Health and Social Stability in the Former Soviet Union

The Need for Policy Direction

EDWARD J. BURGER, JR.

The United States has both a humanitarian and a foreign policy interest in intervening constructively in health and health care issues in the republics of the former Soviet Union. Our efforts thus far have been very uneven and have lacked direction. The humanitarian issue derives from the indices of health that point to a continuing deterioration of health status, excess morbidity, and a continuing or even increasing adult male mortality. The contributors to this pattern are multiple but include some factors amenable to both medical and social intervention. The foreign policy issue turns around the linkage of a continual deterioration of health to an increasing probability of social and political instability. Contributions to the medical sector in the form of professional exchanges carry with them enormous leverage value and are seen as tangible benefits by the host population.

In December 1993, the West was startled by the results of parliamentary elections in Russia reflecting a sharp turn to the right. A great many of the immediate post-election analyses of these extreme ballot box results spoke of deteriorating economic conditions and of disintegration of the social fabric. Writing in *Kuranty*, Nugzar Betanli stated that "the social situation in the country is becoming fairly tense. The majority of the people . . . feel socially and politically defenseless."[1] Several commentators wrote of an increased likelihood of a "threat of fascism." One described the circumstances leading to the election results as a "loss of character . . . bordering on our national non-existence."[2] Richard Laird, a professor at the London School of Economics, remarked that "the change in

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policy [recommended by the elections] was caused by the recognized necessity to re-think the condition of Russian society."[3]

As recently as September 1995, Vyacheslav Alexeyev, a Russian physician, borrowed on an earlier phrase from John Reed when he wrote in the *Moscow Times*, "Russia is once again in gloom." His litany of "glooms" included a host of economic ills, deterioration of standard of living, political disintegration, local military conflicts, and the medical and health sectors. He claimed that highly unfavorable social consequences of the "miserable state of public health care" were already evident.[4]

The West was awarded some of the responsibility for not having attended adequately and effectively to what are known as the social safety net factors—the aggregate of social welfare institutions and support mechanisms upon which the citizens of the former Soviet republics and the Eastern bloc countries had come to depend. Prominent among these was medical care.

As these events illustrate, it is in the self-interest of the United States, as it is in Russia's, to develop a coherent strategy toward medical and health care needs in the republics of the former Soviet Union. This does not necessarily imply large, new expenditures. It does recommend a coherent plan, making the best use of resources, and taking account of complementary bilateral and multilateral assistance. Most of all, it demands that someone be in charge. The absence of direction and of a coherent strategy to guide U.S. policies and programs will be looked upon as an enormous missed opportunity to modulate the trend of continuing deterioration of both the health and the social fabric of the former Soviet Union.

American foreign assistance programs have historically (and properly) been governed by a combination of national security, economic, and humanitarian interests. The Foreign Assistance Act of 1961, the statutory basis for U.S. foreign development assistance, speaks to the importance of promoting economic and political stability. Virtually every one of the successive reviews of U.S. foreign assistance has emphasized the combination of humanitarian, security, and economic interests. All of these are operative in the case of assistance to the New Independent States (NIS).

Humanitarian Issues: Unprecedented Demographic Trends

On the humanitarian side, the case for aid is compelling and, in some ways, without precedent. The USSR (along with the Warsaw Pact countries) showed striking improvements in mortality rates and in what is known as the epidemiological transition—the shift away from infectious diseases as major contributors to morbidity and mortality. In terms of health, the Soviet Union had been catching up to the Western industrialized world. In the ten years between the early 1950s and the early 1960s, life expectancy for both males and females in the USSR increased at a rate much faster than in Western Europe and the United States. By the mid-1960s, life expectancy at birth in the USSR trailed that in the United States by only a year.[5] Yet these trends of steadily improving health status abruptly began to reverse in the mid to late 1960s.[6] As Nicholas Eberstadt and many other demographers have documented, stagnation and reversal of health condi-

tions and mortality rates occurred throughout Warsaw Pact Europe and the Soviet Union to an extent that is unprecedented in times of peace.[7] Remarkably, by the end of the 1980s, and for the region as a whole, mortality rates were higher than they had been in the mid-to-late 1960s! Further, particularly for males, this pattern of worsening mortality and decreasing longevity has continued. Life expectancy at birth for males was sixty-four years in 1989. By 1993, it had declined to fifty-nine years. As pointed out recently by Professor Mark Field of the Harvard Russian Research Center, males born in the Philippines or Indonesia now live longer than those born in Russia.[8]

This new pattern of excess mortality (and illness), which has continued generally unabated to the present, reveals a particular negative effect on adult health. Most affected have been adult males aged forty to fifty-nine.[9] Contributors to this excess mortality (excess, that is, in comparison with what earlier trends and patterns in neighboring countries would have predicted) are cardiovascular disease, cerebrovascular disease (stroke), respiratory disease, and various forms of violence—injury, poisonings, and suicides. Behind much of this pattern is the combination of social habits, violent behavior, despairing outlook by members of the citizenry, and inadequate medical care.

This record of excess or premature mortality in Russia has now combined with a second important trend, a sharply reduced birth rate, resulting in a striking net decrease (*negative* natural increase, as it is termed by demographers) in population. During the period since the mid-1980s, when life expectancy for Russian males showed a dramatic decline, birth rates in the former Soviet republics fell by as much as two-thirds. In the years between 1988 and 1993, about 900,000 fewer babies were born than in the preceding five-year period. According to official figures, in the first nine months of 1993, the ratio of deaths to births in Moscow was 2.5:1. In St. Petersburg, the corresponding ratio was nearly 3:1.[10] As a result, the nation, which is in transition to a market economy and where we are promoting democracy, cannot replace itself and is currently declining in population at a rate of approximately 4 percent per year. Circumstances such as these provoke natural anxieties and enhance the environment for extremists.[11]

State of the Medical Care System

There are multiple contributors—economic, social, and medical—to these striking and unprecedented demographic changes. The character and adequacy of medical care never fully account for the health status of a society. Yet, they do account for some of the ultimate health record. In addition, an exceptional historical and social dependence on the medical care system in Russia has given it perhaps an unusual role in contributing to social order and stability.

The present Russian medical care system evolved from a rigid, hierarchial state system, top-heavy with both institutions (hospitals and clinics) and professionals (including physicians). Currently, there are twice the number of physicians per capita and three times the number of hospital beds per capita as in the United States. At the same time, the historical lines of authority from the Russian Federation Ministry of Health have been substantially weakened, both by redis-

tribution of political power according to the new constitution and by new financing arrangements that rely on local and provincial sources of revenue.

The former professional associations of physicians, as they existed in pre-revolutionary times, were disbanded by the Bolshevik regime. Physicians were made employees of the state and were remunerated at a rate of 70 percent of the average industrial wage.[12] Perhaps most important, the physician community has been largely isolated from the advances in science and medicine in the West for the past seventy years. The medical care arrangement was further complicated by an admixture of parallel or closed systems—different sets and qualities of institutions and practitioners for different classes of citizens. Added to this is an overlay of secondary or underground payment expected or demanded by practitioners as a prerequisite to care.

Financial resources available to the health care structure, less than adequate since the late 1960s, have decreased dramatically during the current period of economic and political restructuring. Whereas the United States expends roughly 14 to 15 percent of its GDP on health, the current estimates are that Russia's health care expenditures approximate 3 percent.[13] Both capital and operating budgets are inadequate, and there are marked shortages of basic pharmaceutical products and medical equipment.

At the same time, there is a traditional and continuing heavy dependence by Russian citizens on the health care sector as an essential part of the social safety net. Russian citizens are accustomed to paying many more visits to physicians and hospitals than is common in Western countries. On the average, a Russian sees a physician seventeen times a year. One-quarter of all Russians are hospitalized each year, compared with one in seven in the United States. If admitted, a Russian remains hospitalized three times as long as a patient in an American institution.

Political and Foreign Policy Interests

In this category, the principal issue of concern is preservation of political and economic stability in the former Soviet republics during the difficult period of transition. One may well ask whether the striking demographic record of high and increasing mortality and sharply lower birth rates is a result of the current social and economic transition or is itself a cause of, or contributor to, social instability. The best answer is that both may be true. It appears that the demographic record is a function of social, economic, and other forces, and the resultant record may have profound consequences for the social well-being of the country.

For example, a major contributor to rising excess mortality in the former Soviet Union is violence—including a rising tide of suicide. A second is heavy use of alcohol. Violent deaths due to accidents, poisonings, and suicide are thought to mirror, in part, a deeply troubled and somewhat despairing society. Again, as Eberstadt has noted quite correctly, "The very fact of secular mortality increase is evidence of a serious failure in [Russian] health policy. But it is much more. Mortality conditions are affected by a constellation of social, economic and environmental factors."[14] What makes this record of demographic trends in the former Soviet Union even more striking is the fact that whereas a number of other

countries have endured very deep economic and political shocks, none has exhibited such striking declines in longevity and fertility in the absence of war.

Is it conceivable, or even likely, that continuing decreases in longevity and fertility will affect social and political behavior? There appears to be substantial evidence and much professional opinion to answer this in the affirmative. Morbidity and mortality trends have a direct bearing on labor potential and productivity and, hence, on a community's capacity for economic growth. Ironically, among the many consequences of a declining "natural increase" in population (and especially one whose impacts are most pronounced on adult males) is a recently reported decreasing size of the cohort of young men available to serve in the armed forces. A report at the end of January 1995 from Russia's Institute for Social and Political Studies noted that the number of people between the ages of fifteen and nineteen had dropped in the past fifteen years. This striking demographic trend, combined with large numbers of deferments and the fact that many men simply fail to register for the draft, has meant that Russian ground forces can fill just over one-half of their billets.[15]

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Continued mortality increases and declines in fertility make individuals increasingly aware of their poor standard of living and make societies anxious over the state of their national prowess. By now, a number of commentators have warned that a continuation of these trends could translate into unfavorable populist and political pressures.

The question raised for U.S. policy is, How important is it to tide over the elements of the traditional safety net apparatus in an effort to preserve political and social stability? Given the large historical dependence of Russian citizens on the health care system, it is conceivable that major disruptions and discontinuities in the health care arrangements will further contribute importantly to social unhappiness and, in time, to political turmoil.

Within a short period following the dissolution of the Soviet Union in 1991, Jeffrey Sachs, Harvard economist and advisor to the Russian government, and others argued that it was important for the West to develop a coherent strategy to support Russia's economic reforms during the expected difficult transition to a market economy. These spokesmen recognized that it was in the self-interest of Western nations to support Russian reform through large-scale assistance, drawn in a coordinated manner from several national sources and in a spirit similar to that which accompanied the Marshall Plan. In Sachs's view, there were three reasons underlying this proposal:

• an acute balance of payments crisis leading to a plummeting in Russia's capacity to purchase imports on the world market

• an acute fiscal crisis contributing to hyperinflation, in turn impairing, among other things, the ability to sustain adequate social spending

• an urgent need to cushion the shocks of transition from a planned to a market economy[16]

Among the proposed financing was an $8 billion Social Expenditure Program, of which nearly a quarter was to be devoted to health.[17] In making these proposals, one of the economists recalled the intense opposition and skepticism that greeted the Marshall Plan concept in 1946, when it was attacked politically as "Operation Rat Hole" and stalled until the Soviet-led overthrow of Czechoslovakia occurred in 1948.[18]

This overarching proposal for substantial, multilateral stabilizing assistance to the former Soviet republics did not materialize—neither for general financial stabilization nor specifically for the social safety net, including health. It is not necessary here to resurrect or review the arguments for and against a Marshall Plan-like initiative for the NIS. However, there is a narrower case to be made for attending to health and medical issues in the former Soviet Republics in a studied, coherent fashion and with suitable continuity. The sums of money currently devoted to this are modest. Yet, what may be of even greater importance is the imperative to develop a much more defined strategy, to make the best use of resources, and to exercise appropriate direction. In the case of health, what has emerged so far has been a highly fragmented and uncoordinated mosaic of public and private bilateral programs and offerings from various countries, the World Bank, and the European Bank for Reconstruction and Development (EBRD).

The World Bank, with potentially the most funds to expend, concentrated its early efforts almost exclusively on health care financing, this as the Russian federal government, ironically, replaced a traditional state-run financing arrangement with a new health insurance law based principally on employers payroll tax (supplemented by monies from the Mutual Settlements Account and the General Transfer/Equalization Fund).

The U.S. Agency for International Development, beginning in 1992, mounted a highly useful and well designed Hospital Partnership Program that now links twenty-two American medical institutions with thirty-two former Soviet ones. These linkages concentrate on disease categories and specialty areas that correspond to the largest negative impacts on Russian ill-health and excess mortality, such as cardiovascular disease. The exchanges and training offer a break in the seventy years of enforced isolation of the Russian medical profession. As important, the partnership arrangements have brought forth a community of *volunteered* professional contributions from the American side where expenses are paid but fees are not. Lawrence Summers, under secretary of treasury and former chief economist of the World Bank, recently emphasized the importance of the transfer of knowledge and experience as a component of our foreign assistance. He referred both to the immediate, direct benefits and to the enormous, second-order leverage that flows from such efforts.[19] This is clearly the case in the issue of health and medicine. An additional, and not inconsiderable, benefit is a spirit of

enlightened interest and enthusiasm in each of the U.S. partner communities—enlarging the always sparse constituency for foreign assistance.

With its work only begun and representing only a modest expenditure, this single, highly useful USAID-sponsored program in medicine is currently in jeopardy of being weakened, altered in character, or put out of business. Technical assistance (the name given to the general program area under which the program operates) is being phased out in favor of other health-related initiatives reflective of a number of current theologies—encouragement of trade and investment, privatization, market creation. Further, the core of the Partnership Program—the quality and character of clinical medicine, both curative and preventive—is alien to the traditional health interests of the USAID bureaucracy, which is more comfortable with relatively narrowly defined public health measures. At the same time, USAID has entered haltingly into a number of other, much more expensive health-related programs that seek to reshape the organization and financing of Russian medicine in ways that appear to be more congenial to our own views of a private versus a public sector.

In the absence of a recognizable and coherent direction, a very large number of independent private activities have emerged in the past several months concerned with health and medicine in the NIS. Sponsors range from religious organizations to nonprofit entities to a host of individual entrepreneurs. The quality and motivations of all of this activity are mixed. Humanitarian assistance in the form of drugs, medical equipment, or proffered advice on private health insurance is conceived and executed well in some cases but tarnished by embarrassing aspects of outdated or unusable materials in others.

Again, the key is not necessarily more money. Rather, it is the necessity that there be someone in charge. A hoped-for locus of this direction was the State Department Office of the Coordinator for U.S. Assistance to the NIS, repeatedly described by the Clinton administration as *the* point of responsibility for direction of our policies and programs for the New Independent States. The Freedom Support Act, enacted in October 1992, gave birth to the role of a presidentially appointed coordinator for strategies, programs, and policies for the independent states of the former Soviet Union, including foreign assistance. Unfortunately, Congress failed to appreciate the conflict created by this measure with the already existing statutory authority held by the administrator of USAID under the Foreign Assistance Act. While the office of the coordinator proceeded early in its history to take account of the health and social safety net issues, its role quickly dissolved when Ambassador Strobe Talbott assumed the job as deputy secretary and the former center of gravity shifted away.

The current forum of the Gore-Chernomyrdin Commission represents yet another potential focus. This was made more likely a few months ago when the Russians asked that health be added to its agenda. However, as is often the case, the permanence and quality of arrangements behind the twice-yearly Gore-Chernomyrdin meetings are uncertain. While the vice president's office is taking the exercise very seriously, it has not yet captured a corresponding enthusiasm within other parts of the bureaucracy.

A Useful Model from Law

At this writing, there is a place for a private initiative to help guide appropriate policies and programs for medicine and health in the former Soviet Union. It is perhaps to the legal profession that one should look for a useful precedent in this case. As early as 1990, the leadership of the American Bar Association helped put in place an institution, in association with the ABA, termed the Central and Eastern European Law Initiative (CEELI). Financed by a combination of private philanthropy and government funds, CEELI serves as a vehicle for a wide array of directed exchanges between members of the practicing and academic bar in the United States and counterparts in the NIS and Eastern Europe. It currently boasts 130 different "sister law school" exchange programs. Large numbers of American lawyers and their institutions have supplied volunteer assistance in helping to draft statutes, design legal frameworks, and advise on the drafting of the federal constitution. The overall goal is to bring the rule of law to the former Communist world and to do this in a fashion divorced from commercial or business interests.

The parallel for medicine is, if too obvious, correspondingly important. As in the case of the law, there is a compelling case for the leadership of the American medical community to put in place an initiative that would guide our policies in this matter. It would also serve as an institutional umbrella under which professional exchanges and volunteer assistance could be derived from both the practicing and academic medical communities. Professional exchanges should be substantially expanded from the present number. An important goal should be to help the Russian medical community help itself make up for its prolonged isolation from the ever-evolving scientific basis of medical practice that has taken place in the rest of the industrialized world.

There is much current discussion about the importance of keeping alive a social and civil society in Russia and avoiding the threat of social disintegration. We have placed an enormous emphasis on the goals of private ownership of property, a capitalist economy, and privatization of former state institutions. Without the glue of social cohesion and basic elements of a civil society, those goals may remain unrealized for some time to come. The question is, Will the process of social disintegration likely lead to further political deterioration, and will we have sufficient wisdom in a timely fashion to deal constructively with this possibility?

NOTES

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