an increasing number and diversity of interests developed and captured the state.

4.5 Conclusion

The crucial decisions of the 1990s set the unique and varying healthcare reform trajectories that we see across the former USSR today. In this chapter, I provided evidence from the Russian and Ukrainian cases for both a quickly reforming (Russia) and a non-reforming (Ukraine) trajectory. I hypothesized that these differences in reform decisions were based on existing threats to state stability and the way that alignments of those threats along both nationalist and ideological lines connected to the implications of healthcare reform decisions. In the case of Russia, politicians took advantage of the transitional moment and passed legislation on major structural reforms early. Today, though there is criticism of the workings of the healthcare system on the ground, reformers are able to focus on specific projects within already restructured healthcare institutions. In Ukraine, decision makers in the 1990s chose to delay reforms as they prioritized state stability in their state- and nation-building efforts. This choice set the scene for the muddled healthcare reform efforts seen in Ukraine today. I discuss these contemporary healthcare reform efforts and how they are rooted in the decisions of the 1990s in more detail in the next two chapters.
Chapter 5
The Legacy in Russia:
Institutionalization of Hierarchies of Power

5.1 Introduction

“Russia’s Health Care is Dying a Slow Death.” This headline, boldly written by Nikolai Epple of The Moscow Times in April 2015, accompanied a fitting cartoon of a Russian soldier etching into a headstone the bowl of Hygieia, a universal symbol of the pharmacy profession, as a doctor looks on, holding charts showing dramatic drops in unnamed indicators. In the article, Epple focuses on the apparent failures of the authorities’ moves to “optimize and modernize” the healthcare system, as well as the poor health indicators that have accompanied these efforts. He cites as evidence of the “slow death” of healthcare in the country the difficulty of access to healthcare for rural residents, the lack of communication between the authorities and the doctors and patients their policies are affecting, and the disaffection of medical personnel in light of new bureaucratic regulations.

The picture of Russian healthcare in Epple’s article is grim, and he certainly is not the only person to perceive it that way. In fact, amongst those looking at the Russian healthcare system – scholars, journalists, analysts – the use of the word “crisis” has almost become second nature. Mortality levels (especially amongst men), alcohol use, HIV rates, and the conditions of hospitals have been consistent topics of conversation for

\[35\] This image can be found at: The Moscow Times. “Russia’s Health Care is Dying a Slow Death.” 16 April 2015. [https://themoscowtimes.com/articles/russian-health-care-is-dying-a-slow-death-45839](https://themoscowtimes.com/articles/russian-health-care-is-dying-a-slow-death-45839). Permissions to reproduce the image here were sought by the author through all means possible, but no response was ever given.
those seeking to understand why Russia’s citizens appear to lack the high health status that usually accompanies improving economic development. But what leads to such a dark picture of Russian healthcare?

Some of the voices speaking out about healthcare, like Epple, look to the cold calculations of the authorities and the preference for “optimization” over greater access. Citing healthcare expert Larisa Popovich from the Higher School of Economics, he argues that the decentralization of the healthcare burden to regional budgets will further exacerbate this problem, because not all regional authorities have equal resources to maintain certain levels of universal healthcare for their citizens. This tension between the belief in the value of universal access and the economic efficiency of healthcare resource distribution is one that continuously plagues efforts by Russian officials to implement healthcare reforms.

In this chapter, I show how Russian healthcare reform today can be understood as the manifestation of the legacy of reform decisions made in the 1990s. I demonstrate that, after the Yeltsin administration’s decision to establish a mandatory health insurance system, powerful economic actors already winning from the transition quickly captured the insurance and pharmaceutical markets. The institutionalization of specific designs in building and reforming an insurance system then became entrenched, shaped and reinforced by the highly developed and cohesive hierarchy of elites in the country and the sharp division between the pro-reform actors with great influence over policy and the anti-reform constituency, made up of healthcare personnel and average citizens.

In other words, I demonstrate how these modern characteristics of the Russian healthcare system can be connected to the critical juncture of the 1990s that I highlighted
in Chapter 4 of this dissertation. The chapter is laid out as follows: First, I provide a brief overview of the course of healthcare reforms since the end of the 1990s. I discuss the structure of administration and financing, as well as economic trends. Next, I look closely at the actions that produced the legacy of the 1990s, those that have been taken by economic and political actors following the decision to establish a mandatory health insurance system. I show that the founding of the MHI system acted as a clear signal to powerful actors about the future structure of possible benefits in the healthcare system, incentivizing quick moves to capture the necessary markets. The decentralization of authority also empowered these actors further, allowing them greater opportunity to take advantage of regional and local knowledge of the system. Next, I highlight the importance of the hierarchy model of Russian healthcare and the role of regional and local health authorities, the rural-urban divide, and information asymmetry in the reproduction of the legacy over time. I show how the cohesiveness of elites regarding positions toward the reforms has aided in the process, and has, in fact, caused the process to remain a gradual one – though this is often seen as a problem to those who wish for a more extreme overhaul of the system. Finally, I conclude with a short note on the Russian case within the overall picture of post-Soviet healthcare reforms, and especially in relation to Ukrainian reforms, which are discussed in the next chapter.

5.2 The Russian Healthcare System Today: An Overview

What does the Russian healthcare system look like today, and what is the legacy of the critical juncture of the 1990s? In this section, I provide an overview of the functioning of the modern healthcare system in Russia, establishing the institutional basis for my analysis of the critical junctures’ legacies in the next subsections. I show here that,
as was begun in the early 1990s, the funding in the Russian healthcare system has largely moved to insurance funds and away from central budgetary sources. Responsibility for funding has been reorganized in favor of regional authorities, exacerbating inequalities across regions. Delivery for most basic services remains in the hands of the state.

5.2.1 Organization

The Russian Mandatory Health Insurance (MHI) system provides services through a hierarchy of federal, regional, and local authorities and private organizations, with financing organized through a Federal Fund and 86 territorial funds (including two in the recently annexed Crimean Federal District). These funds are responsible for distributing payments to health insurance organizations, which use them to fulfill plans and pay for medical services (FFOMS 2017). The Federal Fund and Territorial MHI Funds are semi-autonomous entities that contract with approved insurance companies.

Decision making about the health policy trajectory is generally concentrated at the national level, often spurred by the president and his administration and then supported by the State Duma Committee on Health Protection and the Committee on Social Policy in the Federation Council. Though generally secondary in the healthcare reform process following presidential initiatives, these committees demonstrate the patterns of interest with some influence over healthcare reforms. The current State Duma Committee consists of twenty members, fourteen of whom have had a medical education. Sixteen of the committee members belong to United Russia, two to the Communist Party, and one each to the Liberal Democratic Party of Russia and A Just Russia. Fourteen were born before the year 1960, indicating a continued strong connection to the Soviet era (State Duma 2017). The Federation Council Committee is comprised of seventeen members.
with much more diverse backgrounds, ranging from history and education to economics and medical sciences, with only eight members born before the year 1960. Members of this committee hail from fifteen regions, with two each representing Pskov and Volgograd (Federation Council 2017).

While national policymakers and bureaucrats determine the general policy direction to be taken across the system, regional and local actors are responsible for implementing those programs and adjusting them to the unique conditions of each locality. Regional legislative assemblies make the final decisions regarding budgets for Territorial MHI Funds. They also determine the budgets used to cover populations through general revenue funds. Furthermore, they approve municipal programs. Municipal authorities – made up of health departments or, in the case of rural areas, head physicians of the district hospitals – focus on the day-to-day implementation of policy, including the local organization of service provision, and administration of programs meant to educate the population about public health (Popovich et al 2011, pg. 23-24).

The division of the system into a hierarchy of state-run providers and semi-autonomous funds contracting with insurance companies was meant to promote the efficient use of resources and redistribution, in order to improve and modernize health services nation-wide while still maintaining the level of access provided by the Semashko system under the Soviet Union. However, as will be discussed further in this chapter, the decentralization of responsibility, rather than guaranteeing more efficient use of resources, has instead led to greater inequalities across the country.
5.2.2 Funding

5.2.2.1 Payments to the Mandatory Health Insurance Funds

Funding for the Mandatory Health Insurance scheme comes from a combination of federal, regional, and individual (through employers) contributions. Support from the central budget still covers certain areas of health, such as research centers and high-tech medical care. Funding for most citizens is covered by employer contributions to the health insurance fund, which consists of a 5.1% tax. This tax is taken out of the gross payroll by the employer before other taxes are applied and before income tax is taken out, therefore “hiding” it more than if it were taken out after the fact.\(^\text{36}\)

The government is responsible for covering the contributions to the health insurance fund for any citizens who are not covered by an employer, such as the retired and disabled.\(^\text{37}\) These contributions are divided amongst the federal and regional authorities, with the regional authorities covering a larger proportion. The responsibility of the regional authorities in terms of both funding and administration of the healthcare system has been increasing, moving from a little over 30% to around 40% in recent years (Shainyan 2014).

Beginning in 2015, there have been concentrated efforts to move the system closer to single-channel financing. The goal is to have the system fully funded through the MHI funds, with no funds coming from the central budget or other sources. This move is also putting more and more responsibility on the territorial funds for financing.

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\(^{36}\) I learned this information from a Russian friend, who informed me that, while they are told that they have health insurance, there is no information given on how much it is.

\(^{37}\) This coverage of anyone who is not covered by an employer is what makes the Russian system “universal.” In other systems, the people covered by the state are limited by indirect targeting rules (for example, it will only cover those living in families below a certain income level, only children under 18 years, etc.) (see charts in Mathauer et al 2016).
These changes can be seen in Shishkin et al (2016)’s graph (reproduced in Figure 15) showing the percentage of public funds towards healthcare coming from budgetary sources versus the percentage of those coming from the MHI funds. The percentage of health expenditures covered by public financing has been just above 50% in recent years (World Bank 2017).

**Figure 15 Share of Funds in the Budget System of Healthcare Financing and in the Russian MHI System**

(\% of total government funding)

Source: Calculations according to the data of the Ministry of Finance of Russia and the Federal Fund of OMC. Red indicates payments through general budgetary sources and blue through the MHI system (Shishkin et al 2016).

5.2.2.2 Payments for Services

Insurance companies act as third-party payers in the Russian system. That is, they write contracts for which they agree to distribute payments to healthcare institutions from
the MHI funds. Furthermore, insurance companies receive payments from organizations and individuals for penalties, such as those who “cause harm” to the health of an insured person or medical organizations that do not meet certain guidelines of protocol. Rosstat’s 2013 and 2014 reports on the insurance market provided a breakdown of these different types of funding, as well as the distribution of payments (Table 3). The funds received (through all channels except miscellaneous income) for the MHI system have increased over time, parallel to the increases in the funds used. Furthermore, the use of funds going toward paying for medical assistance (as opposed to “other uses”) has increased. This demonstrates a slow but increasing importance for the MHI structures.
Table 3 Main Indicators of Work of Insurance Medical Organization in the Area of Mandatory Health Insurance
(Millions of Rubles)

<table>
<thead>
<tr>
<th>Total Funds Received</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>funds received from territorial funds for financial support of MHI in accordance with agreements on financial security of compulsory health insurance</td>
<td>718801.9</td>
<td>1145366.3</td>
<td>1291923.2</td>
</tr>
<tr>
<td>funds received from medical organizations as a result of applying sanctions to them for violations found during the monitoring of the scope, timing, quality and conditions of the provision of medical care</td>
<td>22380.4</td>
<td>46302.2</td>
<td>64916.3</td>
</tr>
<tr>
<td>funds received from legal entities or individuals that caused damage to the health of the insured persons</td>
<td>11.9</td>
<td>12.3</td>
<td>14.0</td>
</tr>
<tr>
<td>miscellaneous income of earmarked funds</td>
<td>99041.7</td>
<td>8069.0</td>
<td>3280.8</td>
</tr>
<tr>
<td>Total Funds Used</td>
<td>804749.8</td>
<td>1137611.7</td>
<td>1305540.0</td>
</tr>
<tr>
<td>to pay for medical assistance rendered to insured persons by medical organizations, in accordance with contracts for the provision and payment of medical assistance for compulsory health insurance</td>
<td>701093.2</td>
<td>1127859.5</td>
<td>1300988.5</td>
</tr>
<tr>
<td>directed to the income of a medical insurance organization</td>
<td>2245.6</td>
<td>3373.0</td>
<td>4198.4</td>
</tr>
<tr>
<td>other use of funds</td>
<td>101411.0</td>
<td>6379.3</td>
<td>353.1</td>
</tr>
<tr>
<td>Return of target funds to the source of financing</td>
<td>56164.5</td>
<td>46215.5</td>
<td>37434.2</td>
</tr>
</tbody>
</table>


5.2.2.3 Registration for Insurance Plans

All permanent residents are entitled to a “free” MHI plan.\(^{38}\) However, because citizens can in fact receive basic healthcare, such as emergency services, for free and because the services included in the Basic Plan are free to everyone, many Russians (especially younger generations, such as university students) do not bother to register for

\(^{38}\) The policies are “free” in that a citizen does not have to pay upfront to receive the policy. However, as mentioned above, funding for these policies come out of wages for those who are employed. Therefore, while citizens may not directly see the payments, they are, indirectly, paying premiums for policies.
an official plan, even though they are entitled to one. Instead, they are simply covered once they arrive at the medical care facility, with the state Funds covering the costs of those services in the Basic Plan. Furthermore, temporary policies can be purchased for a 30-day period, if needed. It is therefore difficult to incentivize some groups to go through the process of officially signing up for health insurance policies. Furthermore, citizens are allowed to switch between insurance companies only once a year. As of April 2014, there were a total of 143.8 million people covered in the MHI system (60 million employed and 83.8 million unemployed).

5.2.2.4 Services Covered

The services covered by the MHI scheme include those listed in the Basic Plan, which is reviewed by state authorities each year. The Basic Plan for 2016 (Decree of the Government of the Russian Federation, 19.12.2015 N 1382) included a list not only of types of services that are guaranteed (such as emergency services, primary care, and palliative care), but also a list of types of diseases for which free treatment is guaranteed, including diseases of the nervous system, respiratory diseases, and infectious diseases. The full list is extensive. Regional governments are allowed to expand upon this list in their own plans, meaning that some territories have more extensive coverage than others. Payment for other services can be covered by voluntary health insurance and out-of-pocket payments.

The extensiveness of the list itself proves to be a problem for Russians. Like many people when it comes to insurance, Russians find the system to be complex and difficult to understand in terms of what is and is not covered. This can lead to confusion,
at times, and stokes a popular idea that doctors are finding ways to charge patients for services that should be free.

5.2.2.5 Risk Equalization

An important characteristic of healthcare systems is how they attempt to equalize risk – that is, how they distribute the costs of the probability of illness across the population. This aspect of healthcare is meant to address the challenge of providing vulnerable populations – who are also often the most likely to get sick and need healthcare – with care when they cannot afford it. Commodification of illness – which is often cited as a main characteristic of systems that put a greater burden on individuals and do not protect vulnerable populations as extensively – is often considered “amoral,” and in the Russian Federation, this is no different.

Budget transfers are used across territories in order to “equalize” spending on health. Richer territories are supposed to help boost up poorer regions, with some aid from the federal fund. However, there is no set amount for these transfers – they are instead the result of a negotiation process across governments (Mathauer et al 2016). It is elements like this and the growing proportion of funding covered by Territorial MHI funds that create further inequalities and give politics an even greater role.

5.2.2.6 Health Insurance Companies

In 2014, Rosstat reported that there were 59 insurance companies working in the compulsory medical insurance system (Rosstat 2014). This was down from 63 in 2013 and 71 in 2012 (Rosstat 2013). As stated above, these companies serve as third party payers in the Russian system. This is different from the days of the Semashko system in that the state itself is not creating the financing contracts or paying directly for services.
This insurance arrangement, with the funds protected through their collection in the Funds specifically meant for health coverage, is meant to defend against a corruption of costs. That is, because insurance companies are interested in earning the business of more and more citizens, they are believed to have incentive to bargain for lower payment and better quality services (this is the logic of any insurance system).

However, because there is such low-quality care and insufficient training of medical personnel (the main complaints – 50% and 49%, respectively – in a Sogaz-Med survey conducted in 2015 [St. Petersburg Legal Portal 2015]) – it is difficult for insurance companies to write contracts that prove to be satisfactory to customers, especially in addition to rising costs. The challenges of competing in a market with few options is driving the dramatic drop in the number of companies working in the system. Furthermore, as will be expanded upon in this chapter, individual-level consumer choice is very low (employers and regional governments choose insurers), and “competition” often plays out through payments/benefits to decision makers (Tompson 2006, Xu et al 2011).

5.2.2.7 Voluntary Health Insurance and the Private Market

While the private market in healthcare is legal in Russia, it is extremely underdeveloped. Private medical facilities are heavily concentrated in the highly urbanized areas (particularly Moscow and St. Petersburg), where foreigners are more likely to be utilizing health services. There have been some moves in recent years to develop public-private partnership in the healthcare industry, though these have not been effective, at least at the national level.
The voluntary health insurance (VHI) market, while it has never been very strong, has been continuously declining over the past several years. According to the All-Russian Union of Insurers (Vserossiyskiy soyuz strahovshhikov (VSS)), the number of contracts in the voluntary health insurance market fell by 34.5% from 2015 to 2016 (Yurgens 2016). The inability of the voluntary health insurance market to compete amid an environment of rising costs in healthcare leads to fewer contracts and higher premiums. Because Russian citizens already have few incentives to sign insurance contracts (given the universal nature of free care at the point of delivery), VHI companies have a particularly hard time staying in business amongst average Russians.

5.3 The Legacy

In this section, I outline the way in which the critical juncture of the 1990s resulted in the de jure and de facto state responsibility institutional legacies described in the previous section. I highlight how the decision in the early 1990s to implement a MHI model led to the capture by powerful economic actors of much of the market that was meant to provide greater competition and, subsequently, quality care. This, combined with the institutionalization of the hierarchy of responsibility, led to the entrenchment of interests in the new healthcare system. National policymakers, both from the executive and legislative branches, continue to use healthcare reform as a platform to gain social support. Regional politicians partner with economic interests to shape the reforms in ways that benefit those with the greatest influence. Subnational decision makers often serve as scapegoats for the failure of implementation. And powerful economic interests at the national level continue to capture the market for insurance, pharmaceuticals, and technology. This system today reinforces itself, as the power distribution encapsulated by
those early moves has exacerbated natural information asymmetries in the healthcare market, furthering the embedding of the institutions.

I first discuss the initial moves that established the power distributions we see today after the decision to pursue a mandatory health insurance scheme. I then turn to the interests that these distributions produced, discussing how they have taken advantage of natural issues of asymmetric information in healthcare systems to reinforce the hierarchy of influence. I show that, while national policymakers continuously discuss healthcare reforms and initiate programs to improve the system, the decentralization of responsibility to regional and local authorities has created the possibility for principal-agent issues. However, central decision makers largely do not address these issues effectively, using them instead as a way of shifting blame for any inadequacies of the system. Distrust in healthcare authorities amongst the population, corruption, and utilization of informal networks also continue to exacerbate these issues, making it difficult for any programs to effectively address the inefficiencies of the system. These mechanisms of reproduction have guaranteed that the Russian healthcare system continues to be influenced by the decisions made in the 1990s by the Yeltsin administration.

5.3.1 Power Distributions and the Aftermath of Elite Decisions

By 1993, Russia has signaled – both constitutionally and through reform legislation – that it intended to dramatically restructure the organization and, particularly, the financing of the healthcare system, moving to an insurance model meant to produce more efficient and greater quality care while reducing state financial commitment. A purchaser-provider split and development of the private market became high priorities in
the state’s efforts to divest from the healthcare system. However, through constitutional guarantees, leaders also re-committed the de jure responsibility of the state as guarantor of universal access to basic healthcare, focusing especially on covering the most vulnerable populations, including the unemployed and disabled, with budgetary funds. The new, more limited role for the central state opened the opportunity for the empowerment of other actors in the healthcare system, including in the development of insurance and pharmaceutical markets and private provision for those able to pay for higher quality care. While the details of these commitments would take time to organize and implement, early legislation provided signals to the population and to potential interest groups what the future of healthcare would look like in Russia. As a result, constellations of interest in favor of and in opposition to the new system quickly developed, and the state’s new role regarding responsibility for healthcare became entrenched.

In the current healthcare system, the level of influence on reform efforts ranges widely, from the high influence of presidential directives on the implementation of new programs, to the low influence of patients, who have few means to affect change and have largely adopted attitudes of quiet resignation or turned to informal payments or networks (Manning and Tikhonova 2009, Popovich et al 2011). The distribution of influence on abstract policy decision making is laid out in Figure 16 below. For influence over implementation and results on the ground, the table is reversed.
While the healthcare system has formally moved through various decentralization and recentralization efforts, the distribution of power across actors has largely remained the same. In terms of system-level policymaking, the president and national legislators continue to have the greatest influence. President Vladimir Putin has consistently made healthcare reform a part of his strategic planning, commenting on the issue in his state addresses and raising it as a priority for his Strategic Development Committee. His Experts Directorate further influences healthcare policy, providing the analysis and recommendations for the President’s directives. The State Duma and Federation Council committees also frequently meet with healthcare experts in an effort to determine the best course for reforms. However, while this planning provides a positive image for their offices’ efforts, the leaders rarely are able to make their programs widely successful, and a consistent political will is difficult to muster.  

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39 Author Interview with World Health Organization official [Anonymous], Moscow, February 2015.
5.3.1.1 Development of the Insurance and Pharmaceutical Markets

A key factor in the new Mandatory Health Insurance (MHI) system was the development of an insurance market that would pool risks and separate purchaser and provider interests. A market soon formed, though it was quickly dominated by the newly empowered oligarchs and reformed institutions under the state’s control.

The early years of the transition, coinciding with the official establishment of the MHI system, also saw the founding (or reforming) of major insurance companies run by state officials and oligarchs that continue to dominate the market in Russia today. Rosgosstrakh (RGS), the successor of Gosstrakh, the Soviet state-run insurance company, became a state-owned joint-stock company as early as February 1992. Having the advantage of already controlling the potential market, RGS soon dominated the market for MHI plans, today covering 1 in 7 Russians, or about 21 million people (Kalinin 2012, Carpenter 2015). The second-largest insurance group in Russia today was also founded in the years immediately surrounding the establishment of the MHI system. In 1998, the Sogaz Insurance Group, a collection of eleven affiliated companies, established Sogaz-Med, a subsidiary specializing in insurance through the MHI system. Today, Gazprom, Rossiya Bank, and the Volga Group all hold substantial stakes in the Sogaz Insurance Group and have shifted holdings to avoid sanctions (Economist 2015, Carpenter 2015).

Similarly, the pharmaceutical market was subject to state capture during the early years of Yeltsin’s reforms. As Vacroux detailed, based on extensive interviews with pharmaceutical professionals:

“Placing their representative near or at the top of important federal and regional bureaucracies allowed these entrepreneurs to capture some of the key regulators of their industry and to lobby the remaining parts of the government for benefits ‘from within.’ Private interests pressured
President Yeltsin and various governors to appoint ‘the right person’ for official positions by noting the resources they had or could provide in past and future elections. These vanguard entrepreneurs had the money and credits desperately needed by national, regional, and municipal politicians” (Vacroux 2004, pg. 144)."

Like those oligarchs who captured the insurance market, the pharmaceutical market was quickly consumed by those who benefited most from the transition to the market economy, though the characteristics and form of this process looked different across regions, depending on the local conditions (Vacroux 2004). These trends of state capture through nascent markets also tended to weed out smaller firms and create perceptions of “crony bias,” or an inequality of the level of influence firms felt they had as compared to their competitors (Hellman and Kaufmann 2004, Slinko et al 2004).

The inability of the average citizen to support the development of a competitive market of insurance companies, as well as the high cost of entering the market, restricted the redistribution of benefits of the newly established insurance system to those actors that were already benefiting from the transition. Oligarchs of the oil and gas industries quickly took advantage of the change, establishing both their position within the new system as well as what would be a long-term constituency of support for the MHI restructuring.

Was the decision to develop an insurance system, reducing the state’s de jure responsibility, the result of the interests of these powerful players influencing policymaking? As I showed in previous chapters, the choice of a MHI system for the newly independent Russian Federation was rooted more in the desire of state officials to reduce financial commitment during the economic crisis and to restructure the system in the mold of existing, relatively successful, healthcare models of European states, while
still preserving the positive elements of the Soviet system. Therefore, while economic interests certainly won out from the choice, their domination of the new system was more the result of good fortune of timing and position than a result of their influence on the model itself.

5.3.1.2 Decentralization: Shifting Responsibility to Subnational Actors

The formal organization of the healthcare system has gone through both decentralization and recentralization efforts, with the overall trend of responsibility for implementation shifting toward regional actors, including regional committees on health, Territorial MHI Funds, and the district hospital administrations. While attempts to develop nationally standard measures of efficiency and quality for better monitoring have centralized system-level policymaking power, regional actors have continually been given greater power over budgetary and implementation decisions. These efforts mirror similar decentralization movements that have been taking place globally, and especially in Europe, since World War II (Saltman et al 2007). The decentralization reforms in Europe have aimed to improve efficiency by empowering decision makers with greater knowledge of unique local conditions. However, positive results, though possible, depend upon other system characteristics, such as the successful development of incentives and the mechanisms developed for resource allocation (Costa-Font and Greer 2013).

In Russia, regional decision makers have the final say not only on budgetary items, but also on the composition of the regional benefit packages (required to provide the services of the Basic Package, but allowed to provide supplemental benefits as well), the way in which the system is organized for vulnerable populations in the region, including the unemployed and disabled, and the coordination of regional and medical
facilities in line with national policy (Popovich et al. 2011, pg. 23). These regional authorities, then, provide the key lynchpin connecting the grand plans and initiatives directed by the federal-level actors to the implementation of reforms on the ground and the state’s de facto responsibility.

These decentralization reforms were initially pursued largely out of necessity, with many federal ministries in the 1990s unable to adequately address issues at the regional and local levels while still recognizing the necessity of reforms. Federal officials were forced to establish greater “freedoms” for regional actors to achieve their reform goals (Vacroux 2004, Radaev 2002). The growing influence of the central state since the early 2000s has challenged this explanation for current decentralization efforts, though some argue that this is still indicative of the weak institutionalization of state authority (Stoner-Weiss 2006). On the surface, however, decentralization has been touted as a tool in the building of a more efficient healthcare system.

The results of such devolution of healthcare authority have been mixed. Data collected through monitoring efforts by the Independent Institute for Social Policy and the Federal Public Health Institute from 2004-2006 showed the wide variation and changes from year to year in regional performance in meeting national policy goals on mortality and quality of services (Independent Institute for Social Policy 2006). The differing resources and priorities of regional authorities significantly shape the approach taken, despite efforts to standardize programmatic modernization efforts across the country. The concerns about the inability and varying willingness of regional leaders to consistently meet federal guidelines has been raised at State Council Presidium meetings (President of Russia 2014).
In order to address these inconsistencies between institutions, resources, and needs, the Russian government has continued to attempt further reforms. Immediately following the years of the Independent Institute for Social Policy’s data, the healthcare system became part of the broader effort to recentralize and reinvigorate federal authority throughout Russia. President Putin established the National Priority Project “Health,” mentioned above, to create a more efficient healthcare system. However, these reforms, according to private as well as government reports, have still not been carried out equally across the country. The Ministry of Health’s evaluation of the Territorial Program of State Guarantees (TPGG), done through a combination of calculations, such as the average number of in-patient days and the average number of out-patient visits, reported in the region’s Form 62 submitted to the Ministry, was used in 2008 as a means of determining the level of realization of healthcare goals within the regions (Figure 17). As was found in the earlier data from 2004-2006, regions varied considerably in how well they met the national standards laid out by the federal government.
However, despite the mixed results, this trend of decentralization of administrative and fiscal responsibility has continued to the present day. The recent release of the 2017 budget plan revealed that the federal authorities are shifting the burden further to the regional authorities and individuals, as has been the case for much of the past decade (Shainyan 2014). From 2016 to 2017, the federal government cut its contributions by 33% (Novaya Gazeta 2016). Given the state of the economy in recent years, the general trends in financing (shifting from federally funded to regionally and individually funded), and the government prioritization of other areas such as defense, this is not a surprise. Beyond economic constraints on resources, shifting political
priorities have continually been a determining factor of attention to healthcare and willingness to pursue reforms, even when it involves international partners and cooperation.40 Speeches and signage at doctors’ protests over cuts to the Moscow city system in the fall of 2014 reflected the public’s frustration over the prioritization of defense over healthcare (Figures 18 and 19 below). Much like in the 1990s, there is a tension – right when the economy is struggling and people need more help, the government appears to be cutting safety nets, leading to criticism of the system.

**Figure 18 Protests Against Moscow City Healthcare Cuts, November 2014**

*Photo Taken by Author. The signs read “Economize on war, not on doctors” and “Without affordable medicine, there is no Russia!”*

40 Anonymous, Interview with United States Embassy science diplomacy official, Moscow, February 2015.
Furthermore, the inability of the system to balance the interests of those involved (insurers, health facilities, patients, the state) leads to perverse incentives, especially when it comes to finances. The lack of measures of effectiveness as a means of distributing money more efficiently adds to this problem (Kravchenko et al 2013). Attempting to shift the financial burden away from the federal level has put more pressure on the regional actors, individuals, and insurance companies, but because there is not an established system allowing for the re-investment of funds, there are few means for these groups (particularly insurers and healthcare institutions) to profit in a way that would provide incentives for better services. There is instead a “negative economic motivation” in providing healthcare as a commodity (Kravchenko et al 2013). The fact that any increases in funding at the regional levels that have been seen have often gone...
toward increasing the salaries of doctors or been canceled out by inflation have not aided in this assessment (Shainyan 2014).

5.3.2 Interests, Asymmetrical Information, and the Reproduction of the Legacy

The establishment of a mandatory health insurance system in the style of Germany’s Bismarckian social insurance system created vested interests that made it difficult to shift course over time (Pierson 2000). Constellations of interest (Cook 2007) developed along the lines of the newly cemented power distributions at the establishment of the mandatory health insurance system in Russia, reflecting similar trends of “winners” capturing the reform process after the initial stages of transition (Hellman 1998). These groups can be traced to the power distributions discussed above.

5.3.2.1 Pro- and Anti-Reform Constellations of Interest

In the years since the initial drive to move the healthcare system to one more conducive with the growing market economy, clear pro- and anti-reform tendencies have formed across groups in Russia, with the major divide forming between the “winners” and “losers” of the transition years. The power distribution of the 1990s has become a seemingly immutable fixture in the healthcare sphere. These “constellations of interest” (Cook 2007) that have formed around the reform efforts have led to the persistence of apparent disconnects between those making and implementing the reforms, and those subject to the effects of those reforms.

On the anti-reform side (if considering the MHI changes to be the basis of reform), patients (everyday citizens) and healthcare personnel have firmly set themselves against the government’s efforts. While acknowledging that improvements must be made, they distrust the market mechanisms put in place, arguing that they are meant to enhance
the wealth of those on top while leaving behind those in need. Instead, these groups remain largely in support of a greater role for the state in guaranteeing a certain level of healthcare. Their power to resist reforms, however, is not only limited to a lack of porous government institutions through which they can introduce their preferred policy trajectories to the political conversation (Immergut 1992, Roberts 2009). In fact, physicians were and continue to often be invited in to Ministry of Health and legislative committee meetings and appointed to analytical and research institutes and committees assigned to advise policymakers to discuss their expert opinions. In fact, the Federation Council and State Duma committees in charge of health policy have numerous members with medical backgrounds (Federation Council 2017, State Duma 2017). Instead, in contrast to the findings of studies of healthcare reform in Western and even post-communist Central Europe, it appears that the major weakness of such groups is not rooted in their inability to introduce ideas, but rather in their lack of influence over the final decision of the reform designs and actual implementation plans, which are largely left to the executive and the Ministry of Health. As Vacroux (2004) stated of the development of the Russian pharmaceutical market, “Whereas one can include transition losers in elections and policy making, it is difficult to integrate them into policy implementation” (pg. 143). What instead occurs is a disconnect between the recommendations of medical personnel and policy, thus incentivizing resistance to reform efforts in daily medical care settings, and a resulting contradiction between the state’s de jure responsibility and its de facto responsibility on the ground.

On the other side, one finds politicians and bureaucrats, oligarchs seeking to take advantage of new business opportunities, and, to a point, international organizations, all
of which have had a direct hand in designing and planning the implementation of the reform efforts – the state’s de jure responsibility – though the level of international organization influence has been limited by the willingness of politicians to allow them into the process. Those who benefited the most from the transition of the 1990s, increasing their power and wealth, remain those in favor of maintaining the drive for reforms. Because they remain the most influential in the economic and political systems of Russia, these actors also have the power necessary to sustain such a trajectory with little challenge to their efforts. Furthermore, by capturing the insurance market, pharmaceutical industry, and ownership of the companies providing technology to healthcare to hospitals and clinics, these actors have guaranteed that the institutions are reinforced.

The support of international organizations for reforms has validated these efforts to an extent, with agreements for meeting World Health Organization standards, encapsulated in the Country Cooperation Strategy for the WHO and the Ministry of Health of the Russian Federation for 2014-2020, backing the movement toward a more efficient mandatory health insurance system:

“The aim of “Health care development”, approved by Government Resolution No. 294-r of 15 April 2014, is to make medical care more accessible and more efficient, with the volume, quality and types of care commensurate with disease incidence rates and the needs of the population, consistent with the latest medical advances and with the WHO European Health 2020 framework” (WHO 2014a).

Though international organizations’ work must function through the channels of domestic policymaking and, therefore, is necessarily – and rightfully – shaped to fit the unique

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41 Author Interview with World Health Organization official [Anonymous], Moscow, February 2015.
conditions of the country, the coordination of international efforts with domestic reforms often provides much needed bolstered legitimization, especially during times of retrenchment of social services.

These constellations of interest, as remnants of the established hierarchy of the 1990s, demonstrate the importance of understanding how actors captured the market during that time, why it was allowed to happen, and what it means for Russia’s healthcare reform trajectory. This continuing divide over reform support corroborates the hypothesis that the 1990s served as a critical juncture for the reform trajectories we see today and, as I will show in the subsections below, the dynamics are, at this time, still strongly reinforcing the legacy of the Yeltsin-era decisions.

5.3.2.2 Healthcare Reform: Formal Channels for Discontent with Few Results

Since Vladimir Putin came to power at the end of the 1990s, national government and regional actors have continuously discussed ways to improve the healthcare system. However, relative to the efforts to create further channels for the voicing of concerns and develop better monitoring mechanisms, the level of improvement in the performance of the system has been low, and satisfaction amongst the public has, similarly, remained minimal. While general satisfaction levels in recent years have shown similarities across urban and rural regions, the top concerns have differed significantly, with citizens in rural areas far more worried about availability than those in the major urban areas, where concern about quality far outweighs that for availability (MoH Russian Federation 2015).

Presidential power has been a key factor in the shaping of the trajectory of healthcare reforms, and political will – particularly that of Vladimir Putin – has been a key factor cited by international organizations in initiating programs to meet agreed-upon
global standards. However, this influence has largely remained at the abstract policy level and the initiation of new programs and directives. The presidential office and cabinet members have consistently promoted the idea of the modernization of the healthcare system. President Putin in particular has shown interest in this modernization effort. Reinforcing this idea at a March 2017 meeting of the Strategic Development Council, he stated that, “It is necessary to create a truly modern health system at all levels,” emphasizing the continuing existence of many problems in need of solutions, including the shortage of doctors, the length of lines, rudeness of staff, and an obligation to improve the “prestige, status, and material position” (prestizh, status, i materialnoe polozhenie) for healthcare personnel (Latukhina 2017).

Indicative of possible corruption and principal-agent problems, the healthcare system has continued to underperform, despite executive attention to its improvement. The disconnect between the rhetoric at the national level, focused on modernizing the healthcare system, and the actual performance of the system, has developed into a point of frustration for much of the population (Grishunina 2015). Auditing reports of the Accounting Chamber of the Russian Federation show that many of the goals of the May 2012 Presidential Decree No. 598, “On Improving of National Policy in Health Care,” have not been met (Accounting Chamber 2014). In particular, the regions of Belgorod, Voronezh, Tver, Kursk, Leningrad, Kaliningrad, Irkutsk regions, Transbaikal and Perm Krai were specifically cited as failing to meet the mortality reduction goals, which “indicate[ed] insufficient effectiveness in the use of funds allocated for these goals” (Accounting Chamber 2014, pg. 39).

42 Author Interview with World Health Organization official [Anonymous], Moscow, February 2015.
Much of the blame for this failure of implementation has been shifted onto subnational actors, a trend followed by national officials to attribute the system’s shortcomings to principal-agent problems, rather than any failings of the federal state to meet the obligations of its de jure responsibility. The cross-regional variation in performance discussed above is often held up as evidence of this problem and the need to improve “the strict control, primarily on the part of regional authorities” (Putin, quoted in TASS 2015). Yet, curiously, regardless of the rhetoric of federal officials, the system has been slow to address these inequalities. National-level policymakers’ ability to use healthcare reforms as a platform for gaining greater support but apparent unwillingness to drastically overturn hierarchies of influence emphasizes the way in which the healthcare institutions and reform trajectory have become entrenched and continue to be reinforced by the initial power distributions first established during the 1990s.

Because this inefficient state most benefits those actors who already profited during the transition, policymakers find ways to legitimize the system and protect their own positions when criticism arises. Beyond addressing these issues publicly and indicating a desire for reform, the most popular tool has been the opening of formal channels for citizen complaints and requests for information. Vladimir Putin’s All-Russia People’s Front (ONF), which he founded in May 2011 as a means of coordinating efforts between the ruling United Russia party and non-governmental organizations to address various social and economic issues of the country, remains the most prominent example of the ruling elites to “reach out” to the public and provide a channel for expressing discontent and concerns. Through such mechanisms, the public finds ways to communicate with the top political leaders and express their dissatisfaction with various
issues plaguing the country. Such channels of communication reflect the letter-writing complaint channels used by citizens to communicate with the Ministries, including the Ministry of Health, of the Soviet Union (White 1983).

The All-Russia People’s Front has proven to be a well-funded and well-known example of this approach, and citizens have been strongly encouraged to express their discontent through its official channels. Approval of the activities of the group have grown since its establishment, despite most people believing the ONF was founded either to broaden Putin’s political support so he did not have to rely so heavily on United Russia, or to increase Putin’s popularity (Levada Center 2015). An All-Russian Public Opinion Research Center (VCIOM) survey conducted in mid-November 2016 showed that, of the possible issues to be addressed by this coalition, citizens felt that health and medicine should be the top priority, narrowly beating out unemployment (46% to 45%). The belief that health and medicine should be the top priority varied based on the size of the respondent’s home region. Belief that it should be the top concern remained lowest in urban regions with more developed health systems, ranging from 35% in Moscow and St. Petersburg, 39% in megacities, and 38% in cities with greater than more than 500,000 residents. In these areas, the top concerns were, respectively, the quality and cost of housing services, environmental pollution, and unemployment. In villages and cities with up to 500,000 residents, however, the belief that health and medicine should be the top priority ranged from 48% to 54% (VCIOM 2016).

At the same time, while the executive branch at the national level has repeatedly called for an improved healthcare system, the presidential office has attempted to avoid blame for any cuts in the retrenchment process that has taken place under reform efforts.
With responsibility for implementing reforms devolved to the regional and local levels, the sub-national officials often come under greater scrutiny from the public for retrenchment efforts.

5.3.2.3 Asymmetrical Information and Power Distributions

While many of these efforts were purported to be an effort to strengthen the state and address principal-agent problems in the actions of regional actors, they did not produce the hoped-for far-reaching results. Instead, they missed the key issue, that it was not the principal-agent problems resulting from ungovernability of the country or the weakness of institutionalization (Stoner-Weiss 2006); rather, it was the institutionalization of an inefficient state and the resulting contradiction between state de jure and state de facto responsibility that plagued healthcare. This inefficient state was the result of the decisions made during the critical juncture.

One of the biggest problems with the MHI system in Russia is the lack of information and education amongst citizens on what their rights are. A medical insurance company in St. Petersburg and the leading company in VHI contracts, Sogaz-Med, found in a June 2015 survey that 54% of respondents admitted not knowing how or when they have a right to make claims through the insurance system. 29% of respondents did not know that there was a list of services covered by the MHI plan available. While 69% said that they had an idea about having rights through the MHI system, only 15% felt that they could consider themselves “knowledgeable” about it (St. Petersburg Legal Portal 2015). Studies from the early 2000s showed similar patterns, indicating very little change over time (Fotaki 2006). As mentioned above, there is no information given on paycheck stubs about the percentage or amount taken out for health insurance.
Despite the lack of information, citizens’ distrust in the system is focused on healthcare providers, with dissatisfaction with quality of care (50%) and the insufficient training of doctors (49%) outweighing concerns over the insurance companies working in the MHI system (9%). Amongst reasons for not visiting a clinic when ill, citizens cited bad organization of hospitals and distrust of the medical staff, rather than lack of knowledge (VCIOM 2015). The distrust of doctors and widespread belief that they are interested only in profits clashes sharply with the reality of the astonishingly low pay of physicians – the average salary of whom is currently lower than the salary of an average fast food worker, according to a recent report published by Nikolai Mironov’s Center of Economic and Political Reforms (CEPR 2017, pg. 15). These trends and the disconnect between awareness of information and perceptions of top concerns point to a legacy of information asymmetries embedded in the healthcare system and a culture of hierarchical decision making concerning health that has been resistant to change. Instead, the information asymmetry has been reinforced with time.

With weak pressure from citizens, the inadequacies in guaranteeing citizens’ right to make a fully informed decision have been slow to improve, and insurance companies have built their businesses around this hierarchical relationship. A March 2017 audit by the Accounting Chamber of the Russian Federation of insurance companies’ roles in communicating information to citizens found vast inequalities and insufficiencies across the regions (Accounting Chamber 2017). Moreover, it found that in many regions, citizens did not have a choice of insurance provider, eliminating the market mechanism that is supposed to drive companies to provide better quality services.
Both economic and political elites have not been wholly hidden in their moves to take advantage of the system. A massive corruption scandal involving leaders of the Federal Fund, Territorial Funds, and pharmaceutical companies, made headlines at the end of 2006. The head of the Federal MHI Fund, Andrei Taranov, was arrested, and charges were brought against him, the former deputy director of the Fund, Dmitriy Usenko, and several other Fund leaders, for accepting bribes from pharmaceutical companies and the heads of the Territorial MHI funds through the Additional Drug Supply (DLO) Program (Kommersant 2006). The general director of “Protek,” Vitaly Smerdov, one of the largest pharmaceutical companies in Russia, was convicted of bribing senior officials of the Federal Fund in August 2007 (Romanova 2007).

Not only did this scandal bring to light the corruption throughout the higher echelons of the system, but it brought to the forefront the possible conflicts of interest and concentration of power captured by those in decision-making positions in the state healthcare system. This brought negative attention to the Fund, eventually leading to a parliamentary declaration of the Minister of Health’s work as unsatisfactory and the splitting of the Ministry of Health and Social Development into two departments (Kommersant 2006, Lenta.ru 2017). Furthermore, the heads of the Territorial MHI Funds involved included those from Tomsk, Voronezh, and Smolensk (Kommersant 2009) – the latter two of which are regions represented on the Federation Council on Social Policy today.

Even more incriminatory of such capture of market power was the relationship of Andrei Taranov to the Minister of Health and Social Development at the time, Mikhail Zurabov. Both were founders of the insurance company MAKS, which, after it was
established in 1992, was one of the companies approved to provide MHI plans in 1993 and later became the official insurance provider of the Ministry of Atomic Energy in 1997 (Insurance News Agency 2017). Zurabov chaired the company from 1992-1998, before becoming Deputy Minister of Health in 1998, an advisor to President Yeltsin on social issues from 1998-1999, chairman of the Pension Fund in 2000, and then Minister of Health and Social Development in 2004. Despite various calls for his resignation during the corruption scandal and the parliamentary declaration of his work as unsatisfactory, Zurabov was not immediately let go and instead stayed on as Minister until later shifts in government positions as a whole in 2007. At that time, he reportedly became an advisor to President Putin (Lenta.ru 2017). Some citizen and amateur news sources even cited unnamed officials as saying that the plan for the arrests had long been in place and known by Putin himself, and though Zurabov was not given much warning, he was able to save face as the arrests took place (Fishman and Raskin 2006).

Yet, despite these activities and discussions of and disgust with the scandal amongst everyday citizens, few systemic changes have been made to the market, and, as noted above, citizens’ frustrations focus on their everyday interactions with medical personnel and medical facilities. This misdirecting of dissatisfaction, exacerbated by rhetorical tactics of national politicians used to shift blame – as with Vladimir Putin’s statements on the need to address rudeness in clinics above –aid in the continuing reinforcement of the power distribution first established during the transition period. The continuing emphasis of the state’s de jure commitment to healthcare as a human right clashes with the conditions on the ground, creating further disenchantment with the system. However, with powerful political and economic elites in charge of the main
channels of information and with little drive amongst citizens to support greater individual responsibility for health, the institutions of the MHI system bolster themselves and continuously entrench the institutions initially established during the Yeltsin era.

5.4 Conclusion: Reformed Institutions, Mixed Implementation

Russian leaders in the 1990s perceived the state as having the capacity to weather major healthcare reforms because of their relatively strong and cohesive structure internally and the lack of a coordinated threat to state stability that aligned both economic preferences and national identities with territorial threats to the state. However, they still had to rely on regional and local authorities to implement the reforms. The hierarchies of influence captured and entrenched by the decision in 1993 to officially implement an MHI system throughout the country has continued to have a significant impact on Russian healthcare today. With powerful interests looking to reinforce relationships based on information asymmetries, it continues to prove difficult to make significant adjustments, leaving many residents without adequate care. The reproduction of the legacy of the critical juncture – the way in which the state’s de jure responsibility, its de facto responsibility at the level of care, and the contradiction between the two interact to shape political rhetoric, public opinion, and health outcomes of today’s healthcare system (which, in turn, reinforce the above institutions) – continues to make the decisions of the Yeltsin regime relevant for Russian healthcare today.

However, unlike in the Ukrainian case, which I explore in the next chapter, the foundation of institutions meant to equalize risk, improve the quality of care, lower costs, and guarantee access have been in established in Russia, putting it one step ahead of
countries like Ukraine, where no significant reforms were implemented during the 1990s. I show that the problems faced by those countries whose systems came out of the 1990s will little reform are, in fact, facing much greater challenges than those in which at least the base of a new system exists.
Chapter 6
The Legacy in Ukraine

“Everyone wants something to happen, but everyone is afraid as if something might happen.”
~ Bulat Okudzhava

6.1 Introduction: A Pattern of Failure

During a June 2017 push for legislative approval for major healthcare system reforms, the Minister of Health Ulyana Suprun, having only been in office for a few months, found herself faced with vicious opposition. In an appeal to her fellow Ukrainian leaders, she beseeched them to move forward, arguing that they “could continue to search for an ideal model (of the reform), but the current healthcare system is in ruins” (Melkozerova 2017). While the legislation squeaked past on that tense summer day, its future remained murky. With staunch opposition from its supposed partner in the healthcare reform fight, the Verkhovna Rada Committee on Health, as well as from major physician-led groups, the Ministry faces a steep uphill battle in following up on the implementation of the planned reforms. Without the cooperation of these major players, the likelihood that the reforms can be successfully executed remains questionable.

This pattern of legislation with few constructive results would be nothing new. Through multiple administrations, the promise of healthcare reform has been flashed before everyone’s eyes and then quickly disregarded as a failure amongst scandals, finger-pointing, and frequent changes in leadership. While it would be easy to look at this as an indications of weak state capacity and corruption, doing so would ignore the impact that the decisions of the 1990s have had on the reform challenges we continue to see
today. What we see instead when considering the pattern of reform failures within the context of those initial decisions is the institutionalization of a healthcare system that weakens the Ministry of Health and empowers multiple opposing actors across the healthcare system, including chief physicians, the pharmaceutical industry, and the Verkhovna Rada Committee on Health. This balance of power had appealed to decision makers of the 1990s who, in an effort to unify the country and build legitimacy for their positions, sought to embrace a more democratic approach and implement reforms utilizing standards promoted by the European and wider international community. This prioritization of state building in the face of threats aligning along national identities and economic preferences institutionalized the contradictions between the state’s apparent de jure commitment to universal healthcare, the conditions on the ground, and the reform efforts. It also institutionalized a division of power that has stalled reform efforts. The continuing failure, furthermore, has bolstered levels of distrust about any reform efforts amongst citizens, making it even more difficult over time to build public support for proposed changes.

In Chapter 4, I argued that Ukraine, like the other post-Soviet countries, experienced a critical juncture in the 1990s, at which point significant structural healthcare reforms had a greater chance to be passed, setting the system on a new trajectory, due to the loss of legitimacy of the Soviet centralized health system organization and the inertia provided by the fall of the Soviet Union for reforms across the region. It was a moment of opportunity. However, at that moment of opportunity, the Ukrainian government was faced with a divided nation in which policies connected to economic preferences and human rights were particularly risky. The Kravchuk and then
Kuchma administrations both addressed this dilemma by shuffling aside difficult structural reforms and pursuing only rationalization efforts. Instead of instituting overarching reforms unilaterally during such an unstable period, the President, Cabinet of Ministers, and Verkhovna Rada attempted to share responsibility in reform efforts and provide an opening for various stakeholders to participate in the decision-making process. They hoped that this more pluralistic and gradual approach would save them from the dramatic experiences of reform occurring at that time in their fellow post-Soviet states. The consequences of these choices established a context for healthcare reforms that further entrenched the existing state-run system, making it even more difficult to pursue significant changes to the state’s responsibility and structuring of the system, and setting them on a trajectory that has brought them to the mid-2010’s with few changes to the main healthcare institutions.

This chapter explores the legacy of those decisions at the critical juncture. I show how the balance of power across political decision-making institutions has persisted today, producing consistently fractured support for healthcare reform efforts and wars of words in healthcare reform rhetoric, despite a widespread consensus that change is needed. The continued failures and contradictions of the country’s constitutional guarantees to the realities on the ground contribute to the reinforcement of the public’s distrust of any reform efforts. Because each of the decision-making authorities relies on having at least the façade of citizens’ best interests behind their efforts, this hardening distrust in turn leads to the ramping up of accusations and blame for the continued failures, further solidifying the fractured nature of the reforms.
I begin the analysis with an overview of the current state of Ukrainian healthcare today. I show that there are several characteristics that have remained stubbornly consistent since the 1990s, including low funding, a decentralization of authority, a high level of involvement for international organizations and some NGOs, and a high level of patient distrust of the system and physicians. I provide evidence that these characteristics are not simply the result of weak state capacity and economic conditions, but rather are connected to the major aspects of the critical juncture’s legacy, including the division of interests amongst decision-making authorities and the growing reliance on the international community for resources and management.

Next, I discuss the initial aftermath of the decisions made at the critical juncture, which were discussed in Chapter 4. Here, I describe the reform strategies of the Yushchenko era, the constant turnover of leadership, the fractured nature of healthcare authority, and the influence of reform resistors amongst the physicians, MPs, and pharmaceutical companies, all of which took advantage of the lack of healthcare reform efforts to seize more authority and power for themselves. I demonstrate that the healthcare reform strategies first laid out Yushchenko’s administration looked eerily similar to initiatives in more recent years. These first years in the development of the critical juncture’s legacy set the stage for the patterns we still see today.

I then turn to the long-term legacy itself, examining the Yanukovych and Poroshenko administrations and showing how the legacy has developed over time. I demonstrate that the Ministry of Health to this day feels compelled to meet the standards set by international and Western-backed organizations to give their reforms and authority greater legitimacy, shaping the human rights rhetoric surrounding the system. This desire
has set the standard high for the planners, and, with intense polarization across the political spectrum on the “right” design and implementation plan for reform efforts, paralysis has ensued. Healthcare continues to be viewed and held up as an example of failure of the current administration, regardless of political affiliation. An endless loop of blame surrounds reform efforts, becoming entrenched within the framework of the necessity of efficiency, stability, and unification first created by the Kravchuk and Kuchma administrations’ decision in the 1990s.

6.2 Current State of Ukrainian Healthcare

The Ukrainian healthcare system, like those of the other Soviet republics, entered the 1990s facing considerable challenges. Average life expectancy, at 70.1 years in 1990, dropped continuously until 1996, when it reached its nadir at 66.9 years, with male life expectancy falling to 61.4 that same year (World Bank 2017). Since that time, life expectancy and health conditions have improved, though this has been attributed to improvements in economic conditions and the various aspects of their social impact, rather than any changes in the healthcare system itself, and they remain below the standards met by comparable countries in other regions of the world (Brainerd 2001; Gilmore, McKee, and Rose 2002). In recent years, the rise of multidrug-resistant tuberculosis and HIV have drawn greater global attention to the healthcare issues still plaguing Ukraine.43

Today, over twenty-five years after the fall of the Soviet Union, Ukraine’s healthcare system largely maintains the fundamental characteristics of the Soviet state-run Semashko system (Lekhan et al 2015). With little privatization, the state remains constitutionally responsible for providing free healthcare at the point of service to all citizens. Financing continues to be collected through general taxation, with only some testing of contractual insurance mechanisms. Many of the doctors who direct the hospitals continue to have life terms, with little incentive for change. Younger generations of healthcare leaders continue to move away from the country in search of better financial and professional opportunities, exacerbating this problem. 44 The institutionalization of the status quo after the dissolution of the Soviet Union remains the core of the system.

Beyond the constitutional guarantee to free healthcare, the baseline for healthcare policy has long remained the Principles of Legislation on Health Care in Ukraine, the legislation passed in 1992 that set forth the basic process by which healthcare reforms would be formed, including stipulations that “national policy is defined by the Parliament and involves establishing policy goals, setting standards, allocating budgets and creating national health care programs” (Betliy et al 2007, pg. 9). In June of 2017, a new piece of healthcare reform legislation, the draft law On State Financial Guarantees for the Provision of Medical Services and Medicines, passed by just one vote (Verkhovna Rada 2017a). This legislation aims to move the system toward a national health service model,

44 Interview with Kyiv-Mohyla Academy healthcare analyst and university health program director [Anonymous], Kyiv, Ukraine. May 2015.
with a guaranteed package of healthcare services paid for through the state and a schedule of co-payments for those services not included on the guaranteed “green list.” The battle over this new piece of legislation will be discussed in more detail later in this chapter.

While there have been reforms such as those discussed in Chapter 4 – including the reduction in hospital beds and other indicators of input as promoted by the Soviet authorities – and the recent passing of reform legislation has raised hope for change, there continues to be disagreement on the design and, particularly, on the implementation plans for the reforms themselves. Parliamentary committees hold the Ministry of Health hostage to their interests, and Ministry officials make fatal mistakes due to lack of information. While there continues to be a general consensus on reaching a point in line with international standards – an initiative for which the Ministry of Health has often been at the center – as well as agreement that some type of mandatory health insurance system or national health service (a “mixed” state responsibility system) should be the ultimate goal of any fundamental reform, there is disagreement on how much structural reform is needed, how much extra funding from the state is needed, the level of the state’s commitment to financing, and how to correct the lack of incentives that currently poses significant obstacles to reform implementation. While these are all issues commonly debated in many countries – American citizens today will recognize a few points of tension in the list – in the case of Ukraine, the consequences of lack of reform climb ever higher, as the quality of care remains desperately low, and technology, some of which dates back several decades to the Soviet period, becomes increasingly more obsolete, drawing complaints about the lack of a developed set of standards (Apteka.ua 2015).
6.2.1 Economic Conditions

Like in other countries of the post-Soviet region, low levels of funding have remained a key aspect of concern in analyses of the Ukrainian healthcare system. While expenditure on health as a percentage of GDP has remained relatively constant (Figure 20), the health expenditure per capita has increased significantly since 1995 (Figure 21). Out-of-pocket expenditures, though often difficult to calculate, remain high and have increased over time, with just some decline in the early 2000s before they began to rise again after 2007 (Figure 22).

Figure 20 Ukraine Health Expenditure, Total (% of GDP) (1995-2014)

Figure 22 Ukraine Health Expenditure per Capita, PPP (constant 2011 international $) (1995-2014)


Figure 21 Ukraine Out-of-Pocket Health Expenditure (% of Total Expenditure on Health) (1995-2014)

Arguments about the optimal percentage of GDP spent per capita remain unresolved, however, with some institutions pointing to the fact that a government can spend a smaller percentage but do so efficiently and produce better results than a country that spends more (OECD 2010). Therefore, efficiency has risen as a measure of the quality of healthcare system financing in countries in recent years. This aligns with rhetoric that has been present in Ukrainian reform efforts since the 1990s, with “optimization” splashed across Ministry of Health meeting transcripts and continued in the discussions surrounding the most recent reforms.

The effects of the larger economic picture on health expenditure, and, in turn, the argument that healthcare reform has failed due to lack of resources, remains questionable. While much of Ukraine’s economic history after the Soviet Union’s collapse has been a tale of struggle, the country has had periods of stabilization and growth between 2000-2008 and 2010-2012, as shown in Figure 23 (IMF 2017). These periods of stabilization and growth should, according to the weak state capacity argument, provide an opportunity for the state to make greater progress toward healthcare reforms. However, as I will outline in this chapter, the healthcare sector has remained stubbornly consistent across periods of both economic growth and decline, and healthcare reform has continuously failed due to political factors, regardless of the economic situation. Even during times of economic crisis, when we might have expected to see a push for the retrenchment of healthcare and broader welfare reforms, Ukraine has persisted in its maintenance of a healthcare system with a high level of state responsibility.
6.2.2 Decentralization of Authority

While economic indicators do not provide clear insight into the pattern of healthcare reforms in the country, the immediate aftermath of the fall of the Soviet Union led to a large amount of decentralization of authority in Ukraine, which, to some extent, did touch upon the healthcare system. Due to the low level of institutional development – for example, a centralized healthcare reporting system – much power and influence in the system fell into the hands of regional and local officials, as well as chief physicians. This lack of centralized accountability systems has remained an issue in recent years and has been a major focus of modern reform efforts (MoH Ukraine 2015). The administrations in turn, as I discussed in Chapter 4, sought not to centralize that authority over healthcare, but rather to utilize the “default pluralism” as a means of building legitimacy for their
reform efforts. This decentralization within the framework of de jure state responsibility and the pluralism promoted along with it could be viewed as significant steps toward a fully functioning democracy, something that fit well with the values promoted by international financial institutions working in the region.

Scholars have pointed out the paradox of these types of movements, arguing that the same factors, such as weak institutions, that cause such “moves toward democracy” also lead to a low governing capacity. That is, instead of these changes leading to a stronger state with the means, and indeed, willingness, to implement reforms, they instead were changes created “by default” due to the existence of little ability of authorities to retain centralized power – in other words, the rise of democratic state was instead the “product of failed efforts to create an authoritarian one” (Way 2015, pgs. 43-44). This provides a clear counterargument to my own, in that it points to weak institutions and an inability of the state to centralize authority as possible explanations for the lack of healthcare reforms. However, as I will show in this chapter, Ukrainian healthcare reforms have not failed due to the power of civil society groups or any other challenge to the state’s authority from outside actors. Instead, it has been infighting within political institutions and the resulting fractured nature of reform efforts – which then impacts rhetoric and creates greater contradictions between de jure and de facto state responsibility as actors on the ground take advantage of the fragmentation, influencing public opinion of reform efforts– that has led healthcare reform on this trajectory, rather than the weakness of the state itself or an inability to pursue major structural reforms.
6.2.3 Non-State Actors

Finally, non-governmental organizations (NGOs), international financial institutions (IFIs), and broader international organizations (IOs) have played an important role in the Ukrainian healthcare system since the demise of the Soviet Union. These groups, including the World Health Organization, IMF, USAID, and smaller grassroots organizations, have worked to fill the gap in care and financing left by the lack of government resources. The IMF has played a particularly important role in shaping not only healthcare, but larger welfare and economic reforms across Ukraine since the fall of the Soviet Union. Some local groups, like Patients of Ukraine, an anti-corruption initiative, have moved to coordinate with these reform efforts and pushed for the removal of powers from the Ministry of Health in attempts to combat corruption. IOs have served as advisors and providers, even acting as the medication procurement organs for two years while anti-corruption measures were initiated (Cohen 2016).

Regarding reform design rather than implementation, the ability of outside groups to influence state decision-making in areas like healthcare reform has been a question of interest for many scholars examining the region. NGOs working in the FSU have oftentimes focused on quantitatively-driven goals, such as vaccination levels or HIV/AIDS rates. As studies examining NGOs working on civil society and democracy-building efforts have shown, this type of approach largely ignores the key to longer-term change – that is, the qualitative characteristics of the networks, and ways in which to influence the central components of the decision-making structure. Because of this, the influence of NGOs on greater structural reforms or trends has been relegated to the margins (Mendelson 2002). Some have argued that NGOs filling these roles and focusing
on the quantitatively-driven results relieves the state of the responsibility to do so, thus
strengthening the status quo of the state structure and causing longer-term development
consequences (Clarke 1998; Mercer 2002; Jones Luong 2014). Others have argued,
however, that the role of “non-state providers” in welfare and their influence on such
aspects as state capacity will depend upon the characteristics and approaches of the non-
state actors themselves (Cammett and MacLean 2014).

The involvement of these groups could be interpreted as an indicator of the state’s
inability to provide those services, supporting the argument that healthcare reform is not
happening simply due to the state’s inability to control resources. In the countries of the
former Soviet Union, the role of these organizations in providing healthcare has often
been interpreted as an instance of their “filling the gap” where the state could not perform
its duties adequately, or where the state had simply removed itself due to lack of
resources. However, as I discuss below, the role of these groups proves much less
transformative in the Ukrainian case than such interpretations would suggest. On the
contrary, the ability of these groups to provide services when the state does not can
sometimes provide motivations for state actors to delay or abandon reform plans,
particularly if government officials are able to point to their initiatives to involve these
groups in the first place. They can, in other words, “legitimize the status quo” (Mercer
2002, pg. 17). In the case of Ukraine, I show that, while these groups have played
important roles, their influence on reforms has largely been through the framework
provided by IFIs and IOs, which is often used as politicians and bureaucrats as a
legitimizing factor in the debates and infighting that forms the core of the obstacle to
reform.
6.2.4 Lack of Major Reforms and Dissatisfaction with the System

The involvement of non-state actors and the decentralization of some authority in the healthcare system has done little to quell dissatisfaction amongst the public. Instead, they have fueled a broader disenchantment with the government and reform efforts – despite high levels of support for improvements – and a widespread loss of trust pervades the system. A study conducted by the Ilko Kucheriv Democratic Initiatives Foundation in May 2016 found that one third (33.4%) of those surveyed felt that healthcare reform should be prioritized.\textsuperscript{45} However, the survey also found very little confidence amongst Ukrainian citizens in the government and its ability and willingness to pass reforms. Instead, most people believe that their best bet for reform lies with NGOs and Western countries. The majority of citizens in the survey blamed oligarchs (55%) and bureaucratic officials (51%) for resisting any efforts for change. The government (38%) and the President (36%) followed in third and fourth place, though with lower levels of blame attributed to them than in the previous year’s survey (Ilko Kucheriv Democratic Initiatives Foundation 2016). The International Republican Institute reported similar findings in 2015, showing that, after the Euromaidan revolution, any positive change in outlook on reforms was quickly abandoned (International Republican Institute 2015).

Exacerbating this grim outlook for the future of the system, distrust between the non-governmental actors hinders any coordinated reform efforts. Strong cynicism about doctors and their motivations – something relatively common in former Soviet states since the establishment of more market-oriented economies – leads patients to shy away from cooperation in a more unified societal push for change (Lekhan \textit{et al} 2015).

\textsuperscript{45} The top two scoring priorities going to reforms in the fields of anti-corruption [55.7\%] and law enforcement [40.1\%].

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None of this dissatisfaction with the broader welfare system and reform efforts is new. The public in Ukraine has expressed strongly negative feelings toward the welfare system and complex preferences for reform since the first decade of independence. (Whitefield 2002). With the Ukrainian government taking a more pluralistic approach than some of its fellow post-Soviet states (including Russia), citizens’ beliefs that oligarchs and bureaucratic interests will continue to hinder reform efforts have often been proven valid, as infighting continues to plague healthcare reform debates and parliamentary and Ministry officials often base their claims against one another’s approaches as motivated by concern for the citizens.46 By placing significant legitimacy on the framework of pluralism and cooperation, those in government in charge of healthcare reforms have put themselves into a difficult position in which there is continual discussion and resistance backed by accusations of isolated decision making, leading to few actions or results.

This lack of trust in reform efforts reinforces the lasting institutional characteristics of the critical juncture that we see today. By failing to consolidate power in the Ministry or create at least the roots of new institutions during those first years after the Soviet Union’s collapse – instead focusing on stabilization and unification, rather than change – and establishing a fragmented de jure state responsibility, the Kravchuk and Kuchma administrations entrenched the multi-pronged hierarchy of the Soviet healthcare system and created further contradictions between the promises of the state’s

46 The Head of the Verkhovna Rada Committee on Health, Olga Bogomolets, has been particularly active when it comes to discussing the challenges to healthcare reform over the last several years. She maintains a YouTube channel (https://www.youtube.com/user/UkraineOlga) with many of her interviews and speeches. Analysis of these demonstrates her consistency in basing her arguments around the prioritization of universal access and a concern for citizens.
responsibility for healthcare and the state’s de facto responsibility observed in daily life. With the public’s strong opinions on the responsibility of the President and Cabinet of Ministers for reform efforts (International Republican Institute 2015), the disagreements between the Verkhovna Rada Committee on Health, physicians’ groups, and Ministry of Health since that time have largely been seen by citizens as the administration’s incompetence in their reform efforts, furthering their distrust in the system. Today, as the many elites empowered by the multi-pronged system continue to contradict and challenge one another on any major reform efforts, this lack of trust is vindicated and exacerbated by the seemingly endless failures to implement promised changes, and public support for reforms becomes increasingly difficult to attain. The need to base any reform proposals in the framework of what is best for Ukrainian citizens to gain legitimacy turns that lack of support into a flaming arrow thrown between decision makers as they fight to control the reform trajectory.

The lack of cooperation amongst decision makers and the push for influence from various stakeholders during the latest three administrations serves as the focus of the rest of this chapter. I discuss how oligarchs and heads of pharmaceutical companies who rose in power during the 1990s are often accused of controlling reforms more broadly through their grip on agenda-setting tools, such as the media and the list of MPs, and their close connections to political officials (Forrest 2015; Borisov 2017). I also further outline the battle over authority between the Verkhovna Rada Committee on Health, the Ministry of Health, and physicians’ groups. I show how these groups use the failure of reforms and the framework of citizens’ rights to delegitimize one another’s reform efforts. In doing
so, I demonstrate that the institutionalization of the early reform framework still shapes healthcare reforms in Ukraine today.

6.3 Aftermath and Legacy of the Critical Juncture

6.3.1 After the Orange Revolution: The First Test of Regime Change

The Orange Revolution and resulting change in leadership once again brought about hope that major reforms may take place to improve the quality of the healthcare system. After the crisis brought on by the “Kuchmagate” cassette scandal and alleged electoral fraud of the 2004 presidential election, Ukrainians were ready for a fresh start for their post-Soviet country. This was to be the first test of the importance of administrative change and ideological fervor for reform.

Yushchenko’s Minister of Health Mykola Polishchuk – the first of four that would cycle through during Yushchenko’s 2005-2010 term – outlined reform priorities at a meeting of the Board of the Ministry of Health on 22 July 2005. He argued that the healthcare system was being run in such a way to satisfy business and healthcare industry interests, rather than those of patients, that there was a woefully insufficient level of funding for the system, and that the ubiquity of informal payments and inefficient use of resources continued to create barriers to an improved level of care. He then stressed the priorities for addressing these problems (Table 4).
Table 4 Ukraine Health Minister Mykola Polishchuk’s Priorities for Healthcare Reform

<table>
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<th>Priority</th>
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<tr>
<td>Restructuring the system to emphasize primary care and the needs of the patients</td>
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<tr>
<td>Developing a healthcare system focused on contractual principles rather than those of a command economy</td>
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<tr>
<td>Introducing new financing mechanisms through a state social health insurance scheme</td>
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<tr>
<td>Reworking the structure of state financial commitments, including, possibly, revising Article 49 of Ukraine’s Constitution guaranteeing full, free medical care</td>
</tr>
<tr>
<td>Creating institutions to monitor licensing and standards of quality</td>
</tr>
<tr>
<td>Revising staffing policies, including moving more specialists to primary care</td>
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Source: Apteka.ua 2005.

These reform efforts would ultimately fail, with Polishchuk soon dismissed by Yushchenko with the rest of the Cabinet on 8 September 2005. Polishchuk recently asserted in a radio interview that it was the Cabinet’s dismissal that caused the reforms to fail (Polishchuk 2017). Some at the time attributed the decision to sack Polishchuk along with the rest of the Cabinet to the fact that his policies – such as attempting to improve healthcare in less populated areas by appointing young doctors to rural hospitals – were not “popular.” However, Minister Vasyl Knyazevych, in an interview in 2008, countered this speculation, stating that many reforms, including his own planned initiatives, would be unpopular, especially amongst those who benefited from the current system of mismanagement (Knyazevych 2008).

6.3.2 Continued Pressure for Reforms

With three other Ministers of Health at the helm over time – Yuriy Polyachenko (October 2005 – March 2007), Yuriy Haidayev (March 2007 – December 2007), and Vasyl Knyazevych (December 2007 – March 2010) – the push for reforms continued throughout Yushchenko’s presidential term. In August 2009, the President predicted “great reform” in the healthcare system in a speech given at Bogomolets National
Medical University, stating, “I hope that we will be able to reform medicine effectively and in short time” (Radio Svoboda 2009). That fall, at a regional security meeting convened to address the influenza epidemic, he again made the call for deep reforms, emphasizing that he had counted eighteen “mini-Ministries of Health.” This, he said, demonstrated the fractured nature of the system and the urgent need for consolidation (Ukrainian News Agency 2009).

However, like the administrations before it, Yushchenko and associates failed to overcome the institutional barriers set up by the decisions made at the point of the critical juncture. The focus of any concrete actions revolved around specific diseases. In August 2009, then-Minister of Health Knyazevych announced a new “State Target Program ‘Pancreatic Diabetes’ for the years 2009-2013, as well as a draft law that was meant to be the first of approximately sixty focused on improving the healthcare system. When discussing the draft law, he warned that “rather complex processes are coming but we are in the process of preparing the country and will assist to prepare our citizens to those changes we plan” (Office of Mass Media Relations 2009). His prescient warning provided what would become the axiom for the healthcare reform efforts still to come.

6.3.3 Conflict Amongst the Elite: Lack of Coordination and Cooperation

6.3.3.1 The Era of Yanukovych

The election of Yanukovych in 2010, once again, brought some hope of change, at least for those who believed he could consolidate power and force through what had before been relatively unpopular initiatives. His move to increase the powers of the presidential office, while dismissed as authoritarian in nature, offered an opportunity to
challenge the idea that reforms were not happening simply because there were, as one could say, “too many cooks in the kitchen” for any coordinated reform effort.

Initially, his administration did bring with it seemingly strong promises. He quickly presented a program of economic reforms entitled, “Prosperous Society, Competitive Economy, Effective State.” In this reform plan, he argued that the problems of the healthcare system were caused by a combination of insufficient mechanisms to promote quality of medical services and patient management, a lack of autonomy for facilities in the distribution of financial resources, insufficient budget management, and a lack of emphasis on primary care. His proposed solutions included moving toward a contract system and then to a full mandatory health insurance system, the creation of quality-control indicator systems and dedicated institutions, better differentiation of levels of care, and support for the development of a private sector (Committee on Economic Reforms 2010).

This outline of problems, solutions, and goals, upon examination, looks similar to those presented under the Yushchenko administration, as well as those presented recently under the Poroshenko administration (discussed more below). In 2008 and 2010-2012, the Ministry of Health published lists of the regulations by each authoritative institution regarding health from each year. Table 5 below shows the breakdown across these years, spanning from the end of the Yushchenko administration to the beginning of the Yanukovych presidency.
Table 5 Count of Normative and Legal Acts on Health, (2008, 2010-2012)

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verkhovna Rada - Laws</td>
<td>25</td>
<td>63</td>
<td>82</td>
<td>53</td>
<td>223</td>
</tr>
<tr>
<td>Verkhovna Rada - Resolutions</td>
<td>44</td>
<td>57</td>
<td>139</td>
<td>15</td>
<td>255</td>
</tr>
<tr>
<td>President of Ukraine - Decrees</td>
<td>72</td>
<td>70</td>
<td>70</td>
<td>41</td>
<td>253</td>
</tr>
<tr>
<td>President of Ukraine - Orders</td>
<td>13</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Cabinet of Ministers - Orders</td>
<td>157</td>
<td>159</td>
<td>112</td>
<td>82</td>
<td>510</td>
</tr>
<tr>
<td>Cabinet of Ministers - Resolutions</td>
<td>86</td>
<td>149</td>
<td>146</td>
<td>134</td>
<td>515</td>
</tr>
<tr>
<td>Ministry of Health - Orders</td>
<td>832</td>
<td>1211</td>
<td>1032</td>
<td>1142</td>
<td>4217</td>
</tr>
</tbody>
</table>


While there was some increase in activity after Yanukovych’s election for the Verkhovna Rada, the Ministry of Health, and the number of resolutions issued by the Cabinet of Ministers related to health, the activity of the President himself and the orders issued by the Cabinet of Ministers remained the same and even decreased in 2012. Despite the slight increases and decreases in activity on the part of each of these institutions, however, the struggle to bring meaningful reform to the system remained the same. The number of Ministry of Health orders developed jointly with other with other ministries and departments – an indicator of the level of cooperation in healthcare reform across the government – did not change significantly from 2010-2012, with 64 (2010), 71 (2011), and 60 (2012) orders recorded. Furthermore, very few of these orders involved changes to the structural characteristics of the healthcare system. Most of the laws passed

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47 This number was not reported in the 2008 publication.
by the Verkhovna Rada, for example, addressed specific diseases or health issues, such as tuberculosis, HIV, tobacco, and alcohol, or the regulation of specific types of treatment and pharmaceuticals, such as psychiatric care and emergency aid.

This consistency in both the number of normative-legal acts on health and in the level of coordination across the state institutions indicates a lack of change with the new administration. Despite the recognition of necessary reforms, the understanding of the barriers against which the previous administration had fought, and the increased presidential powers, Yanukovych’s Ministry of Health still failed to reach its healthcare reform goals. In February 2013, Health Minister Raisa Bogatyrev gave a press conference on the topic, expressing frustration that, despite their best work, a “shortage of funds, lack of staff, and lack of trust” continued to hold back any major success. Furthermore, she argued that the solution required “systematic action, consistency, understanding, and willpower” (MoH Ukraine 2013b). Her frustration and concerns were later echoed by President Yanukovych, when, at a meeting of the government, he stated that “[t]here are many complaints about sluggishness and open negligence of human interests from officials at all levels.” He then went on to complain that there was too little communication of instructions to the regions from the central authorities (Interfax-Ukraine 2013). Despite the negative feelings expressed by the administration regarding healthcare reform at that time, Minister Bogatyrov ended her discussion with a reassuring tone:

“I assure you that I and my colleagues well know all of the flaws and problems of the health system. We are well aware that changes cannot be achieved in one day. So, besides discussing problems and disadvantages, I ask you to talk about ways to solve them. Find opportunities for support and advice. We do not have the right to lose the chance to reform” (MoH Ukraine 2013b).
The next year, however, spelled trouble for Minister Bogatyrev and the rest of the Yanukovych administration. After the Euromaidan crisis, she, Yanukovych, and the rest of the administration were driven from power. In October 2014, she was accused of large-scale embezzlement of state budget funds (Interfax – Ukraine 2014). By January 2015, Interpol put her and several other former officials in the Yanukovych administration on its “red notice” list (Tucker 2015; Antonovych 2015).

Parallel to the fall of the Yanukovych administration, from 2013 to 2015, nearly all state procurements of medicine were stalled due to corruption concerns (Bedratenko 2016). In early 2015, these concerns would lead the Anti-Corruption Action Centre and Patients of Ukraine to press for a bill that stripped the Ministry of Health’s authority over drug procurement and gave it to the UNDP, UNICEF, and Crown Agents (Cohen 2016). The Poroshenko administration, bolstered by the mandate given to it through these scandals and the success of the Euromaidan revolution, took control, promising a real change in the agenda.

6.3.3.2 Post-Euromaidan

Initial short-lived changes followed Yanukovych’s exit, but with the appointment of Alexander Kvitashvili, formerly the Minister of Health, Labor, and Social Affairs in Georgia, as Minister of Health in later 2014, the Poroshenko administration revived the push for a new strategy in healthcare reforms. Out of this was developed the National Reform Strategy 2015-2020. This plan utilized the perceived mandate for change given by the Euromaidan movement and election of President Petro Poroshenko to bolster the legitimacy and support the drive for a complete overhaul of the system:
The new political situation is in itself the clearest demonstration of how Ukraine has changed, and for that reason, citizens will not accept a health system that fails to serve their needs and honor their aspirations in sensitive areas as health, disease and disability anymore. Conserving the existing system in the fields of management, financing, staffing, etc. would only lead to deteriorated public health, deepened problems in financial resources use, increased inequality in access to health care by the vulnerable populations, further population dissatisfaction with medical servicing and government policy, etc. A shy modernization mostly in primary and emergency health care as it was starting to happen recently, without changes in other system areas would not be very different either. The only acceptable course of action is overhauling the current system in a deep but controlled manner. (Strategic Advisory Group 2015, pg. 16. Emphasis their own).

The key intermediate goals listed in this document, however, rather than demonstrating some major change in the reform approach, echoed much of what had earlier been prioritized (Table 6).

### Table 6 Ukraine National Reform Strategy, 2015-2020: Intermediate Goals

<table>
<thead>
<tr>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting, promoting, enhancing and creating environment for individual responsibility for citizens’ own health</td>
</tr>
<tr>
<td>Guaranteeing free choice of service providers</td>
</tr>
<tr>
<td>Creating a more transparent, accountable, business friendly environment in the healthcare sector</td>
</tr>
<tr>
<td>Prioritizing assistance to the most disadvantaged part of the population</td>
</tr>
</tbody>
</table>

Source: Strategic Advisory Group 2015.

Much like their predecessors, the Strategic Advisory Group hoped to tackle the problem of corruption, modernize the system, and establish a new structure for the financing of the system that would put more responsibility on citizens for their own wellbeing, while still creating an environment that would promote market principles of competition and quality amongst providers and insurers. Like Polishchuk’s initial goals for the healthcare system,
the desire to meet international standards of care utilizing market and democratic principles formed the basis of this plan for change.

The hope for success in areas where others have consistently failed was not unfounded. With the Euromaidan movement bringing about revolutionary change and the rise of anti-corruption efforts, the environment for advancement in social policy reforms seemed imminent. Findings that the first Cabinet of Ministers was one of the “most fairly composed” in post-Soviet Ukrainian history provided further support that this administration might succeed where others had not (Chaisty and Chernykh 2015). The population’s belief that the administration was on the right track with reforms increased significantly during that first year, before falling again in 2015 (International Republican Institute 2015).

Unfortunately, similar patterns of previous administrations have persisted. Both the Minister of Health and the Head of the Verkhovna Rada Committee on Health expressed frustrations about the division of authority across branches at a roundtable held with members of international organizations and non-governmental organizations in May 2015. Referring to the role of the various “specialty” divisions of healthcare in the country, such as those run by the military, Minister Kvitashvili argued that such divisions continued to erode the authority of the Ministry and central healthcare structures. MP Olga Bogomolets – Chairman of the Committee on Health, a family member of a long-standing medical dynasty, and, at one time, the personal physician of President Yushchenko – stressed that, at that time, only approximately 60% of healthcare in the country was run by the Ministry of Health. The other 40% was spread across ten different departments, including six in the military (MoH Ukraine 2015). These concerns, so
similar to those expressed by President Yushchenko in 2009 about the fractured nature of the healthcare system and the “mini-ministries” dividing it, highlight the lack of improvement and change in the Ukrainian healthcare system over the years.

However, despite calls from President Poroshenko for a unified vision for reform across the Government, Parliament, and the public (President of Ukraine 2016, para. 6), conflicts between even the highest decision-making authorities have continued. Kvitashvili accused members of the parliamentary committee on health of blocking reforms, while those parliamentary members claimed that the Ministry could not be trusted with their reform efforts due to incompetence (Holt 2016). Stories of disappearing money invested into vaccines – where companies based in India had somehow disappeared before the vaccines were provided – have caused discomfort over the success of reform efforts (MoH Ukraine 2015). In an interview with the Ukrainian media outlet Texty in September 2015, Kvitashvili accused the Verkhovna Rada of sabotaging medical reforms. He argued that coming into the Ministry of Health, he had “underestimated the resistance” within the system. He pointed to both MPs and business groups that continue to resist major reform efforts due to their personal financial and political interests. He also emphasized the need for coordination between the executive and legislative branches for successful reform (Velichko 2015).

The appointment of a new Minister of Health, American-trained Dr. Ulyana Suprun, in July 2016 brought with it new hope for a reformed system. Supporters of Minister Suprun have argued that she has been more pro-active and is better trained to manage reforms than her predecessors. She has also been lauded for taking an approach focused on concrete implementation plans (Bedratenko 2016), as well as her cooperation
with the National Anti-Corruption Bureau (Francis 2017). Indeed, Minister Surprun oversaw the expansion of independence for hospitals, as well as the approval of a reform package in December 2016. Her reforms aim to restructure the system, creating a new financing mechanism in the design of the United Kingdom’s National Health Service, introducing contracts between doctors and patients, guaranteeing state payment for specific pharmaceuticals and services, and the creation of tertiary-care facilities (Waller and Goncharova 2016; Verkhovna Rada 2017a).

However, miscommunication and accusations continue to plague Dr. Suprun and her Ministry staff. Supporters on either side – the older regime versus the new, liberal Euromaidan movement – continuously blame one another for the faults of the healthcare system, sometimes involving the spreading of vicious rumors (Shandra 2017). Concerns about the Ministry’s ability to finance all guaranteed medications to the level it has promised has also caused alarm (Ulyanitsky 2016). Furthermore, a poll completed by Sociological Group “Rating” in December 2016 showed that only 27% of Ukrainians believe that the contract system and an increase in doctors’ salaries will improve medical care (Sociological Group “Rating” 2016).

The lack of cooperation and coordination even between the Ministry of Health and the Verkhovna Rada continues to slow reform efforts to this day. MP Bogomolets, still head of the Committee on Health, has called out the Ministry for lacking a model of approved standards of treatment in their proposed reforms in March 2017 (Kunits’ka and Koshlyak 2017). While the Verkhovna Rada Committee on Health furthermore continues to support the idea of reform – including the need to reduce departmental hospitals, protect veterans and military officers, and provide a realistic and transparent set of
standards and costs – its members consistently contradict the Ministry of Health. There are no strong supporters of the Ministry’s healthcare reform plan, which centers around a national health insurance system, on the Committee. Even in the June 2017 vote on the structural changes, when only 227 deputies – just one more than required – voted in favor of the law, the Committee members remained reluctant to support the reform efforts. Only five members voted for the legislation (Verkhovna Rada 2017b).

The breakdown of the vote by party factions is shown below in Table 7. I then break down the votes from members of the Committee on Health in Table 8. As the voting records show, support for or against the bill in the Verkhovna Rada as a whole was largely based on party affiliation. However, interestingly, Committee members were often amongst the few in their factions to break from those patterns – 8 of 14 were not aligned with their faction, despite the strong party line divisions in the overall vote. The continued resistance from the Committee and its effect on the planning and implementation of reform legislation, which I discuss further below, indicates that it is not simply legislative support that determines the attitudes toward and success of reform. Instead, the Verkhovna Rada Committee on Health remains influential in the healthcare reform trajectory, serving as a standard-bearer of resistance to the Ministry’s efforts.
Table 7 Verkhovna Rada Voting Record on the Draft Law “On State Financial Guarantees for the Provision of Medical Services and Medicines” (No. 6327)

<table>
<thead>
<tr>
<th>Parliamentary Faction</th>
<th>For</th>
<th>Against</th>
<th>Abstain</th>
<th>Did Not Vote</th>
<th>Absent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petro Poroshenko Bloc</td>
<td>117</td>
<td>1</td>
<td>5</td>
<td>10</td>
<td>7</td>
<td>140</td>
</tr>
<tr>
<td>People’s Front</td>
<td>64</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>81</td>
</tr>
<tr>
<td>Opposition Bloc</td>
<td>0</td>
<td>22</td>
<td>1</td>
<td>13</td>
<td>7</td>
<td>43</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>Revival</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>12</td>
<td>26</td>
</tr>
<tr>
<td>Fatherland</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Radical Party</td>
<td>2</td>
<td>15</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>People’s Will</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Non-Affiliated</td>
<td>12</td>
<td>3</td>
<td>9</td>
<td>9</td>
<td>14</td>
<td>47</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>227</td>
<td>42</td>
<td>27</td>
<td>60</td>
<td>66</td>
<td>422</td>
</tr>
</tbody>
</table>

Source: Verkhovna Rada (2017).

Table 8 Verkhovna Rada Committee on Health Voting Record on the Draft Law “On State Financial Guarantees for the Provision of Medical Services and Medicines” (No. 6327)

<table>
<thead>
<tr>
<th>Member</th>
<th>Faction</th>
<th>Vote</th>
<th>Aligned with Faction?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bogomolets, O.V.</td>
<td>Petro Poroshenko Bloc</td>
<td>Abstain</td>
<td>No</td>
</tr>
<tr>
<td>Korchinska, O.A.</td>
<td>Radical Party</td>
<td>For</td>
<td>No</td>
</tr>
<tr>
<td>Donets, T.A.</td>
<td>People’s Front</td>
<td>Abstain</td>
<td>No</td>
</tr>
<tr>
<td>Musiy, O.S.</td>
<td>Non-Affiliated</td>
<td>Against</td>
<td>No</td>
</tr>
<tr>
<td>Sisoenko, I.V.</td>
<td>Self-Reliance</td>
<td>For</td>
<td>Yes</td>
</tr>
<tr>
<td>Kolganova, O.V.</td>
<td>People’s Front</td>
<td>Did Not Vote</td>
<td>No</td>
</tr>
<tr>
<td>Bakhteeva, T.D.</td>
<td>Opposition Bloc</td>
<td>Against</td>
<td>Yes</td>
</tr>
<tr>
<td>Berezenko, S.I.</td>
<td>Petro Poroshenko Bloc</td>
<td>For</td>
<td>Yes</td>
</tr>
<tr>
<td>Bilovol, O.M.</td>
<td>Revival</td>
<td>Absent</td>
<td>Yes</td>
</tr>
<tr>
<td>Kirichenko, O.M.</td>
<td>Radical Party</td>
<td>Abstain</td>
<td>No</td>
</tr>
<tr>
<td>Melnichuk, S.P.</td>
<td>People’s Will</td>
<td>Against</td>
<td>No</td>
</tr>
<tr>
<td>Shipko, A.F.</td>
<td>Revival</td>
<td>Absent – For, in absentia</td>
<td>No (in absentia)</td>
</tr>
<tr>
<td>Shurma, I.M.</td>
<td>Opposition Bloc</td>
<td>Against</td>
<td>Yes</td>
</tr>
<tr>
<td>Yarinich, K.V.</td>
<td>Petro Poroshenko Bloc</td>
<td>For</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| For: 5* | Against: 4 | Abstain: 3 | Did Not Vote: 1 | Absent: 1 |

Source: Verkhovna Rada (2017). Listed in the same order as listed on the Committee’s website, from the Chairperson down to members. (*Includes a For vote in absentia)
Blame for abandonment of the Ukrainian people serves as a common line in accusations from both the Committee and the Ministry. Minister Suprun has accused the Committee of attempting to propose a private insurance system, arguing that such a reform would leave many people without healthcare during the economic downturn (Shklyarska 2017). On the other hand, even while reluctantly – and amongst outcry about illegal “piano voting”48 – passing a piece of reform legislation (and rejecting three others, including opposing reform strategies formulated by former Health Minister Oleh Musiy), parliamentary members have accused the Ministry of Health of abandoning the basic principles of universal free healthcare guaranteed by the Constitution. MP Bogomolets abstained from voting and declared that she was “she was ready to take over responsibility for the reform,” as the current legislation was an example of “throw[ing] Ukrainian patients under the tanks.” Minister Suprun meanwhile appealed for action, indicating that debate over reform models had overshadowed the urgency of the collapse of the current system (Melkozerova 2017). With patients and historical guarantees at the center of the debate between competing authorities, the institutional constraints of the past persist.

Outside of the parliamentary and bureaucratic authorities, resistance to streamlined services, financial restructuring, and reduced costs comes from chief physicians and pharmaceutical companies. While most doctors have very low wages – a fact that has been blamed at times for poor quality of service (MoH Ukraine 2013b) – chief physicians, who are the heads of hospitals and health facilities and have lifetime

48 “Piano voting” is the term for when parliamentarians vote for members who are absent. The name comes from the action of reaching across to the next desk to press the missing member’s button to vote (Melkozerova 2017).
appointments, often accumulate massive levels of wealth over the course of their terms. The Anti-Corruption Action Centre has published information on the declarations of these individuals, pointing to the fact that some of the biggest critics of healthcare reform are, in fact, millionaires (Anti-Corruption Action Centre 2017). The chief physicians, on the other hand, argue that they are against the reforms because they have not been consulted in their design, which has produced unrealistic and ineffective plans for the restructuring. They have accused the Ministry of Health of allowing international organizations to breach contracts, not taking any action when, for example, drugs have not been supplied within a certain time period after pre-payment (Kovaliov 2017).

The lack of support of healthcare workers at all levels remains a key aspect of Ukraine’s healthcare reform process. The administration has recognized the necessity of support from medical personnel, with President Poroshenko declaring that “the decision of the authorities cannot become a reality without the active support, work and creativity of thousands of medical workers” (President of Ukraine 2016, para. 6). Yet, even many lower-level physicians have been critical of the Ministry of Health’s decisions, complaining that the state is to blame for making promises for free care and then expecting underpaid doctors to fulfill that promise (Yabchanka 2016).

Formally, healthcare workers’ unions have acted in opposition to the reforms, basing their position on the legitimacy of the constitutional guarantee of free healthcare for all. After a May 2017 meeting of Ukrainian, Georgian, and Moldovan healthcare and social workers in Kyiv, the Trade Union of Healthcare Workers of Ukraine and its affiliates issued a statement condemning the increased workload with insufficient pay.

49 Author Interview with Kyiv-Mohyla Academy healthcare analyst and health program director, [Anonymous], Kyiv, Ukraine. May 2015.
incentives and the reduction of vital staffing promoted by the newest reforms. Arguing against the bypassing of health workers in the reform design process and the prioritization of “optimization” over quality, they declared that “the health system in the Ukraine should be built upon the ‘classical’ public services principles [of] ‘universality,’ ‘accessibility,’ ‘affordability,’ ‘continuity,’ ‘user rights,’ [and] ‘transparency and accountability’” (EPSU 2017b). The European Public Service Union [EPSU] and Public Services International [PSI] supported the Ukrainian groups with similar statements addressed to the Ministry of Health and Prime Minister. In their statements, they highlighted the commitments enshrined in the Ukraine-EU Association Agreement to protect “the rights, the health, and the safety of workers and of patients” (EPSU 2017c, pg. 2) and urged them to comply with court rulings in favor of the Trade Union that would halt the reduction in staffing, hospital beds, and other efforts to make cuts to the current system (EPSU 2017c, pg. 3-4).

Adding to this resistance, the pharmaceutical market has been increasingly captured by those with connections to power. Along with the “bureaucratic machine” (byurokratychna mashyna), President Poroshenko has pinpointed the “pharmacological mafia” (farmakologichna mafiya) as an important barrier to be overcome to ensure the fair distribution of medicine (President of Ukraine 2016, para. 4). One who has drawn attention in recent years is MP Gleb Zagory, who is also head of the pharmaceutical company Darnitsa. In 2015, Mikheil Saakashvili, then-Governor of the Odessa Oblast, accused the “pharmaceutical mafia” of capturing the Ministry of Health, singling out Darnitsa in particular (Channel 5 2015). In 2017, RBK-Ukraine ran a profile on Zagory, outlining his moves to gain a monopoly in Ukraine’s pharmaceutical market (Borisov
2017). His support of legislation revising the tax code and budgeting for pharmaceutical products from international organizations (“On Amendments to the Tax Code of Ukraine regarding the exemption of certain pharmaceuticals and medical products” № 332-VIII) underlines the capturing of power by special interests. Zagory also voted in favor of the most recent structural reforms, raising the question of the expected outcomes of the changes on the pharmaceutical industry (Verkhovna Rada 2017b).

Furthermore, support amongst Parliament and bureaucratic officials depends upon their position within or outside of the institutions of power at any particular time. While the reform efforts across administrations and legislatures have largely remained similar in character, those who are outside of power at that time often deem them insufficient or unsuccessful and blame those in power for their lack of ability to succeed – even if they themselves had attempted comparable reforms at an earlier time. For example, using accusations of the famous director of the Heart Institute Borys Todurov as a springboard, former officials of Yanukovych’s administration launched a brutal attack on the current Ministry of Health’s plans in January 2017 – despite the fact that, as outlined above, much of the plans and goals of this Ministry of Health align with previously laid out strategies for reform (Shandra 2017).

6.3.4 Reinforcing Failure: The Public’s Lack of Trust

Along with the concern about corruption, much of the Ukrainian healthcare debate revolves around the fundamental question of responsibility for citizens’ health.50 With constitutional guarantees in the post-Soviet countries largely assigning this duty to the state, moves toward greater responsibility for individuals remains a difficult topic,

50 This is similar to healthcare debates in other countries, including recent discussions of reform in the United States.
particularly when it comes to building public support. The global trend that began in the 1980s and 90s of focusing on the patient, quality of care, and health as a basic human right has been echoed by members of the National Academy of Medical Sciences of Ukraine (Ustinov 2013).

While many countries have attempted to emphasize the individual and provide greater freedom in choice of care through the introduction of insurance structures, research has shown that the movement from tax-based systems to insurance-based systems does not necessarily produce better outcomes. Higher costs and possible negative effects on mortality from illnesses that require coordinated public health campaigns provide disincentives for lower-income countries to adopt such structural changes (Wagstaff 2009). Additionally, it complicates the picture on what the “best” reform approach is for transitioning countries if they wish to preserve health as a human right.

Today, surveys show that citizens in Ukraine (and in the post-Soviet states broadly) still largely back the idea of state responsibility for providing free healthcare. When asked whom they considered responsible for improving healthcare facilities, 70.6% chose the Minister of Health, 46.3% chose the chief physician or director of the facility, and around one-third considered either the Prime Minister (35.3%) or President (33.2%) to be responsible. Far fewer pointed to local (15.4%) or regional (9.3%) government officials, the District Administration Head (7.6%), or physicians broadly (17.9%) (Health Index: Ukraine 2016). In terms of institutional design, this expectation of state responsibility directly contradicts some of the proposed reforms that put greater financial burden on citizens. Furthermore, it indicates a division between the state’s and the public’s desired reforms. This mismatch leads to a high level of distrust in the reform
trajectory and a belief that, while changes are needed, the central authorities in charge of those changes cannot be trusted to do so in a way that is sustainable or, in the long term, positive for the Ukrainian people.

These patterns of distrust are not surprising. As discussed earlier in this dissertation, previous studies have shown that post-communist populations continue to hold strong beliefs about the government’s role in providing welfare, particularly in the areas of pensions and healthcare (Lipsmeyer 2003), as well as about the predominant role of structural conditions in causing poverty (Habibov 2011). Additionally, surveys in the 1990s showed the Ukrainian population to be supportive of targeted reforms in the abstract, but wary of their implementation when they feel unsure as to who would qualify as beneficiaries (Whitefield 2002). However, the continuation of these beliefs and fears does provide context for the consistently low approval rating and levels of trust in government that polls on reforms reveal (Ilko Kucheriv Democratic Initiatives Foundation 2016).

Exacerbating the issue of the public distrust is the way in which the population’s relationship to the healthcare system differs across regional divides, continuing the tension that initially set back reforms in the 1990s. Populations in the East continue to trust medical personnel who are part of the state healthcare system more than do the populations in the Center and West, while populations in the West trust health advice from religious figures more than do populations in other regions (Table 9). With regard to the recent healthcare reforms, populations in the East are more supportive of maintaining financing like that of the Semashko system than populations in other regions, while
populations in the West are more supportive of the new “money follows the patient”
mechanism (Figure 24).

Table 9 Trust and Health Advice in Ukraine

| How much do you trust in counseling about treatment or healthy lifestyle from the following categories of people?* |
|---|---|---|---|
| | West | Central | South | East |
| Relatives and Friends | 71 | 70 | 77 | 67 |
| Ambulance assistants | 70 | 64 | 67 | 76 |
| Qualified nurses | 65 | 61 | 70 | 71 |
| Pharmacists | 63 | 60 | 67 | 72 |
| Family doctors, therapists | 63 | 62 | 63 | 69 |
| Teachers of medical specialties | 54 | 43 | 56 | 53 |
| Athletes | 38 | 42 | 53 | 51 |
| Priests, ministers of the Church | 47 | 25 | 30 | 21 |
| Folk practitioners, psychics | 13 | 13 | 16 | 22 |
| People’s deputies | 5 | 2 | 2 | 11 |

* the sum of answers "I totally trust" and "I trust more," % (Sociological Group “Rating,” 2017)
The numbers in bold italics represent the most trusted category for that region. The numbers in yellow represent the region in which that particular category of people is most trusted.
Though the public’s expectations do not hold as much importance in countries where the state is strong and more authoritarian in nature, they do carry weight in a country searching to consolidate a unified nation while seeking to satisfy Western standards of democracy. Scholarly works examining post-Soviet Ukraine have pinpointed the influence that the legacy of the Soviet-era policies have had on expectations, and the pressures that politicians feel to avoid risking a challenge to those expectations (Way 2001). The debate in Ukraine, as described in this chapter, has often relied upon the legitimacy provided by finding the “best solution for Ukrainian patients.” Each side has accused the other of abandoning Ukrainian citizens (the state’s de jure responsibility for healthcare) when attempting to undermine their attempts at reform, and reform packages


Figure 24 Opinions on Financing Reforms in Ukraine

This past year, the Ministry of Health proposed to change the model of financing of medicine: instead of distributing budget funds based on the number of state-owned medical institutions and hospital beds in them, the principle of "money follows the patient"
have often sought to meet the democratic standards set out by international financial institutions and international organizations. Therefore, unlike either Przeworski’s (1991) theory of short-term losers or Hellman’s (1998) of initial winners would suggest, the cause of partial or stalled reform results from the constraints of the initial institutional design decisions – something indirectly influenced by these groups – rather than from either the initial winners or losers themselves. The way in which the balance of power is structured by decisions at the critical juncture continuously shape how these groups must relate to one another. Those decisions created the “rules of the game” by which today’s actors must abide. The early Ukrainian government’s desire to prioritize state building efforts in their push for long-term stability and international recognition has lent, at least in political rhetoric, legitimacy to citizen’s rights, a contradiction between a high level of de jure state responsibility and a low level of de facto state responsibility, and framework for blame in the face of failed reforms.

6.5 Conclusion: Comparing the Russian and Ukrainian Cases

Both the Russian and Ukrainian cases demonstrate that the national political elite’s decisions – in particular, the decisions of the executive offices, with support from the majority in the relatively ineffective legislative branch – signaled reform intentions early in the 1990s. These signals sent a message to both the potential winners and losers of reform about their benefits and losses in the future of the system, leading to actions by those potential winners and losers to influence the process in a way that suited their interests. More importantly, those decisions established the institutional constraints by which decision makers today must still abide.
The Ukrainian case stands out as an example of the limits of reform when elites institutionalize divisions of authority over reform and legitimacy in a pluralistic approach as an attempt to create stability for state building efforts. This in turn can empower multiple actors, including the potential losers of reform, as well as multiple central authorities. With the first two post-Soviet administrations prioritizing state- and nation-building because of the threat to stability presented by reforms connected to both the economic and human rights spheres, they created a legacy of emphasizing consensus over conflict, producing long-lasting competitions over reform authority, of guaranteeing state responsibility for reform and being unable to follow through, and of continuing public distrust because of these apparent contradictions. These institutional constraints have halted any fundamental reforms to the healthcare system beyond the “trimming” done by Kuchma during the first years after his election. While many call for reforms, lack of trust and apprehensions about attempts at significant overhaul persist and bog down any reform initiatives in Ukraine. In a March 2017 interview, Deputy Health Minister Paul Kovtonyuk described this challenge vividly with a Bulat Okudzhava quote: “Everyone wants something to happen, but everyone is afraid as if something might happen” (Kunits’ka and Koshlyak 2017).  

51 «Все хотят чтобы что-нибудь произошло, но все бояться как-бы чего-нибудь не случилось»
Chapter 7
Post-Soviet Healthcare: Patterns of Reform

The Russian and Ukrainian cases presented in the three preceding chapters highlight the importance of timing and incentive for healthcare reforms. These two cases, chosen based on their similarities but differing outcomes, explain why we cannot assume that similar religious or cultural values, historical traditions, technical advice, or health challenges will lead to similar results. Instead, my findings demonstrate that the determinant of the reform trajectories lies in the political realm, within the context of economic considerations and national movements that shape the concept of the state. That is, the Russian and Ukrainian cases demonstrated the importance of (1) the incentive for reform to ensure stability for the future and (2) the greater likelihood of reform to bring stability, rather than to further threaten the state. From the perspective of decision makers, the probability of reforms increasing stability had to be greater than both the probability that they would fail and decrease stability and the probability that they would make no difference, if they were to begin major restructuring efforts. Based on this, we would expect that, in states where there is an opportunity for reform (a critical juncture), decision makers will consider what the likely outcome of reforms is, given the cleavages and threats to the state in the country. In lower-income or transitioning states, as was the case in the post-Soviet region, this outcome will be a judgment of the state’s ability to weather reform and the longer-term consequences on the state-building effort – and, in turn, the longer-term legacy for the group in power.
In this chapter, I look briefly at four other cases in the post-Soviet region to evaluate the external validity of the findings and determine how well it can travel across diverse states. I first examine the explanatory variables pinpointed in the Russian and Ukrainian case studies – that of timing and conditions of the state shaping incentives – and develop an argument for what type of reform trajectory we would expect to see in each state based on these variables. I then analyze healthcare reforms in Kazakhstan, Kyrgyzstan, Moldova, and Georgia to determine whether the dynamics of the policymaking process and expected outcomes are present in each of these cases. These cases were chosen based on their comparative value to my two main case studies: Kazakhstan, with its resource wealth and authoritarian nature, provides an excellent comparison to Russia; Kyrgyzstan, with its low level of wealth and greater involvement of international organizations, provides an interesting comparison with Ukraine; Moldova, also with a greater involvement of international organizations and low level of wealth, but with the additional aspect of ties to Western Europe, too provides a compelling comparison with Ukraine; and finally, Georgia, with its involvement of foreign organizations (largely American), its desires to be more closely connected with Europe, its low level of wealth, and its dynamic post-Soviet political conditions, provides a further test of those dynamics that I expect to be at work in places like Ukraine, Kyrgyzstan, and Moldova. In the cases of Kyrgyzstan and Moldova, reforms were passed and implemented relatively successfully. In Kazakhstan and Georgia, reforms were initially introduced and some hasty implementation attempted, but then quickly reversed or cancelled. Through these case studies, I find that there is indeed evidence to support my hypotheses on the dynamics of healthcare reform across the post-Soviet region.
Furthermore, I argue that these explanations, because they can be abstracted beyond the post-Soviet legacies, can be expected to travel well to other states, particularly states in transition and emerging economies.

7.1 Reform Motivations: Protecting the State and Stability

My findings from the Russian and Ukrainian case studies suggest that healthcare reform trajectories can largely be explained by the timing of reform efforts and by state actors’ prioritization of stability in state-building efforts. This can explain why, in those countries where divisions of economic preferences and national identities aligned and threatened the integrity of the state, leaders were more likely to follow a reform trajectory involving a greater role for the state in the provision, financing, and regulation of the healthcare system and to delay major structural reforms, as happened in Ukraine.

These findings contradict previous studies’ results. They suggest that it is not necessarily the constellations of interest in power that will directly lead to certain types of healthcare reform, nor is it the country’s wealth or resources. Interestingly, it also contradicts the idea that the post-Soviet legacies in healthcare will overwhelmingly determine these countries’ reform trajectories. Instead, these legacies appear to influence the barriers that must be overcome in implementation, such as the bloated infrastructure for in-patient care, attitudes toward medical care, and expectations and payment levels for doctors, rather than the design of the new structural reforms themselves. However, there does appear to be some influence of the Soviet legacy on ideas of universal access that are both supported strongly in these states as well as in the global health community. Therefore, the legacy of the social values driving the Soviet healthcare system appear to influence the access aspect of designs from within the states as well as from external
sources. The indirect way in which the legacies are influencing healthcare design is through the spread of these values, as well as through the need to overcome the financing barrier, which, along with the push for universal access, motivated leaders to move toward payroll tax-based financing, which would lead to the earmarking of funding specifically for healthcare that could not be impinged upon by other sectors (an issue that had often arisen during the Soviet era, as discussed in Chapter 3) (Ensor and Thompson 1998).

7.1.1 Expected Reform Trajectories

These findings suggest two possible explanatory variables to identify when examining healthcare reforms in other countries: 1. The alignment of national identities with economic preferences, connecting the territorial integrity of the state to leaders’ decisions about reforms to economic structures; and 2. The context within which the reforms are attempted, including whether a recent crisis (economic, political, organizational) has occurred to create an opening for the reformulation of the values upon which the institutions are based. Finally, with the increasing influence of international organizations in areas of human rights, the global health sphere is likely to play some part in the any trajectory that is chosen: major reform efforts are likely to follow global trends in healthcare financing and provision when they are instituted, whereas those countries that do not introduce major reform are likely to frame any rationalization or optimization efforts in the language of those same trends. Table 10 below lays out a 2x2 typology of the expected reform trajectories.
Table 10 Typology of Expected Reform Trajectories

<table>
<thead>
<tr>
<th>Existence of a Critical Juncture</th>
<th>Structural Incentive – Lack of Threats to State Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><strong>Major Structural Reforms.</strong> The state’s responsibility is restructured to be shared with other key actors</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td><strong>No Major Structural Reforms.</strong> Moves to protect the state are made – maintaining full responsibility within the context of universal trends to maintain authority or absolving the state of all responsibility to maintain legitimacy</td>
</tr>
</tbody>
</table>

|                                   | Yes                                                     |
|                                   | **No Major Structural Reforms.** Attempts to reform inefficiencies in the system (fee schedules, etc.) are enacted to keep the system functioning. |
|                                   | No                                                     |
|                                   | **No Major Structural Reforms.** There are few attempts to reform the system. |

As the table above shows, the outcomes of both categories exhibiting a mixture of incentives and opportunities (the Yes-No types shaded above – the existence of a critical juncture with threats to the integrity of the state, and the lack of a critical juncture with no threats to the integrity of the state) can often exhibit similar characteristics that, without further research, will appear the same when simply observing a country’s healthcare reform trajectory. In a broader statistical study, this challenge of apparent equifinality when simply utilizing a superficial look at the end design of the systems would miss the unique types of paths followed by those systems to that point in time.

Based on these findings, we would expect to find the outcomes as suggested in Table 11 below. The states highlighted in gray are those in which we would expect to see newly restructured healthcare systems implemented.
Table 11 Expected Reform Outcomes in the Post-Soviet States

<table>
<thead>
<tr>
<th>Country</th>
<th>Threats to Territorial Integrity</th>
<th>Alignment of National and Economic Cleavages</th>
<th>Outcome – Major Reforms Implemented?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armenia</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Belarus</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Estonia</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Georgia</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Latvia</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lithuania</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Moldova</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: Author Analysis.

To review, the logic behind these expectations lies in the differences in how the threats to the state function depending on whether territorial threats coincide with an alignment of national and economic cleavages. If they do coincide, or if neither exists, then it is unlikely that the healthcare trajectory of the state will be one involving major structural reforms. This is because we would expect leaders of the post-communist regimes to be self-interested in not only the short term (that is, focusing on winning the next elections) but on the broader picture of the state and longer time horizons of their legacies on the formation of the state as well. This is due to their awareness of the crucial moment in
which they are making decisions, meaning that the critical juncture shapes their preferences in ways that would not happen during “normal” periods of politics. Therefore, we can expect them to have the following reactions:

(1) Yes/Yes – The state is at risk with moves to institute radical economic reforms, including to healthcare institutions. Therefore, no major structural reforms will be attempted, and any brief attempts will likely be abandoned in favor of maintaining stability.

(2) Yes/No or No/Yes – The state is unstable, but there is a possibility (and, therefore, incentive) to advance the country and improve conditions with reforms. This is because there is either (i) a territorial threat, but it does not align with a national identity-economic preference cleavage, or (ii) there is some alignment of economic preferences with national identities, but this does not coincide with any territorial threats to the state. Therefore, the state will implement reforms to cut back on public expenditures on healthcare and raise revenue through other means.

(3) No/No – The state is not facing any major cleavages along national lines or territorial threats that would threaten the existence of the state as it stands. As a result, leaders will not have incentives to implement major reforms. Any attempts at major structural reforms are likely to be short-term and not maintained, as decision makers do not have the incentives to follow through on them.

We would thus expect that Armenia, Belarus, Kazakhstan, Turkmenistan, and Uzbekistan would have no incentives to introduce major restructuring to the state’s
position within the healthcare system. Azerbaijan, Georgia, Tajikistan, and Ukraine would all be too unstable to prioritize the implementation and maintenance of major reform efforts that introduce shared responsibility between the state, the public, and private enterprises. Finally, Estonia, Kyrgyzstan, Latvia, Lithuania, and Moldova would all be expected to introduce these reforms, as they faced some instability to motivate reform efforts, but not instability with alignments of cleavages that would make the reform efforts even more threatening to the state’s existence.

7.1.2 The Role of Development Aid and International Organizations

An important factor in the advancement of any lower-income state in today’s world is likely to be the role of international organizations, both in providing finances and technical expertise as these countries attempt to “catch up” to high-income countries. In my theory, the role of these groups is not discussed in detail, and for good reason – based on my findings, I do not expect that international organizations will play the key deciding role in determining whether or not a state reforms its healthcare system. Instead, I argue, funding and resources provided by these groups will be used in the way it is most likely to aid in reaching the main goal of decision makers: stability in the longer-term for state-building efforts.

This does not mean that international organizations do not target their efforts toward countries that are more likely to follow certain reform paths. Indeed, many organizations during the post-Soviet transition very openly supported specific market reforms and were not shy about sharing their motivations in bringing these countries more in line with the West and capitalism. However, these efforts were not the final determinant in shaping a reform path, as Figure 25 below demonstrates. While there is
clear targeting of aid on the part of organizations, the outcomes did not necessarily follow the funds. Even within the set of poorer states who received larger amounts of aid, there is variation. Armenia and Tajikistan did not implement major restructuring reforms to share responsibility in the healthcare system, while Kyrgyzstan and Moldova did. Georgia introduced reforms very briefly, never got them off the ground, and eventually canceled the establishment of the new structures and moved to a fully privatized system. This could be due to the lack of donor coordination (Ulikpan et al 2014); however, those countries described as most “fragmented” in donor coordination also saw various outcomes, with Kyrgyzstan and Tajikistan following diverging long-term trajectories. These patterns instead appear to demonstrate that development aid and an influx of international influence, while it may provide a short-term boost to the economy and to market reform discussions, will not definitively shape the long-term trajectory of the healthcare system.
7.1.3 Conclusion

As I have discussed above, the reforms paths we would expect to find in the post-Soviet states given the argument that they all experienced a critical juncture for reform after the fall of the Soviet Union appear to, very preliminarily, be supported. In the next section, I discuss four cases in more detail, outlining their specific reform paths and the conditions within the state during that time.
7.2 Reform Experiences

In the following subsections, I examine four cases – Kazakhstan, Kyrgyzstan, Moldova, and Georgia – using information from Health Systems in Transition profiles published by the European Observatory on Health Systems and Policies,\(^\text{52}\) reports from international organizations and national governments, resources on the Ministry of Health websites, media coverage of healthcare reforms, and published literature from the health policy and political science fields. I discuss broadly the patterns of cleavages and reform trajectories in each country and conclude that the patterns seen in these four cases provide further support for my hypotheses on the relationship between timing, state stability, and healthcare reforms.

7.2.1 Kazakhstan

After the dissolution of the Soviet Union, Kazakhstan was initially considered one of the most progressive of the Central Asian republics (McKee, Figueras, and Chenet 1998, pg. 138). With an abundance of natural resources relative to other post-Soviet states, the issue of funding reform efforts appeared less daunting than in other cases, particularly compared to its fellow states in the Central Asian region. Throughout the first decade of the 1990s, however, President Nursultan Nazarbayev’s regime demonstrated an increasingly aggressive tendency toward authoritarianism, shifting international optimism surrounding the regime toward skepticism.

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\(^{52}\) These profiles are comprehensive reports on the structure, functioning, and principal reforms of each system. They are compiled by country experts using national and regional policy documents, national statistics, international data sources, and published literature. More information about these highly regarded reports can be found at: [http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits](http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits)
Healthcare reforms in Kazakhstan during these years were relatively quickly proposed but slow in terms of expert design and implementation. Like the case of Ukraine, the country’s Ministry of Health remained unstable structurally throughout the 1990s, with personnel changes every two years on average (Katsaga et al 2012, p. 113). However, during this time, the national regime remained the same. Nazarbayev, a man of strong Kazakh identity in addition to close ties to the Communist regime – having worked his way up the ladder in the Soviet era – ruled (and continues to rule) the country with a strong hand and a penchant for quelling dissent to his leadership. Just before the introduction of the MHI system, in 1995, Nazarbayev moved to consolidate his power, dissolving the legislature and introducing a referendum to extend his term beyond its 1996 expiration, to December 2000. He also managed the approval of a new constitution in August 1995 that created a bicameral parliament and consolidated his powers further, shifting the emphasis toward his personal staff and away from the committee and ministry appointments (Banks, Day, and Muller 1998, pg. 489). His (unofficial) party, the People’s Union of Kazakhstan Unity (SNEK), dominated the 1995 parliamentary elections to the new bicameral legislature.

The Mandatory Health Insurance Fund was introduced in 1996, after Nazarbayev laid out his idea for the program via Presidential Decree No. 2329 “On compulsory medical insurance of citizens” in June 1995 (President of the Republic of Kazakhstan 1995, World Health Organization 1999). Yet it only remained in existence from 1996 to 1998. In terms of rejuvenating the system’s finances to address the legacy of the low level of funding – and, in turn, issues of access to quality care – left from the Soviet system, the concept failed miserably. This failure was partially due to the rapid decline in
the amount of state budget funding, which outpaced the new revenues from the payroll
taxes established through the new system (Kutzin and Cashin 2002, pg. 96), and partially
due to a lack of government will to maintain the new system. The first of these – the
failure to maintain adequate financing for the system – had emerged as a difficulty with
the introduction of pilot projects in four oblasts (McKee, Figueras, and Chenet 1998).
The oblast administrations often did not transfer the funds required for socially
vulnerable groups, worsening the financing issues. Without sufficient funds, the MHIF
could not follow through in its payments promised through contracts with health
providers (World Health Organization 1999, pg. 54).

The other cause of failure for Kazakhstan’s initial reform efforts could be found
in the government’s inflexibility in power relations regarding the roles of both regional
actors and external actors. The entire reform process experienced high levels of
fragmentation, particularly across oblasts as regional actors were provided greater
influence (World Health Organization 1999, pg. 55). IFIs led the charge in implementing
social insurance. Yet, due to funds from oil revenues and frustration with the reform
efforts, the government canceled a World Bank loan dedicated to the program. Without a
necessity for ties to IFIs for funding or an interest in further empowering regional actors,
the Kazakhstan leadership quickly decided to reverse the reforms and reinstate a state-
budget-funded scheme after 1998 (Borowitz and Atun 2006).

Possible explanations for the many failures in healthcare reforms during these
initial years of independence can be found through an examination of the political and
social dynamics at the time. With a greater abundance of resources than its neighbors and
a decision to move back to the costlier state-run system, the argument that funding was
the main issue with reform efforts remains unconvincing. Instead, a stronger explanation lies in the lack of incentives for reform under Nazarbayev’s rule. The tensions across national groups had grown after independence between ethnic Russians and Kazakhs, but with few consequences for the regime. While the state moved to ease some tensions by simplifying the citizenship process, the ethnic Russians, rather than pushing for sovereignty or greater control of the state, instead moved en masse back to Russia, with only 300,000 (less than half of the original population) left in Kazakhstan by early 1995 (Banks, Day, and Muller 1998, pg. 490). This lessened the pressure on Nazarbayev to incorporate diverse interests in his regime’s policymaking. Furthermore, many of the divisions between ethnic Russians and Kazakhs remained along identity lines, with relations with Russia representing the most persistent political source of tension, rather than opinions on market reforms. With very few national threats to the integrity of the state, Nazarbayev had few incentives to focus seriously on a long-term reform effort. Instead, he continued to prioritize the consolidation of power in his regime.

The long-term trajectory for Kazakhstan’s healthcare system has changed very little since these initial reform efforts, supporting the proposal that healthcare reform trajectories become difficult to change significantly after decisions are made during critical junctures. In 2017, the Kazakh government once again re-introduced plans for a health insurance scheme, but has again delayed its full implementation, pushing it back until 2020 (MoH Kazakhstan 2017). The issue of funding has again been blamed, with the government emphasizing the continuing issue of self-employed people not contributing (Seisembayeva 2018). Unlike in the case of Russia, where there existed some alignment of national and economic cleavages and a strong opposition movement to
the regime in power – and, thus, an incentive to reform to better achieve stability for the advancement of their state-building efforts – and no strong territorial threats – lessening fears that reforms might threaten the state’s existence – Kazakhstan faced little threats to its state-building agenda. While the importance of clans always a role in Kazakh politics in terms of shaping center-region relations, there have been few true threats to Nazarbayev’s efforts. Therefore, as expected, Kazakhstan has followed a long-term trajectory of no major restructuring reforms since the critical juncture of the 1990s.

7.2.2 Kyrgyzstan

Kyrgyzstan is the first of two countries (Moldova being the other) that appear to contradict the long-held theory that wealth is required for successful reforms. While Kyrgyzstan did receive the greatest amount (in terms of percentage of GDP) in development aid during the 1990s of the post-Soviet states, this does not mean that it was inevitably going to be a healthcare reform success story.

During the first years of the transition, President Askar Akayev was praised by Western leaders, leading Kyrgyzstan into the position of being “one of the most enthusiastic governments for market reform” (McKee, Figueras, Chenet 1998). By the mid-1990s and with the help of the World Health Organization, the state had launched the Manas reform program (1996-2006) that brought “comprehensive structural changes of health care delivery, financing, and management” and introduced a mandatory health insurance system in 1997 (Ibraimova et al 2011, pgs. xviii-xix, 99). The program plan included a detailed layout of short-, medium-, and long-term components and training programs for those in charge of implementing the reforms (McKee, Figueras, and Chenet 1998, pg. 138). The effort put into these details likely aided in the success of the reforms.
As opposed to the case of Kazakhstan, whose mandatory health insurance system had been introduced just one year earlier, Kyrgyzstan did not rapidly drop state budget revenues toward healthcare while introducing health insurance. While the payroll contributions did not increase as quickly as they did in Kazakhstan, Kyrgyzstan’s state budget contributions slowed at a much more gradual rate (Kutzin and Cashin 2002, pg. 96). Furthermore, though the contribution of the healthcare system remained low initially, the establishment of these institutional changes were seen as a catalyst for continuing reforms (Bonilla-Chacin 2005). Kyrgyzstan’s government has also proven to be flexible in terms of adjusting to inefficiencies with the system as they arise. When contradictions in payment methods and budgeting and problems of fragmentation became clear, the Ministry of Health quickly moved between 2001 and 2004 to develop a single-payer system for the State Guaranteed Benefits Package, in order to maintain consistency of access for all populations (Ibrahimova et al 2011, pg. 101).

With the end of the Manas program, the Ministry of Health launched a new reform plan, Manas Taalimi (or “Lessons of Manas”) in December 2006 with the technical support of the World Health Organization. This program was meant to build on the Manas program, including developing a greater role for the population in reform efforts (Ibrahimova et al 2011, pg. 104). The dedication to consistency and coordination has been very rewarding for the country, as it stands as an exemplary case of a low-income country beating the odds and improving its healthcare system.

What can explain Kyrgyzstan’s success? While some argue that development aid makes a difference as long as it is well-coordinated (Ulikpan et al 2014), this hypothesis fails to explain why the government would be so motivated to implement reforms in the
first place. Economic crisis and desires for greater connections to Western countries and international organizations are possible arguments, but they do not explain well the variation that we see across the post-Soviet states, or even just across the four states highlighted in this chapter. While these certainly were factors shaping the policymaking contexts, the choice for a committed reform effort can instead be better understood through the lens of the political and social conditions of the time.

The political landscape during the initial years of independence was significantly shaped by national uprisings from the 1980s, and particularly from Kyrgyz-Uzbek clashes in the Osh region in 1990 (Huskey 1997, pgs. 661-662). During these years and the initial years of independence, the rising Kyrgyz nationalism alienated the other nationalities within the country, including Uzbeks, Russians, and Ukrainians, who all began to form their own national organizations. However, like in the case of Kazakhstan, some groups – including the Russians, Ukrainians, and Germans – decided to leave Kyrgyzstan, rather than live under a nationally-biased regime. This led to alarm on the part of the government, who knew that these groups were “valuable political and economic resources,” and President Akayev began to make concessions, beginning with language laws and other means of greater recognition for the minority nationalities (Huskey 1997, pgs. 663).

Despite these tensions, Kyrgyz nationalism remains one of the less aggressively pursued in the Central Asia region. Rather, the Kyrgyz nationality itself is divided, with cleavages along urban-rural lines more prominent than between nationality lines (Huskey 1997, pg. 664-6650). This reflects some of the dynamics discussed above with Russia’s healthcare reforms in the 1990s and the opposition of the “Red Belt,” as opposed to
solely nationally-driven groups. Instead of fearing instability for the state along national
tlines from the introduction reforms, the Akayev government felt pressured to meet the
demands of both international donors, who pushed for rationalization measures, as well
as domestic audiences, who wanted better protection during the economic crisis,
especially for the Kyrgyz people (Huskey 1997, pgs. 666-667). While the economic
cleavages did align somewhat with the grievances between nations (in that the Kyrgyz
were calling for stronger paternalistic protection), there was no threat to the territorial
integrity of the state driven by these differences. Instead, a regional rivalry between north
and south, rather than along national lines, developed and has remained the key cleavage
over time (Ryabkov 2008). Akayev, then, with little incentive to delay reforms, felt
compelled to focus on implementing reforms in order to improve the economy and
maintain his government’s state-building efforts in the longer term. This included
increased welfare payments and a detailed and extensive plan for restructuring the
healthcare system. His endorsed party, the Social Democratic Party of Kyrgyzstan
(PSDK), which won the most seats in the parliamentary elections of 1995, fully
supported his pro-market, reformist efforts. Akayev further consolidated his power during
these years as well after his reelection in December 1995 and the constitutional
referendum of February 1996 (Banks, Day, and Muller 1998, pg. 519). This further
cemented the reform efforts, though these moves and the later irregularities in the 2000
elections damaged the reputation of the country as an ‘island of democracy’” and
weakened Akayev’s declared claim that he wanted to make Kyrgyzstan the “Switzerland
of Central Asia” (Abazov 2002).
Later unrest over corruption posed a possible threat to the positive healthcare reform trajectory that had been initiated by the Akayev regime. The 2005 Tulip Revolution and subsequent overthrow of President Akayev, as well as the 2010 protests that led to the removal of his successor, Kurmanbek Bakiyev, represented moments at which one might expect significant changes in reform efforts. However, through these regimes, as well as that of Almazbek Atambayev, elected in 2011, and Sooronbay Jeenbekov, elected in 2017, have so far remained consistently committed to the healthcare reform efforts. Because Kyrgyzstan has gained a reputation amongst international organizations as a committed reformer and because the cleavages have not shifted dramatically since that time, the government has little incentive to deviate from those initial decisions. This again demonstrates support for my argument that the decisions made at the critical juncture in the 1990s had a lasting impact on the long-term healthcare reform trajectories in these countries.

The explanatory variables for which I have argued – the existence of threats to the state due to territorial disputes or alignment of cleavages along national and economic lines – have similarly remained consistent throughout the multiple years of unrest. The Communist Party, which campaigns against radical market reforms but has weakened over the years, remains a party that gathers support across national lines (Abazov 2002). Furthermore, the regional rivalry between the north and south of the country, rather than threats to territory that align with national and economic cleavages, has remained a main source of tension. Indeed, the intra-ethnic rivalry within nationalities across those regional divides are a greater source of tension than any between the majority and minority nationalities (Ryabkov 2008). This lack of alignment of national and economic
cleavages remains safely untied, then, from any threats to the territorial integrity of the state. This has, as I have argued, created incentive for reform (to maintain stability), but within the context of lessened fears of the consequences of that reform.

7.2.3 Moldova

Moldova, along with Kyrgyzstan, is often talked about as a “success story” for post-Soviet healthcare reforms. Though it introduced reforms a few years later than others and though it is much poorer than some of its compatriot reformers, Moldova has earned the distinction over the years of having the best performing restructured system in terms of increasing the generation of public revenues for healthcare (Sheiman et al 2010, pg. 102). However, it still remains the poorest country in Europe, and therefore has many barriers that it must consistently overcome in its pursuit of reforms.

As a poor country newly independent in Eastern Europe, Moldova’s expected trajectory would, at first glance, appear similar to Ukraine’s. With high levels of national tensions, including a separatist movement supported by Russia in the Transnistria region, Moldova would likely be predicted by many analysts to avoid major reform efforts, and to follow the paths of states like Armenia, Azerbaijan, or Ukraine. Lucan Way’s analysis of democratization trajectories in the former Soviet states argues for an understanding of the Moldovan case as similar to that of Ukraine, stating that “Moldova, like Ukraine, provides a clear illustration of the ways in which weak organization and divided national identity facilitated pluralism in the post-Cold War era” (Way 2015, pg. 93). However, the existence of threats to territorial integrity combined with the lack of alignment of the national cleavages with economic cleavages – which distinguishes Moldova from Ukraine, as well as the Armenian and Azerbaijani cases – provided an opening for
Moldovan leaders to use reforms as a means of unifying an otherwise unstable state. This allowed them to take advantage of the critical juncture’s relaxation of the social values underpinning the healthcare system to introduce a new, restructured role for the state.

Moldova’s early years of independence were fraught with crisis, not only of the economic and political type as seen in all of the post-Soviet countries, but of violent clashes and threats to territorial integrity. As in the Caucasus region, this violence arose around the nationalist movements that grew in strength at the end of the Soviet era and were exacerbated with the sudden establishment of sovereign entities and international borders that resulted from the fall of the USSR. Violence in Moldova began as early as 1989. The passing in August 1989 of a state language law that provided concessions to protestors favoring greater status for the Romanian language further bolstered these movements, leading to rising tensions between ethnic Moldovans and Russians (Crowther 1997, pg. 291).

These years of crisis were spurred on by the Popular Front, whose main goal, as was revealed over time, was to reunite Moldova with Romania. However, though violence broke out both in Transnistria and the southern Gagauz regions, these conflicts had lessened by 1995. While discussions about how to best deal with these conflicts were still at the forefront of political discussions after 1995, they began to overwhelmingly take on a rhetoric of conflict resolution, including the proposal of the OSCE’s representative, Ambassador John Evans, that suggested that an idea of a “common state” be established to keep the peace (OSCE 1998, Williams 2004). Furthermore, through all of these tensions, the cleavages along national lines did not correspond with cleavages of
economic preferences. Rather, all of the groups – Moldovans, Russians, Ukrainians – were supportive of reform efforts (Crowther 1997, pg. 306).

Moldovan leaders first introduced and approved the Law on Mandatory Social Health Insurance in late February 1998. This came at a time of stabilization in the state and followed the beginning of an “extended implementation lapse” of IMF reforms that had begun in late 1997 (Pop-Eleches 2009, pg. 215). Despite the seeming relaxation of economic pressures to reform, healthcare reform was pursued consistently from 1998 onward. The implementation of the healthcare reforms was approached gradually after the defeat of the ruling Democratic Agrarian Party of Moldova (PDAM) in the March 1998 parliamentary elections, but they were never canceled or reversed. Instead, the Communist Party of Moldova and the Democratic Convention of Moldova, which won 40 and 26 of the 101 seats respectively, continued their commitment to the reform efforts. Though from the late 1990s to the early 2000s there was frequent turnover in the Ministry of Health officials, including the position of minister, this did not change the long-term reform trajectory. While it may have delayed some implementation of reforms, the Moldovan government managed to avoid the trap of discontinuity with such turnover – as was seen in Ukraine – and used this unstable period to better develop the reform strategies with its financing partners, so that when they were implemented, they would be successful (Atun et al 2008, pg. 111).

During this newly difficult economic time brought on by the collapse of the ruble in 1998, four pieces of legislation were passed that set the stage for the full implementation of the restructured healthcare system: the Regulation on Fees for Health

53 For the full text of this document, as well as links to the texts of amendments, see: http://lex.justice.md/md/311622/
Services (1999), the Law on Evaluation and Accreditation in Health Care No. 552-XIII (2002), the Statute of the National Health Insurance Company (2002), and the Basic Benefits Package of Health Care Services under Mandatory Health Insurance (2003). The Moldovan leadership also amended the original Law on Mandatory Social Health Insurance passed in 1998 and began to make some rationalization changes (a reduction in bed numbers, a change in the funding distribution from per bed to per capita, and decentralization of some funding and planning mechanisms) during this time. These strategies were laid out in the government publication “Health Sector Strategy for the Period 1997 to 2003,” approved in 1997 (Atun et al 2008, pg. 112-113). All of these demonstrated a consistent commitment to the planned restructuring of the healthcare system. While funds ran short for providing the universal access to quality care that the government was planning during that time, their ability to maintain the pace of providing basic care during the crisis set the stage for their later efforts at full implementation.

When the scheme was finally fully implemented in 2004 – a time at which the Communist Party held 71 of the 101 parliamentary seats after the 2001 elections – leaders introduced the healthcare reforms using a “big bang” strategy. With the centralization of budgets and a focus on the overall system, rather than on the insurance scheme itself, Moldovan leaders implemented their reform strategy relatively successfully. Furthermore, the consistency across parliaments after elections demonstrated a commitment to reforms that further enhanced their credibility with the public and with potential development partners.

54 For a full table of the legislation passed from the mid-1990s to 2007, see Table 7.1 on page 112 in Atun et al (2008).
The Ministry of Health increased its accountability and transparency efforts involving decision making and resource allocation processes in recent years by instituting annual surveys on the use of development aid funds and decision making since the mid-2000s. In 2013, the Ministry of Health had 21 identifiable development partners, consisting of a range of organizations and governments, from the World Bank to the European Union and the governments of Japan, Romania, Estonia, and China. The reports show that, as far as geographic coverage in development projects, the Swiss Agency for Development and Cooperation (SDC) has far out-paced other partners (WHO 2014b, pgs. 14-16).

In their analysis of Moldova and Kyrgyzstan’s reforms, Kutzin, Jakab, and Shishkin (2009) determine that, regarding the sequencing of reforms, the cases of Moldova and Kyrgyzstan (discussed above) “suggest only that such considerations are situation-specific and may depend more on leaders with the vision to seize political opportunities…than on particular technical design issues” (pg. 309; emphasis my own). That is, Moldova’s reform approval and implementation had more to do with opportune timing, a coordinated effort, and political will than anything else. This political will was rooted in a desire for stability and unification.

Moldova’s success lies in the lack of alignment between the ethnic cleavages that drove the threats to territorial integrity and the political-economic cleavages across ethnic groups. Unlike in Ukraine, where choosing market reforms also meant supporting the position of the right Ukrainian nationalists over the socialism-leaning Russians, the

55 The latest few years of these reports, as well as lists of the nongovernmental organizations and other partnerships involved in various projects, can all be found on the Ministry of Health’s website at: http://msmps.gov.md/ro
Moldovan people – whether ethnically Moldovan, Ukrainian, or Russian – were supportive of the necessity of reform and were inclined toward market reforms. In this case, the Russian population was even slightly more likely to favor reform efforts (Crowther 1997, pg. 306). While identity and nationalism still divided these groups, that division did not carry over to their preferences about the economic and political future of the country, thus lessening the decision makers’ uncertainty about the future of the state with the implementation of reforms. This incentive for reform – a need to unify the country – but one lacking in strong cleavages along economic preferences aligned with the national divisions, supports my argument that decision makers will seek out reforms to the healthcare system within the context of greater reform efforts when they are more certain about its likelihood to advance their state-building efforts.

7.2.4 Georgia

Georgia stands out as a unique case for healthcare in the post-Soviet space. Initially reform-minded, Georgian leaders, like leaders in Kazakhstan, reversed the early efforts to establish a mandatory health insurance system. However, unlike the Kazakhstan case, Georgian leaders chose to radically privatize their healthcare system at that time, moving to the opposite end of the spectrum from those regimes maintaining state-controlled systems. This rejection of a continuing central role for the state in financing and providing healthcare represents a clear break from any of the other cases I have examined in this dissertation so far. Yet, despite this unique outcome, I contend that the Georgian case can still be explained through the lens of decision makers seeking security for their state-building efforts in the long term.
Decision makers in Georgia began to plan healthcare reform strategies in 1993. These reforms were supported by the World Bank in its initiatives to encourage market reforms and democratization in the former Soviet states. The United States government, the US Agency for International Development (USAID), and the American International Health Alliance (AIHA) also served as strong supporters of these reforms (Jorbenadze 2000, pg. 6). After two years of planning, the Georgian Health Care Reform package, which introduced a mandatory health insurance scheme, was initiated in 1995. In 1996, the document “Georgian Health System Reorientation: Major Directions” laid out the strategy for further introduction of reforms meant to modernize and improve quality of care in the system. The list was extensive, ranging from changes in financing mechanisms to medical education reform. Decision makers eventually developed the Georgian National Health Policy and the Strategic Health Plan for Georgia 2000–2009 from this work, publishing them in 1999 (Jorbenadze 2000; Gamkrelidze et al 2002).

Finally, in 1998, rationalization reforms were initiated (Bonilla-Chacin 2005, pg. 394). Yet, due to limited funding and inadequate institutionalization of the new scheme, especially under conflict conditions and an extreme level of unemployment that limited the funding flowing to the new system, the quick implementation of the reforms failed. During this time, out-of-pocket expenditures were calculated to make up between 60 and 80% of all healthcare expenditures in the country (World Bank 2002). The failure of this system put a black mark on market reforms in the welfare sphere. As market reforms failed to improve life in the country, pushback against these reform plans grew.

After the 2003 Rose Revolution and overthrow of President Shevardnadze, the new government under Mikheil Saakashvili, a strong supporter of market reforms who
had been educated in the United States, committed to neoliberal principles brought in by outside experts and officially abolished the health insurance system in 2004. Yet, against the recommendations of international organizations and political leaders, the administration decided to recognize a largely privatized, out-of-pocket payment system (Chanturidze, Ugulava, Durán, Ensor, and Richardson 2009). This restricted access to many Georgians who could not afford the payments required to receive adequate care. In recent years, the state, under the leadership of President Giorgi Margvelashvili, has stated its continuing efforts to become develop closer ties with Europe and, as part of its reform efforts, has attempted to address these issues of access with payment system adjustments and other rationalization efforts detailed in its “2014-2020 State Concept of Healthcare System of Georgia for 'Universal Health Care and Quality Control for the Protection of Patients' Rights.”

While Georgia’s unique long-term trajectory at first appears to stand as an outlier in the post-Soviet region, a closer look at the patterns of national and economic cleavages and threats to the integrity of the state reveals similarities to the other cases examined here. Threats to territorial integrity from the early years of independence in the Abkhazia and South Ossetian regions as well as alignments of national and economic cleavages represented serious challenges to the integrity of state-building efforts. While Western-backed international organizations pushed for rationalization and liberalization, the Georgian government was torn over how to address these concerns while still maintaining their long-term vision for a stable Georgian state.

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Violence shaped the Georgian state from the very beginning of independence. From the coup d’état that overthrew President Zviad Gamsakhurdia in 1991, to the violence in South Ossetia and then Abkhazia, to the continued tensions with Russia that resulted in the short Russo-Georgian War in 2008, the Georgian state has rarely seen extended periods of stability to support state-building efforts. Yet these threats to the territorial integrity of the state, though very strong, do not align with political cleavages. Instead, there are “few signs of political cleavages that reinforce ethnic divisions” (Sichinava 2015, pg. 39).

This would seem to indicate, according to my theory, that Georgia would be likely to implement reforms – while the territorial integrity of the state is threatened (giving an incentive to reform in order to unify the country), this threat does not align with the national and political cleavages along lines of economic preferences (lessening any uncertainty that restructuring might lead to even greater threats to the integrity of the state-building efforts). This can explain why reforms were hastily passed and implemented in the late 1990s. However, the instability of the economic preferences of minorities and their consistent lack of (or isolation from) political participation makes the cleavages difficult to determine at any given time. While there is some evidence that these groups simply vote for the incumbent (Nodia 2006), there is uncertainty about the motivations and clear delineations of political cleavages across national lines, making the threat less cohesive, and yet possibly more volatile, than in countries where the divisions are clearer. This leaves open possibilities such as self-exclusion (Sichinava 2015) that could prove difficult for the decision makers to recognize as patterns of support. Therefore, the uncertainty about the political consequences of economic reforms is likely
to overwhelm decision makers, giving them incentive to abandon reforms at the first sign of trouble. This would support my theory and stands as a possible interpretation of the Georgian case results.

7.3 Conclusion

In this chapter, I have shown evidence that the patterns I identified in the Russian and Ukrainian case studies connecting healthcare reforms to the wider economic reform and state-building efforts are in fact present across the post-Soviet region. In these cases, the decision makers in states that felt the most and least threatened by the national movements in connection with economic reforms were less likely to make lasting reforms to the state’s responsibility in the healthcare system. In those states that (1) had incentive to improve conditions to maintain stability due to nationalist movements, but (2) either did not see a threat in implementing reforms because there was no clear alignment of the national and economic cleavages, or faced a situation in which those cleavages did not align with any territorial threats, were more likely to introduce major restructuring to their healthcare systems allowing a sharing of responsibility for health between the state, individuals, and private enterprises.

These findings are not exclusive to the post-Soviet states. This type of argument – that reforms of this type can be described using a structural model, regardless of the particular groups involved – reflects previous arguments on healthcare system reforms, such as Alford’s (1975) theory on the hierarchies of interests in healthcare. Concerns about the stability of the state in lower-income countries or “emerging economies” are dynamics that can be found across regions. While the barriers facing the post-Soviet healthcare systems were particular to the state-run Soviet healthcare system’s legacies –
the low level of funding, the underpayment of doctors, the infrastructural emphasis on inpatient care – the *dynamics of restructuring a healthcare system*, including the interest group pressures, the short-term and long-term costs of change, and the wider international context of trends in global health values, would be consistent, I argue, across a variety of countries and regions. I discuss this further in my next and final chapter.
Chapter 8
Conclusion: 
Post-Soviet Healthcare Reforms and Global Trends in Social Policymaking

My dissertation was inspired by a simple empirical puzzle: Why have the post-Soviet states followed such varying trajectories of healthcare reform? As I began to dig deeper into this subject, the daunting task of healthcare reform – and, particularly, the difficult decision about the role of the state in healthcare during political and economic transitions – slowly revealed itself to be a question of stability, long policy time horizons, and self-interest on the part of decision makers. The case studies examined in this dissertation suggest that the transition and state-building experiences produced by the dissolution of the Soviet Union created a policymaking environment similar to that of other newly independent and lower-income countries. They also suggest the importance of institutional legacies and the policy feedback process in shaping the trajectory of healthcare reforms across time – an aspect of healthcare reform that appears to be consistently present across countries, whether low-, middle-, or high-income, and regardless of culture, political structures, or health needs. This points to the importance of characteristics of policy areas, such as healthcare’s connections to both the economic and human rights spheres and its high levels of information asymmetries.

Whereas the “politics matters” literature on welfare reforms showed that these policymaking processes were subject to political interests and strategies, this dissertation has worked to bridge this literature with that of healthcare policymaking, demonstrating not only that it matters, but how it matters – and how it does not matter. By pinpointing
how and when interests influence policymaking the most, I have sought to explain why it is that these various interest configurations suggested by the policy and sociological literature have a seemingly inconsistent impact on institutional change across time.

In this conclusion, I discuss briefly the implications of these findings across four different areas: First, I discuss a broader picture of the external validity of these findings, suggesting that they correlate strongly with patterns that we see in other countries of similar development and state-building levels. I also discuss the way in which the broader abstraction of these findings – that healthcare policymaking comes down to the competition of interests within the framework of social values, and that these interests will be more influential at shaping the policy trajectory at critical junctures than at other points in time – can be applied to many countries, even the advanced industrialized societies. Second, I briefly discuss how this picture of policymaking compares to other welfare areas, suggesting that those welfare areas that see similar principal-agent problems will see similar patterns of policymaking. Third, I turn inward and discuss briefly the way in which these patterns may vary across healthcare policymaking for different vulnerable population groups within one country. I suggest that the patterns of competing interests and institutional legacies will broadly remain the same, but that the particular actors involved will change, impacting the design outcomes for these different “types” of healthcare within one system. Fourth, I provide some brief policy implications from these findings. Finally, I conclude with some brief final thoughts on the dissertation.
8.1 Theoretical Implications

8.1.1 Global Health Systems

The politics of health in the post-Soviet states reflect similarities in health policymaking processes of other countries, particularly the groups of countries known as “late industrializers” or “emerging economies” (Gerschenkron 1962; Amsden 1989; World Economic Forum 2014). The conflict between the global push for a human rights framework for health and the limits of resource scarcity and political instability in many of these countries leads to a greater role for international organizations and donors (Jeffery 1988; Osman 2004). A rising trend in the importance of universal access and patient-centered quality of care measures as standards of modern healthcare pushes decision makers in these later-developing countries to prioritize these aspects of healthcare system design over other considerations, such as financial streamlining. This has led many emerging economies to focus on “leapfrogging” in order to catch up to the healthcare system of the advanced industrialized democracies, which can, without support or careful planning, lead to significant financial struggles (World Economic Forum 2014). The importance of these factors combined with the reality of economic limitations has led to an increase in the number of countries establishing insurance system or national health service designs, rather than designs relying on general taxation and state control of provision or largely privatized designs, like that of the United States. However, these systems often incorporate a greater role for the state than in more

57 The difficulty of defining “quality of care” adds to the struggle for countries seeking to catch up to the advanced industrialized economies; when one does not know what the end goal is that one is trying to achieve, then it is difficult to strategize efficiently. For more information on the difficult of defining “quality of care,” see Avedis Donabedian’s classic 1966 and 1988 articles, “Evaluating the Quality of Medical Care,” *The Milbank Memorial Fund Quarterly* 44 (3, pt. 2): 166-206, and “The Quality of Care: How Can It Be Assessed?” *JAMA* 260 (12): 1743-1748.
advanced industrialized economies, with a mix of public and private providers favoring the state-run institutions, rather than largely private providers with state funding mechanisms, as in Germany (Mossialos et al 2016).

While these global trends are important, the way in which they are filtered through the domestic political lens of each country remains significant to shaping the state’s healthcare reform trajectory. Kleinman (2002), for example, has argued that, even with European Union integration and the shared social and demographic trends that affect the majority of states, the national institutions and attitudes still serve as the key factors in shaping a welfare state. Therefore, while some level of abstraction allows for comparison across countries, the importance of the historical background and political landscape cannot be ignored. This dissertation, however, has demonstrated that, while still taking into account the historical experiences of states, the tension between these domestic forces and international pressures can be understood systematically and can lead to predictable patterns of healthcare reform trajectories.

The experience of the post-Soviet states, I argue, can tell us about three major aspects of healthcare reforms in other countries: 1. The impact of institutional legacies in healthcare across low-, middle-, and high-income countries; 2. The dynamics of healthcare reform in later-developing countries, where the pressure to “catch up” and the pressures of external actors as well as internal politics creates greater possibilities for economic struggle and collapse; and 3. The particular experience of moving from a more state-run system (both in financing and provision) to one that involves the empowerment of and coordination with a variety of actors, and the ways in which that challenges both the role of the state and societal values. This last antecedent condition – that of a state-run
system – does not have to match the Soviet Semashko healthcare system exactly, as recent shared experiences in countries as diverse as Ireland and Croatia have shown.⁵⁸

First, the Soviet experience demonstrates clear support for Pierson’s (1993, 2000) idea of a policy feedback loop in which constituencies in support of institutions will develop along with their creation, leading to increasing returns for simply modifying the system rather than replacing it with a new one. The overarching Soviet welfare system did just that, giving rise to not only specific groups that supported a more wide-reaching healthcare system, but also shaping social values in its progressive nature. This, as I have shown in this dissertation, led many to question the value of simply throwing away a system that had some positive and highly praised elements.

This is not unique to the post-Soviet states. Because changes in healthcare systems can lead to short-term costs that put citizens’ lives at risk, many populations tend to be risk-averse when it comes to supporting an overhaul in the existing system. This risk aversion reflects similar patterns as those seen in the slow diffusion of technological and practical innovations in healthcare (Berwick 2003). Therefore, my dissertation findings suggest that healthcare reform, because it is looking to restructure institutions based on entrenched social values, will be most malleable at times of crisis or significant social revolutions, whether in low-, middle-, or high-income countries. Smaller changes to the healthcare system – such as changes in financial bundling, regulatory measures, or medical education – are likely to occur between these major turning points, as societies

⁵⁸ Many thanks to Vivienne Byers, Dublin Institute of Technology, and Dagmar Radin, University of Zagreb, of the Comparative Approaches to Health and Educational Policy panel at the 2016 MPSA Conference for discussing this concept with me, particularly in the cases of healthcare reform in Ireland and Croatia.
continue to attempt to improve the quality of their healthcare systems. However, the definition of the role of the state is unlikely to significantly change during these periods.

Second, the post-Soviet experience reveals much about the way in which new networks of key actors can play a role in healthcare reforms in ways that reforms in more advanced industrialized countries do not reveal. This can explain why studies of healthcare reforms in high-income Western countries, such as those of Alford (1975) and Immergut (1992), may provide insights, but do not seem to take into account the more complex dynamics of healthcare reforms in most countries today. The rising role of donors plays a significant role in changing the position and perceptions of state decision makers in the reform process (Jeffery 1988; Osman 2004). My dissertation has demonstrated that significant financial aid can help decision makers overcome uncertainty about the state’s capacity to weather significant reforms, though it will not directly definitively shape the long-term reform trajectories.

Despite discussions about the low level of funding in post-Soviet states, compared to other countries of similar levels of GDP per capita, the health expenditure levels of these states as individual countries do not stand out as significantly worse or better than others (see Figure 26 below). ⁵⁹

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⁵⁹ The outliers of Slovenia and Portugal have been left out in order to create a more readable chart. Slovenia’s GDP per capita was reported as 28417.66 and its health expenditure per capita as 2697.67. Portugal’s were reported as 26023.70 and 2689.94, respectively.
Figure 26 Comparative Health Expenditure (2014)

This, along with reports of similar dynamics of healthcare reform in other emerging economies (World Economic Forum 2014), indicate that there may be a similarity of patterns across late developers in healthcare reform like those larger economic patterns highlighted by Gerschenkron (1962) and Amsden (1989). This suggests that the importance of the role of external financial institutions and their connection to international healthcare trends, as well as the way in which this shifts state decision makers’ positions in the policymaking process, will be observed in any country seeking to modernize its healthcare system within the existing context of global healthcare standards.

However, as I have also shown, aid is also not the defining factor of reform trajectories. Instead, financial assistance will be most likely to lead to significant reforms moved toward mixed state responsibility (an insurance or national health service model) only in cases where, at the critical juncture, there is either a significant threat to territorial integrity – where a state has incentive to modernize its healthcare system to address its ability to control the territory and provide during times of crisis – or a split between those supporting nationalist movements and those supporting economic liberalization, in which a state has incentive to restructure the healthcare system as a means of unifying the state. In cases where both are present, the state is more likely to be caught in a battle over sovereignty due to its divisive nature, making any aid that comes to the state become prioritized as short-term conflict resolution aid. In cases where neither are present, the state is likely to have no incentive to use aid to restructure a system over which it already has full control and has no incentive to improve for greater integration into the global economy. This suggests that two key factors that have not previously been directly
connected to major structural healthcare reforms – threats to territorial integrity and alignments or splits between nation-building (nationalist) and state-building (economic liberalization) cleavages – should be taken into account when examining which healthcare reform trajectories will be most likely to succeed when the previously discussed critical juncture emerges.

Third and finally, my dissertation has suggested state-run systems of healthcare will be especially difficult to reform due to that same policy feedback loop mentioned above (Pierson 1993, 2000). Within the context of growing popularity for the importance of universal access and the human rights framework of health, it will be particularly difficult to attempt to “modernize” while appearing to limit access by increased responsibility for individuals through insurance payment mechanisms. States attempting to do this have to quickly replace access with significantly higher quality care in order to justify the changes. The pressures of this – especially as quality of care continues to improve worldwide – will become increasingly difficult to overcome, providing incentives for state decision makers to simply modify the existing systems. In countries beginning at other starting points – such as the United States, with its largely privatized system – major structural changes may prove easier over time as values shift within this global context. President Obama’s effort to establish greater regulation of healthcare to provide broader access certainly capitalized on these trends. However, the Affordable Care Act (ACA) did not seek to fundamentally restructure the state’s responsibility in financing and provision, relying instead on greater regulation of private insurers and putting a larger burden on individuals who are not insured, in order to improve coverage for the sick and low-income populations. This suggests that even in cases where states are
looking to expand coverage, some type of critical juncture is needed to overcome the barriers created by vested interests and entrenched values in the healthcare system.

### 8.1.2 Welfare State Policymaking

Beyond the external validity of the findings and their implications for worldwide trends in healthcare, the findings of this dissertation also suggest that welfare policy areas that reflect some of the main characteristics of healthcare policy will follow similar patterns. Though I argued in Chapter 1 that healthcare policy is quite unique, there are certain policy areas, such as education, that share some of the most important characteristics driving the shape of policymaking. These factors include the extent of dependence on principal-agent structures and the level of expertise required for successful implementation.

As mentioned in Chapter 1, economists such as Kenneth Arrow (1963) have suggested that healthcare, with its incredibly high level of information asymmetry, simply cannot be considered to be under the same constraints and expectations as other welfare policy areas. The realities of healthcare, including that policymakers are often not versed in the complexities of medical care and that patients themselves more often than not do not have the time to overcome the enormous obstacle of understanding the details of medical science, do indeed limit the ways in which policymakers are able to strategize reforms to the system, especially if they are aiming for quality of care based on global trends, as discussed above in section 8.1.1. However, while it may seem as if healthcare is unique in the extent to which this is true, other welfare areas that depend upon expertise and a principal-agent structure for implementation should see, my dissertation suggests, some similarities in reform difficulties.
Education is the best example of this, as education systems rely not only on experts to design the structure of the system, but also on the work of teachers and administrators to carry out the day-to-day implementation of this type of service. This adds in the complication of a new interest group, who are neither the policymakers themselves nor those receiving the service but are in fact actors carrying out the policy in the name of the state (in the case of state-run education systems). Similar to the doctors and hospital administrators in medical systems, teachers and school administrators have influence over the working of the system in a way that others do not. Not only can they shape how the system functions on a daily basis, but they can shape the quality of service itself, such as what it being taught (as compared to what is being prescribed in the medical field). This leads to a more complex policymaking environment than in other, cash-based welfare areas, such as pensions or unemployment.

While some scholars in the field have begun to look at the differences in policymaking dynamics across welfare areas (see, for example, Khmelnitskaya (2017)), there is still much work to be done in this area in the field of comparative politics. A closer look at how, for example, donors impact the policymaking process in cash-based versus in-kind welfare policy areas, or at the different ways in which “quasi-state” actors, such as teachers and doctors, act as interest groups or shapers of long-term policy implementation trajectories, can provide greater insights into the dynamics highlighted in this dissertation. Finally, consideration of the existence of critical junctures for major reforms in other welfare areas may provide greater insight into how the different types of welfare states develop over time.
8.1.3 Healthcare for Vulnerable Populations

This dissertation has focused on healthcare system reforms at a broad level – that is, the healthcare system structure for the majority of citizens in each country. However, I did not explore the differences between these reforms and the medical care system structures for certain vulnerable populations, such as the mentally ill, the elderly, and the incarcerated. While further research on these particular medical structures and reforms is needed, my findings suggest some preliminary hypotheses.

First, as I showed in looking at broader healthcare system structures, social values and ideas can significantly shape the population’s perceptions of reform efforts. I expect that this would similarly be found in debates on healthcare for vulnerable populations, though the values of universal access, quality of care, and human rights may be shifted from the perceptions of healthcare for families and the working-age population. Because the goals of care for these populations may be somewhat different than that driving care for the majority of citizens – that is, decision makers likely do not expect the elderly and mentally ill to be significantly more productive economically if they have better quality care – the attitudes about care for these groups, I hypothesize, will reflect a different set of social values than that in the broader healthcare system. Stigmas and cultural factors may play a more significant role in the development of interest networks, changing the shape of the debates and the resulting institutional designs.

Second, in terms of significant institutional change, my dissertation suggests that healthcare reforms, because of the policy feedback process driven both by the social values mentioned above and the development of interests around institutional design choices, will be most successful at critical junctures, or moments of significant political
openings. This, I propose, is likely to be true for medical care for vulnerable populations as well, with some variation in the resistance to change. This is because the vulnerable populations protected by these structures often are less capable of representing themselves in the debates on their care. This means that the influence of social values on the decision makers will be more likely to come from other sources, such nongovernmental organizations. This, along with the stigmas mentioned above, is likely to slow down the process, as the difficulties of coordination across groups representing those who are unable to represent themselves can prove to be a difficult task. Because these are relatively marginalized groups at times, there are also likely to be fewer opportunities for major structural changes, making the work of those nongovernmental organizations even more important in terms of shedding light on a topic that may otherwise be ignored.

8.2 Policy Implications

If passing major healthcare reforms is so difficult, then how should policymakers, activists, and other interested parties strategize to pass what are often considered to be necessary reforms in their countries? The idea of critical junctures seems at first glance to limit the opportunities drastically, making improvement of healthcare systems appear impossible at the worst and extremely difficult at best. While my dissertation findings indicate that it will be very difficult to pass reforms, to interpret this as a message of hopelessness for improvement would be misleading. Instead, my findings point to moments when major structural reforms – in other words, overhauls of the financing and delivery systems that change the nature of the state’s role and responsibilities – will be more likely to be initiated. Smaller changes, such as increased accountability measures,
regulation, and technological improvements, can be made gradually over time and help to improve health outcomes, even without these major structural changes. Therefore, if improvements to health outcomes are the goal, then focusing on quality-improving mechanisms is possible throughout the policymaking timeline.

If major structural reforms are indeed the goal – if, for example, policymakers see the role of the state in the current system as fundamentally flawed, or the system is so broken as to necessitate a reimagining of its innerworkings to make it function at (at least) a minimal level again – then my dissertation findings show that timing of the introduction and design of these reforms will be extremely significant. Restructuring oftentimes leads to high costs in the short-term, and these costs can shape opinions on the reform plan more significantly than can long-term promises of improvement. This means that politicians must either find ways to mitigate these costs or focus the conversation on the details of the long-term benefits.

The first of these – mitigation of the short-term costs – involves the replacement of lost care during this transition period with “temporary” care mechanisms that decrease the burden on individual patients. That is, while the new structures must be put into place quickly during the opportunity provided at a critical juncture, the implementation of changes on the ground can be built on a gradual scale. Gottret et al (2009) examined ways in which countries have successfully navigated these types of costs in times of crises and found that broad efforts to maintain universal access at all levels, like the strategy that Ukrainian officials followed, have often failed. Instead, targeted efforts to maintain access to basic services and cash transfer programs to mitigate the costs have most reliably lessened the impact of crises across states.
The second of these is even more fundamental to a smooth reform process. The lack of clear communication of the plan for healthcare, as well as the complexity of the plans, can serve to distance people from potential designs and provide openings for those who wish to exploit the public’s lack of understanding of the reforms to push back and develop a strong constituency against the changes. Therefore, finding ways to effectively communicate how individuals and families will benefit at a specified time in the future if these reforms are implemented can help to lessen the likelihood that strong private interests can exploit the uninformed. Furthermore, creating more transparent processes of decision making can help to lessen the possibility of distrust in the reforms, improving public support for the new programs and lessening the impact of increasing returns on decision making. Ukraine’s newest Minister of Health, Ulyana Suprun, has attempted to pursue reforms with this more transparent approach in the past two years with some success, including the passing of a reform plan at the end of 2017.

8.3 Final Thoughts

In this dissertation, I have attempted to dive into the incredibly intricate world of healthcare politics, a world that, even with years of research, cannot be easily described or assessed. The complexities of medical care, both at the biological and chemical level in medicine, and at the economic level of healthcare administration, continue to provide new puzzles and insights on an almost daily basis. In looking more closely at the experience of the post-Soviet states in their healthcare reform efforts, I hope to have provided greater knowledge of healthcare reform patterns, of the importance of political and economic factors on the decision-making process, and of the significance of institutional legacies on healthcare systems. While each country’s leaders will be faced
with their own difficult decisions and unique conditions, it is my hope that further research on these topics can help to ease some of the burdens of improving healthcare for populations across the world. Though my insights here are certainly minor ones that can only point to larger questions for research, I hope that they can help to shape some of the thoughts on the politics of healthcare reform in our world today.
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