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"The Politics and Consequences of Privatizing Social Welfare
In Post-Communist States: The Case of the Russian Federation"
Abstract

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Abstract

In the post-communist cases, non-state social welfare providers emerged during the 1990s after decades of virtually complete state monopolization of social sectors. My paper focuses on four dimensions of the contemporary Russian welfare regime: labor markets, financial markets, and the capacities and autonomy of the state. I examine the political origins of welfare privatization in the Russian Federation from 1990-2004, focusing on the domestic and international actors, policy negotiations and decisions that advanced private provision in health care and pension insurance. I argue that health and pension privatization were politically-contested among elites with little popular accountability, and resulted in reforms that were partial, poorly-organized and regulated because of inadequate state-administrative capacities and market regulation. The consequence is a system of welfare provision that features unstable and often corrupt social service and insurance markets as well as pervasive informal payments and exchanges in social sectors, and has led to substantial exclusion and abstention from services. The outcome is an 'informalized' welfare regime characterized by non-transparent financing mechanisms, weak tax and payment compliance, pervasive informal private exchanges, and fragmentary benefit coverage.

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Introduction

In Russia as in other postcommunist states, non-state welfare providers emerged during the 1990s after decades of virtually complete state monopolization of social sectors. Those decades produced a distinctive constellation of welfare state institutions, interests, resources, and expectations. By the end of the Communist period nearly the entire population was incorporated into a broad, basic, internally-stratified system of social provision, including health, education, social insurance, and deep social subsidies. This system entailed a massive infrastructure of bricks and mortar facilities as well as human resources; some 15% of the late-Soviet labor force worked in the public sector, mainly health care and education. This system was administered by an extensive state bureaucracy of welfare ministries, with administrative bodies articulated down to regional and local levels and into the enterprises where many welfare services and benefits were delivered to the population. In 1991 the centralized political, economic and allocational system in which the old welfare state was embedded collapsed, initiating a period of profound transformation.[1]

The first task of this paper is to situate the newly-emergent Russian welfare state within the welfare regime literature. Here I will draw on Esping-Anderson's classic OECD-based paradigms, and Gough and Wood's critique of their applicability to developing country welfare regimes.[2] Gough and Wood focus on four key assumptions or dimensions of Esping-Anderson's developed welfare states: the presence of pervasive formal labor markets; the existence of a legitimated, capable, accountable state; the relative autonomy of that state both domestically and internationally; and the availability of developed, comprehensive, regulated financial markets. In Gough's words, in OECD welfare states, "People can reasonably expect . . .to meet their security needs via participation in labor markets, financial markets, and the financing and provisioning role of a 'welfare state'. . .they establish rights-based claims to a range of social service and cash benefits and back these up with extensive tax funding and public provisioning."[3]

[1] Linda J. Cook, *Postcommunist Welfare States: Reform Politics in Russia and Eastern Europe* (Ithaca: Cornell University Press, 2007)

[2]Gosta Esping-Anderson, *Three Worlds of Welfare Capitalism;* Ian Gough, Goef Wood, et. al., *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts* (Cambridge, 2004)

Gough and Wood propose an alternative model of an 'informal security regime' that is characterized by informal labor markets, weak, domestically and internationally penetrated states, and absent or corrupt financial markets. Russia's current welfare regime stands between these two paradigms on all four dimensions, and its labor and financial markets and state capacities have shaped both the politics and effects of welfare state privatization.

The following section of my paper situates the Russian welfare state between Esping-Anderson's formal OECD and Gough and Wood's 'informal security regime' model. The next section develops several arguments about how the historical and contemporary role of the state shaped the emergence of non-state welfare provision from 1990-2004, and presents case studies of the re-negotiation of state and non-state roles in health care and pension provision. The third section examines patterns of access, exclusion and accountability in non-state provision. The paper by proposing a model of a new hybrid, 'informalized' welfare regime type that is the product of large inherited welfare state infrastructure, partial and contested liberalization, and relatively weak state taxing and administrative capacities.

Situating the Russian case among Welfare Regimes

Gough and Wood contrast the fully-commodified, formal labor markets assumed in OECD welfare states with the substantial levels of informal employment, corrupt and illegal exchanges, and reliance on informal networks that are typical in developing states. In post-transition Russia as well corruption and informal networks became pervasive throughout the economy during the 1990s, and the informal sector grew to over 40% of the economy by mid-decade.[4] While the dominance of the formal sector has been strengthened since 2000 (under the Putin Presidency), the informal labor market continues to be estimated variously at **25-30%**[5] Moreover, the distinction between formal and informal labor markets has eroded, as attested by official reports of systematic and large-scale violations of labor code provisions and protections (i.e., reliance on unrecorded or 'grey' payments in the formal sector.) A second dimension of informality affects the social

[3]Gough, Ian, Geof Wood, et. al. (2004) *Insecurity and Welfare Regimes in Asia, Africa and Latin America: Social Policy in Development Contexts* (Cambridge: Cambridge University Press), p. 33

[4] *EBRD Transition Report, 1997* (London, EBRD, 1997), p. 74.

[5] Find source

sector directly. During the 1990s, when official wages for a large majority of Russia's inherited public sector labor force fell below subsistence and systems of social provision were disorganized and in flux, workers and administrators used existing skill sets and *de facto* controls over access to craft survival strategies that relied on 'informal privatization' of social facilities and informal payments for access to services. These strategies have become institutionalized and resistant to governmental efforts at reform or formalization.[6] Unrecorded and unregulated work and monetary exchanges (as well as reliance on person/social networks to access and provide services) remain pervasive especially in health care.[7] **(revise)**

Esping-Anderson's welfare regime paradigms are also premised on the presence of a legitimated, capable, and accountable state that plays three roles: it negotiates democratically a formal political settlement about government's rights to tax and redistribute; it regulates social taxation and rights to social insurance; and it guarantees and provides legislated social benefits and services, usually promising a minimum standard. The state, in sum, is the main institutional provider of welfare. In Wood and Gough's informal welfare state, by contrast, there is no democratic negotiation, state regulation is weak and guarantees are largely absent.

The Russian case stands between these two ideal types. The former Communist state created welfare programs 'from above,' in the absence of negotiation with society. Limited democratic negotiation over welfare outcomes in the 1990s gave way to authoritarian policy-making by 2000. The state does formally regulate rights to social insurance and guarantee benefits, but compliance procedures remain weak. The early post-transition state substantially lost the ability to monitor financial transactions or regulate emergent businesses in the new market economy, to generate reliable information about wages and incomes, or to extract revenue from individuals, economic or federal units. New private economic actors obscured financial information, and tax collections collapsed in the 1990s.[8] Social benefits that were legally guaranteed by the state fell into arrears, and regional and local units regularly withheld federally-mandated social insurance

[6] Sotsial'noe Polozhenie i uroven zhizni naseleniia Rossii 2002: statistichiskii sbornik, (Moscow: Goskomstat Rossii, 2001, 2002); *Russia in Figures 2000* (Moscow: Goskomstat, 2000) 98.

[7] Julie V. Brown and Nina L. Rusinova, "Holding Up the Social Safety Net: Gender and the "Hidden" Health Care System in Urban Russia," paper presented at the 8th Aleksanteri Conference, Welfare, Gender and Agency in Russia and Eastern Europe, Dec. 10-12, 2008.

[8] Gerald Easter, "Building Fiscal Capacity," pp. 21-52 in Timothy Colton and Stephen Holmes, eds., *The State After Communism: Governance in the New Russia*

contributions. Under Putin there has been a partial restoration of the state's institutional and financial capacity to provide public goods. Most social benefits are now paid at least at subsistence standards. But the state's capacities remain weakened. High levels of corruption and tax evasion, patterns of minimal compliance in the formal sector (i.e., payments of minimal social security contributions that make employees eligible for only subsistence benefits), and poor compliance of regional units with federal tax and regulatory policies undermine efforts to re-establish effective social security. Table 1 (below) provides a range of measures showing Russia's comparative weaknesses in governmental accountability, effectiveness, regulatory quality, rule of law, and control of corruption.

Table 1
Governance Indicators, 1996-2004
Russian Federation

	1996	1998	2000	2002	2004
Voice and accountability					
Estimate (-2.5+2.5)	-0.36	-0.26	-0.44	-0.44	-0.81
Percentile Rank (0-100)	39.8	41.4	36.4	25.7	25.7
Government Effectiveness					
Estimate (-2.5+2.5)	-0.5	-0.62	-0.62	-0.4	-0.21
Percentile Rank (1-100)	31.3	23.5	29	41.3	48.1
Regulatory Quality					
Estimate (-2.5+2.5)	-0.41	-0.37	na	-0.35	-0.51
Percentile Rank (1-100)	31.5	31.5	na	43.4	30.5
Rule of Law					
Estimate (-2.5+2.5)	-0.84	-0.78	-0.87	-0.84	-0.7
Percentile Rank (0-100)	19.9	22.7	18.7	21.4	29.5
Control of Corruption					
Estimate (-2.5+2.5)	-0.74	-0.69	-1.02	-0.92	-0.72
Percentile Rank (1-100)	26.7	25.7	9.7	18.9	29.1

Source: World Bank Governance Indicator Country Snapshots (2005), cited in . . .
See Cook, 2007, p. 225, Share of Unofficial Economy in GDP

Table 1a

Share of Unofficial Economy in GDP, 1989-2001;
Transparency International Corruption Perception Index, 1997-2001

	1989	1991	1993	1995		2000-2001
Rus. Fed.	12.0	23.5	36.7	41.6		45.1

Sources: Data for 1989-1995 are from Janos Kornai, Stephan Haggard and Robert Kaufman, *Reforming the State: Fiscal and Welfare Reform in Post-Socialist Countries* (Cambridge: Cambridge University Press, 2001), 276, based on EBRD *Transition Report, 1997;* Data for 2000-2001 in Cook, 2007, p. 225. **(check)**

OECD welfare regimes also assume the relative autonomy of the state domestically and internationally. Here welfare state outcomes constitute an inter-class settlement among domestic interests. In Gough and Wood's informal welfare regimes, by contrast, the state is permeable or captured by private interests that dominate public**. . .** "The state is not impartial, but. working for the dominant classes and segments, including a bureaucratic and political class, which sees state control as a crucial means of their own accumulation and reproduction."[9] Moreover, developing country states are dependent internationally, open to pressures from international financial institutions and international diffusion of welfare reform models by IFIs and social policy elites.

Again Russia stands between these two paradigms. During the 1990s the autonomy of the Russian state was deeply-compromised by domestic economic and financial oligarchic interests. Under Putin it re-established substantial autonomy from domestic economic elites, but welfare policy-making remains dominated by statist-bureaucratic actors who are primarily concerned with preserving their functions and control over resources. These welfare bureaucracies have a vested interest in maintaining the inherited statist system of public financing and administration. At the same time the Russian state has been subject to conflicting dependencies and pressures from international financial institutions and other global elites who promote a competing paradigm of welfare liberalization and privatization, including private health insurance and privately-invested pension schemes. This liberal paradigm is generally supported by economics and finance ministries and by many independent Russian ocial policy elites and private economic interests. The state is not captured, but social and other policy sectors are dominated by bureaucratic and elite actors who represent particularistic rather than broader public interests.

Finally, OECD welfare states assume "sophisticated, comprehensive and regulated financial markets to provide insurance (and enable savings.)" Such markets are essential to the effectiveness of private health and

[9]Gough and Wood, p. 50.

pension insurance. Markets of any kind were largely absent in early transitional post-Soviet states. Nevertheless, International Financial Institutions (IFIs) and others promoted adoption of privatized social insurance models that had to be embedded in functioning markets, in other words, that required institutions and information flows that were absent or nascent in Russia. Moreover, privatization of welfare provision is not anywhere simply a matter of the state withdrawing. Rather, private welfare institutions are structured and regulated by states, which typically craft complex tax and other incentives in order to motivate beneficiaries to transfer from public to private systems.[10] Regulation is especially crucial to the effective functioning of private welfare provision; the archetypal Chilean pension privatization, for example, was accompanied by an extensive/complex web of regulations and restrictions on investment and management of pension funds.[11] Given that Russia's financial markets were both new and chaotic during the 1990s, the state had very limited capacity to craft and regulate private welfare and social insurance institutions.

In sum, the Russian welfare regime stands somewhere between formal and informal welfare regime paradigms. The state remains the main institutional provider of welfare, but Russia features a 'degraded statist welfare regime.' one in which, in Gough and Wood's apt phrase, "the (formal) welfare regime paradigm is clinging to relevance."[12] Below, I propose four arguments about how these historical and contemporary features of the state shaped the emergence of non-state welfare provision from 1990-200.

II.The Political Origins of Non-State Welfare Provision:

1) Privatization of both health care and pension provision in Russia were deeply-contested, but bargaining took place mainly among inherited state-bureaucratic interests on the one hand and reformist domestic and international policy elites on the other. The broader society played a limited and diminishing role. Inherited statist welfare interests resisted the privatizing initiatives of domestic and international reformers. Negotiations over state and non-state roles produced partial privatization, incomplete reforms, fragmented systems of health and pension provision.

[10]Linda J. Cook, 'The Russian Welfare State: Obstacles to Restructuring," *Post-Soviet Affairs*, vol. 16, no. 4 (Oct.-Dec., 2000), p. 355-378.
[11]Sarah Brooks, *Social Protection and the Market: the Transformation of Social Security Institutions in Latin America* (Cambridge: Cambridge University Press, forthcoming) **date??**
[12]It should be noted that Wood and Gough categorize the mid-1990s welfare state as high provision.

2)The Russian state's weakness in the transitional 1990s enabled the establishment of informal labor and social sector markets and exchanges that remain resistant to regulation or formalization. The weakness of compliance procedures on income-reporting, chargeable social services, taxes, insurance contributions, and regulations undermines social insurance, limits access to services, and has negative feed-back effects on the state's capacity to provide public goods.

3)The substantial influence of international actors on privatization– the limited autonomy of the domestic policy process – led to the importation of models for which the system lacked critical administrative and regulatory capacities, including developed financial markets, contributing to early policy failures in privatization.

4)The limited formal privatization that did take place benefited higher-income strata in Russia's rapidly-stratifying society by expanding their access to high-quality services, lowering income and social security taxes, and weakening re-distributive features and mechanisms in health and pension provision.

The following sections of the paper look at policy debates and decisions that have advanced privatization in Russian health care and pension provision. In both cases, domestic and international reformers sought to transfer responsibilities away from the state to the private sphere, and to diversify sources of financing for over-burdened social programs. Their initiatives were supported or resisted by variously-located actors/interests and institutions within the state, polity, and emerging private economy, producing a contested, elite-dominated politics of re-negotiating state and non-state roles. The introduction of market-based health and pension insurance also confronted multiple institutional deficits and obstacles that blocked early success and contributed to ongoing political conflict over privatization. The outcome in both health and pension provision is a mixed pattern of formal and informal private and retained state provision that remains institutionally-fragmented and poorly-regulated, and effectively excludes or severely limits access/coverage for many.

Health Care

Initial efforts at privatization and establishment of an insurance system

The Russian health care system underwent radical reform during the early 1990s. A central goal was to replace the existing system of single-payer public budget financing with mandatory health insurance that would be financed from payroll taxes and other sources. New legislation also legalized private insurers and health care providers. Initiative for reform came from two sources: the executive, especially the Finance Ministry; and reformers within the medical profession, mainly a group of doctors and academics acting through the national legislature's (Duma) Committee for Health Protection. In the fall of 1990 Dr. Viacheslav Kalinin, a reformer committed to the introduction of an 'insurance medicine' model, was appointed to head the Ministry of Health. Reformers also dominated among the ninety-seven doctors who served as Duma deputies. These reformers were initially supported by the health workers' trade union, whose members hoped that the reform would bring increases in health care spending and salaries.[13] Beyond this, there was little societal involvement or accountability in the policy process.

The critical health reform legislation was shepherded through the Supreme Soviet by the Health Committee with little opposition. The infant insurance industry, a new private interest that had a stake in the expansion of social security markets, also made its appearance. (more on this) According to one of the architects of the reform, "There were only about 12 people at the time who really understood the implications /of the health insurance law,/ so it was easy to get it through the legislature. . . at the time, an insurance industry was being created in other sectors (not health), but people in the industry began to see that they could make money in health insurance. So, their lobbyists began to push it in the legislature."[14] The changes made by this legislation amounted to a radical departure from traditional lines of responsibility for financing

[13] Dr. A. Askalonov served as chair of the Committee on Health Protection Ryan, Michael (1992) "Russia Report: doctors and health service reform," *British Medical Journal,* 304 (Jan. 11) pp. 101-103.

[14] Senior Russian Health Economist, Interview with Judyth Twigg , Moscow, May 21, 1997 (transcript provided to the author).

and delivery, an "overnight massive de-statization of medical care . . . extending 'shock therapy' into the health care system."[15]

Restructuring legislation re-organized the financing of medical care and created two new sets of institutions: Compulsory Medical Insurance Funds and Health Insurance Organizations.[16] The Funds would collect and manage payroll-based employer contributions for the employed, and contributions from municipal budgets for non-workers, with most of the monies raised and spent at the regional level. The Funds would contract with insurers, who would in turn purchase medical services from providers. This 'competitive contracting' model was supposed to introduce competition and choice into the health care system, to improve quality and efficiency. Separating purchasers from providers was supposed to facilitate elimination of excess hospital and other capacity, one of the inherited system's major problems. The legislation also legalized supplementary, voluntary private medical insurance and private medical practices, which would provide choice. The reform kept in place guaranteed access to free and comprehensive health services: insurance was to be universal, compulsory, and publicly-financed for those outside the labor force; out-of-pocket payments were rejected. A decentralized, competitive, public-private mix replaced centralized state control, planning, and finance.[17]

The health care reform represents a clear case of Russian reformers adopting a radically-new foreign model that could not be fit to Russian conditions. In the early 1990s a great deal of attention was focused on health care reforms in international circles, capped by the World Bank's 1993 *World Development Report: Investing in Health*, which promoted competition, choice, and other elements of the liberal model.[18] (more about how international actors promoted reform) Russian reformers drew on these internationally-generated ideas as well as on European health care systems, particularly those of the Netherlands and Germany, which were

[15]Judyth Twigg, "Balancing State and Market: Russia's Adoption of Obligatory Medical Insurance," *Europe-Asia Studies* 50: 4 (1998): 586.
[16]"Zakon o meditsinskom strakhovanii grazhdan (June 29, 1991)," *Meditsinskaia Gazeta*, 8, 8-9.
[17]*Public-Private Mix in the Health Care and Health Insurance System (current situation, problems, perspectives:* (Anthology of reports prepared by experts in TACIS Project No. EDRUS 9605 (TACIS, Moscow, 1999).
[18]World Bank, *World Development Report 1993: Investing in Health* (Oxford: Oxford Univ. Press, 1993).

diffusing throughout Eastern Europe in this period.[19] Their belief in the market and receptivity to international influence are well-captured in a quote from an expert who was involved in designing the reforms, "Back then (in 1991) we, the architects of the health insurance legislation, were 'naïve and silly.' We didn't really understand the difference between mandatory and voluntary health insurance; we didn't understand risk assessment and the ability of insurance companies to choose whom they would cover; we didn't think about . . . the need for a socially-responsible body to regulate the system. . . we thought we could rely on the market; we thought market forces would do it all."[20]

Health insurance reform confronted major limitations of institutional capacity in Russia. A 2001 OECD report stated the problems succinctly: "This "competitive contracting" model should in theory promote efficiency; but it is too complex, and requires numerous institutions that are not well-developed in Russia, such as health care insurers and many independent providers in each health care market."[21] In practice, most Russian municipalities held a monopoly on health facilities in their area, and competing private providers emerged in significant numbers only in major urban centers. Insurance companies appeared but remained concentrated in a few major cities, while no competitive market developed in a majority of regions. Implementation of reforms remained very uneven. About one-third of health care expenditures shifted to contract relations, while most spending continued to follow previous patterns.[22] The proportion of spending on in-patient hospital care did not decline significantly, nor did other measures of efficiency improve. While the reform did introduce some mechanisms for competition and quality control, in the short term especially it "disorganized the health sector rather than making it more efficient," leaving multiple institutions – funds, insurance companies, private providers – unevenly-distributed and poorly-regulated.[23]

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[19]According to Judy Twigg (Personal communication, 3/16/03) ideas were taken from Germany and the Netherlands, or hybrid of German and US models. There was no attempt to copy wholesale. Russian reformers were looking for ideas.

[20]Senior Russian Health Economist, Interview with Judyth Twigg , Moscow, May 21, 1997 (transcript provided to the author).

[21]OECD, Social Crisis *in the Russian Federation* (Paris: OECD 2001), 13.

[22]Twigg, *Balancing*; Edward J. Burger, Mark G. Field and Judyth Twigg, "From Assurance to Insurance in Russian Health Care: The Problematic Transition," *American Journal of Public Health* 88:5 (1998): 755-758.

[23]Ksenia Yudaeva and Maria Gorban, "Health and Health Care," *Russian Economic Trends* (1999) 32.

Much health care financing was transferred from public budgets, a key goal of central reformers. Budget financing fell from 100 per cent to about 50 per cent during the 1990s, with insurance and household payments making up the difference. (see Table 2) Reforms succeeded in establishing payroll taxes as a reliable base for health care financing, with most regions reporting 80-95 percent of payroll taxes paid.[24] The proportion of household payments for both medical services and pharmaceuticals also increased significantly, the beginning of an increase in private health expenditures that would continue throughout the decade despite limited structural change.

Table 2
Main Sources of Health Care Financing

(% of total)

Source of Finance	1992	1993	1994	1995	1996	1997	1998	1999
Federal Budget	11.3	8.9	8.6	6.4	4.9	7.7	4.6	4.9
Regional health budgets*	88.7	75.3	64.7	60.6	58.6	53.1	47.1	44.7
Budget contributions or mandatory health insurance for non-working population	--	0.5	4.5	6.7	6.3	5.1	5.6	5.2
Mandatory health insurance contributions for working population	--	--	15.6	14.7	15.7	14.5	16.0	15.9
Private contributions to voluntary health insurance	0	0.9	1.5	2.0	2.5	2.7	3.0	3.5
Household payments for medical services**	--	1.6	2.2	4.7	6.3	7.3	9.1	8.4
Household payments for pharmaceuticals	--	--	7.8	13.2	13.7	15.6	21.1	24.9
Corporate payments for medical services	--	--	1.1	0.3	0.7	1.7	2.1	1.2
TOTAL	100	100	100	100	100	100	100	100

Source: [1]E. Tragakes and S. Lessof in E. Trafakes, ed, *Health Care Systems in Transition: Russian Federation* (Copenhagen: European Observatory on Health Systems and Polities," 2003: 5(3), 98. *Including contributions to mandatory health insurance for non-working population. **Not including under-the-table payments.

[24] Berger and Twigg, "From Assurance."

Contentious Politics

But the reforms were contested, facing powerful opposition from local and regional administrative elites as well as the federal Ministry of Health. Regions emerged as key players producing resistance and fragmentation. Local health administrators stood to lose control over budgets of health facilities to the Medical Insurance Funds. Cash-strapped local governments often refused to contribute their shares for insurance of the 'non-working population,' or to cooperate with fund administrators. The insurance mechanism was seriously under-financed from the outset by their withholding of contributions.[25] Soon Russia's Health Ministry was also moving aggressively to reverse reforms. According to a well-placed observer, "At first, people at the Ministry of Health didn't seem to understand how much of their power and authority were being removed (by decentralization and the introduction of insurance) /later/ it fought against the plan. . . . civil servants in the Ministry of Health at all levels are against /reforming/ through insurance."[26] The Ministry launched a campaign to discredit and eliminate the medical insurance companies, lobbying through the press and in the Duma, so that it could take back control over the money collected by the Health Insurance Funds. From 1995 the Health Ministry promoted legislation that would have reconstituted government controls, while health insurance companies and funds lobbied against it. Private health insurance companies in particular had very limited influence or success in lobbying. (Sokhey More here)[27] The health care system became caught up in time-consuming and destructive battles, with continual bureaucratic and institutional infighting over responsibilities and control of resources.[28]

Attempts by health care administrations in both center and regions to return toward a statist system had considerable *de facto* success. Public authorities reasserted control over the spending of most health funds, which they used to keep existing facilities, personnel and practices in place. The Ministry also tried to re-

[25] In 1996, for example, municipalities in half of Russia's regions made little or no insurance payments.
[26] Senior Health Economist, May 21, 1997, Interview with Judyth Twigg, Trip Report (transcript), Moscow, Russia, May, 1997, 39.
[27] Irina Rozhdestvenskaya and Sergei Shishkin, "Institutional Reforms in the Social-Cultural Sphere," 584-615 in Yegor Gaidar, ed., *The Economics of Transition* (Cambridge: Massachusetts Institute of Technology, 2003); Sokhey
[28] Judyth Twigg, "Obligatory medical insurance in Russia: the participants' perspective," *Social Science and Medicine,* 49 (1999): 377.

centralize, to establish more control over appointments of health administrators, approval of professional qualifications, and the setting of norms and standards for the health care system.[29] By mid-decade fewer than half of Russia's 89 regions allowed insurance companies to operate, and lower-level governments were withdrawing licenses. Eventually most regions suspended implementation of the reform and moved to prohibit the operation of insurance funds. Both legislative and bureaucratic elites, in sum, acted to block the establishment of private and public insurance markets. The Duma also failed to pass legislation that would have regulated private medical practices, though deputies acknowledged the urgent need for such regulation in light of the extensive *de facto* private activity in the health sector.[30]

As elite-level political conflict blocked development of legal private markets, while Russia's deep transitional recession forced down real public health expenditures by one-third, the majority of health care providers' salaries fell below subsistence, and even these low salaries were often in arrears.(see Table 3) At the same time, the numbers of providers actually grew, with numbers of MDs increasing from 407 per 100,000 in 1990 to 426 in 2002, while most infrastructure remained in operation.[31] In response, providers and administrators turned to informal income-generating strategies, including 'spontaneous privatization,' "an increasing tendency to spontaneous and unofficial replacement of free services with paid ones."[32] Health sector employees and elites on a significant scale used their control over access to facilities and their existing skill sets to craft combinations of formal ('cash register') and informal or 'shadow' payment requirements.

[29] Head of Dept. of Organization and Control of Medical Care for the Population, Russian Ministry of Health, interview with Judyth L. Twigg, Trip Report (transcript), Moscow, Russia, June 1998, 23-24.
[30]TACIS, *Governance of Social Security: Social Insurance, Medical Insurance and Pensions: Final Report* (Cologne: Technical Assistance to the CIS, June 1, 2000), 63-64.
[31] WHO/Europe European HFA Database, 2006.
[32] F. G. Feeley, I. M. Sheiman, and S. V. Shishkin, "Health Sector Informal Payments in Russia," at: http://doc2.bu.edu/RussianLegalHealthReform/ProjectDocuments/n650.111B6.

Table 3

Pensions and Health Sector Wages, 1993-1999
(on 1 January, in % subsistence level) – expand dates

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Old Age Pensions:										
Minimum**	63	79	43	47	79	79	42	48.2	44.0	36.5
Average	138	129	101	116	113	115	70	76.4	89.5	100.0
Wages in Health Sector										
Average	195 (1992)	--	--	150	149	134	99	107	126	166
% Workers below Subsistence	--	--	--	48.7	47.8	--	67.2	65.7	61.0	38.8

Sources: Sotsial'noe Polozhenie i uroven zhizni naseleniia Rossii 2002: statistichiskii sbornik, 165 (Table 6.10); 145 (Table 5.19); 147 (Table 5.21); 2001, 148 (Table 5.22), 150 (Tab. 5.24)(Moscow: Goskomstat Rossii, 2001, 2002); Russia in Figures 2000 (Moscow: Goskomstat, 2000) 98.

**with compensation payments.

There also emerged large-scale corruption in the manufacture and distribution of pharmaceuticals. During the early 1990s transition a nascent retail and wholesale pharmaceuticals market replaced the Soviet-era single state distributor. Small, loosely-regulated private distributors and new privatized pharmacies developed rapidly at a time of great institutional and economic instability. Controls on wholesale and retail mark-ups were ineffectively enforced. Research by Alexandra Vacroux shows that key positions in local regulatory apparatuses and regional health administrations were increasingly 'captured' by industry officials. Low salaries, under-funding, institutional flux and poor regulation combined to create incentives and opportunities for corruption, which became pervasive in the production and distribution of pharmaceuticals throughout Russia's health care system. Here too, hardship contributed to corruption that became resistant to later efforts at regulation and formalization. According to Vacroux's study "An organization trying to generate rents to survive in an atmosphere of inconsistent funding can foster an internal corporate culture in which officials also exploit their personal authority for personal rents. The civil servant who has used

reforms to carve out a profitable niche for himself and his organization has an incentive to block later reforms that eliminate this niche." (expand from dissertation; Black Box.; see chapters you have)[33]

By the mid-1990s payments played a significant role in **access t**o health services, and people at all income levels were paying. Survey data show that the percentages making both formal and informal payments in public facilities grew from about one-fourth in 1996 to 40% in 1998 and 80% in 1999-2000.[34] Formal ownership of medical facilities remained almost exclusively public, but private spending on health services grew rapidly, part of it going to legally private or 'chargeable services' and part to 'shadow' payments. By some estimates, private spending equaled or exceeded public as % of GDP by the mid-1990s, with a conservatively-estimated half of private spending informal.[35] Rates of abstention from medical care and treatment fell with income decile, showing the exclusion of poorer strata..

Putin-Era Reform Efforts

The coming to the Russian Presidency of Vladimir Putin in 1999 and the return of high and sustained economic growth, (Russian GDP grew 7% per year on average from 1999-2007), led to partial restoration of the state's institutional capacity and ability to provide public goods.[36] Putin took strong measures to re-establish central control over Russia's regions, and strengthened tax collections and regulatory mechanisms. Social payment and salary arrears were cleared, and real expenditures on health and other welfare benefits increased modestly. But state capacities remained comparatively weak (see Table 1 above, p. 5), health workers' wages stayed at the bottom of the urban wage scale, and pensions remained very low in terms of real value and wage replacement.[37] Average public sector wages rose above subsistence in 2001, but the sector continued to have the highest share of workers with below-subsistence wages economy-wide except

[33]Alexandra Vacroux, "Regulation and Corruption in Transition: The Case of the Russian Pharmaceutial Markets," in Janos Kornai and Susan Rose-Ackerman, ed., *Building a Trustworthy State in Post-Socialist Transition* (New York: Palgrave-Macmillan, 2004), p. 146
[34] Yudaeva and Gorban, "Health",: 32
[35] A study by a group of Russian health experts estimated conservatively that the informal health care market in 1997 captured 0.86% of GDP, equal to about 25% of reported public health expenditures; (see fn 103)
[36] Popov, RAD, 48, Oct. 17, 2008)
[37] See *Trud I Zaniatost*

for agriculture.[38] (See Table 3 above, p. 14) Despite Putin's construction of a social policy team at the top of government, resistance came from social ministries and regional funds that administered programs based on public financing. The Pension Fund chair and regional medical funds resisted diversion of state-administered contributions to private insurance mechanisms.

In 2001 the government, under the impetus of a liberalizing social sector reform team and an activist Economic Development Ministry, revived efforts to complete the transition to a medical insurance system that had faltered since the early 1990s. These initiatives again met resistance, and negotiations over state and non-state roles were once again dominated by bureaucratic and elite actors, with little direct input from (or accountability to) either the public or providers. Regional governments still refused to contribute to insurance, instead continuing to directly finance medical institutions under their jurisdiction.[39] The system remained semi-reformed, institutionally-fragmented, and poorly-managed, with insurance companies largely passive and federal and regional budgets still administering about 60% of public healthcare expenditure.[40] According to close observers of Russian health sector reform, "As things stand now, there is a near equilibrium of forces in the health service between three special interest groups: health bureaucrats, CHI (Compulsory Health Insurance, or Mandatory Medical Insurance (MMI)) funds, and health insurance organizations. The future course of the reform will depend on the fighting and cooperation among these groups. Almost no one seems to care much about the interests of the population, or even those of medical workers."[41]

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[38] World Bank, *Russian Federation: Reducing Poverty through Growth and Social Policy Reform* (Washington: World Bank, Report No. 28923-RU, February 8, 2005), 26.

39 Mikhail Dmitriev, et. al., "Economic Problems of Health Services System Reform in Russia," (Paper prepared for Conference and Seminar on the Investment Climate and Russia's Economic Strategy, Moscow, April 5-7, 2000, at www.imf.orgAccording to Mikhail Dmitriev of the Ministry of Economic Development, "Keeping non-governmental insurance companies in the Mandatory Medical Insurance network has become especially urgent . . . there is a reluctance on the part of government to take action; on the contrary, regional governments oust insurance companies from the system

[40] OECD *Economic Survey, Russian Federation*, 29 2006, p. 191

[41] Shishkin in Gaidar, quote is from pp. 598-599.

B. Political Origins of Pension Privatization

Failure of initial efforts:

The Russian state inherited a mature pension system that carried extensive financial obligations to the population. Because of high labor force participation rates of both men and women in the Soviet period the number of recipients was high, amounting to one-quarter of the population in 1991, a higher proportion than is typical in OECD states. Initially financed from the state budget, the pension system was transferred to Pay-As-You-Go (PAYG) principles in 1991, to be run by the newly-established independent off-budget Pension Fund of Russia (PFR) and financed by a 29% payroll tax. The Pension Fund controlled the largest pool of money in Russia's social security system, amounting to 5-6% of GDP in the 1990s.[42] (OECD 2006) Non-transparent and with a governance structure that shielded it from external oversight, the PFR from the beginning sought to defend its corporate interests against both regulatory and privatizing reforms.[43]

From the early 1990s, Russia's pension system was in an escalating crisis. As the economy diversified, tax authorities proved unable to monitor transactions in the new private sector or enforce compliance with the high social security tax. Payment arrears to the Pension Fund mounted, exacerbated by the ability of oligarchic economic elites, the largest tax debtors, to penetrate the state and negotiate exemptions or evade payment with impunity. The Russia state itself accumulated large-scale arrears for public-sector pensions.[44] Declining employment and early retirements in the contracting economy worsened the payor/recipient ratio. By the mid-1990s average pensions had fallen to a flat subsistence-level, regions were withholding taxes from the PFR, and payment arrears of 3-6 months were common. In response to the system's poor performance, younger and higher-income workers and their employers defected from state-mediated social security mechanisms, often following strategies of 'minimal compliance' that entailed reporting and paying taxes on only a minimum wage, paying the remainder as 'grey wages." In addition to these short-term failures, analysts calculated that Russia's pension system would confront worsening dependency ratios in

[42] *Sotsial'noe polozhenie I uroven zhizhi naseleniia Rossii: Statisticheskii sbornik 1997; 194; 2003, 194* (Moscow: Goskomstat, 1997, 2003)
[43] Linda J. Cook, "State Capacity and Pension Provision," in Colton and Holmes, *State After Communism*
[44] Cook in Colton

coming decades, and that major structural reforms were needed to maintain its viability. Multiple reforms (short of privatization) that would have restricted pension eligibility were proposed during the mid-1990s but the Duma, dominated by the hold-over Communist Party which counted pensioners as its major constituency, rejected out of hand any diminution of their rights (illustrating the limited governmental accountability of the early transition period. For all their limitations, pensions were the only clearly re-distributive social transfer program in Russia during the 1990s.[45]

The first serious attempt at pension privatization came in 1997, as part of a broader social sector restructuring package that the World Bank promoted through loan conditionality and technical assistance.[46] Drawing on its famous 1994 report *Averting the Old Age Crisis,* Bank loan documents called for "moving the system away from public financing and solidarity toward a funded, accumulative, individual market model."[47] Bank officials advocated the expansion of pension insurance markets and introduction of mandatory investment accounts, which would limit the state's role and responsibility. A governmental reform team appointed by then-President Yeltsin initially proposed a more radical "Chilean" variant that would have privatized the entire pension system, but the submitted legislation was closer to the Bank's recommendations, calling for partial privatization through a mandatory funded pillar. Leaders in the finance industry also pressed government officials, arguing that introduction of a funded pillar would stimulate investment in capital markets.[48]

Pension privatization provoked major intragovernmental conflicts, with the Ministry of Economics supporting the reform team while key stakeholders in the existing pension system, including the Labor Ministry as well as the PFR, opposed it. In the end the pension reform was defeated by large legislative majorities. Only voluntary, supplementary Non-State Pension Funds (NSPFs) were legalized in this period.

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[45]OECD, *Social. (Crisis in the Russian Federation??*

[46] WB and 1997 package; progress on privatizing pension reforms was a key conditionality for release of tranches of an $800 million Social Protection Adjustment Loan (SPAL) negotiated with the Russian government in 1997.

[47] Fn 86, p. 168; PAYG systems rely mainly on an inter-generational exchange; the wages of current workers are taxed to pay current pensioners. In funded schemes employees save for their own retirement, usually through investment of pension earnings, and pay-outs depend on accumulation in individual accounts.

[48] Williamson, "Political Economy of Pension Reform in Russia: Why Partial Privatization?" *Journal of Aging Studies,* vol. 20, no. 2, April, 2006. pp. 165-175.

Much of the opposition to pension privatization rested on straightforward bureaucratic self-interest, but a broad range of independent experts also opposed, citing the inadequacies of Russia's financial markets. According to one group writing about the 1997 reform, "Russian financial markets are almost totally undeveloped, the banking system is very weak, law enforcement is poor, corporate governance is very bad, and protection of shareholders' and creditors' rights is inadequate. If we add macroeconomic instability and high inflation to these failings, then we have to . . . /complete/

The Contentious Politics of Partial Privatization

With the economic recovery and improved state capacities/performance/ effectiveness (show w/ table) in the Putin period, the government cleared pension arrears and raised the majority of payments above subsistence levels, but low wage replacement rates, minimal tax compliance, negative demographic trends, and other structural problems remained. Moreover the World Bank was successfully promoting funded pension schemes as a way to ease the growing demographic pressures on PAYG systems caused by the aging of populations, and had been adopted in several other postcommunist states.[49] In 2000, as part of the Gref Program for Social and Economic Development, the government again proposed partial privatization of the pension system.[50] It is worth reviewing here the political and economic ramifications of pension privatization in the postcommunist context: The transition from PAYG to funding limits the state's role and responsibility in pension provision, its potential for re-distributing income among recipients, and pensioners' possibilities to bargain politically over pay-outs.[51] Privatization shifts responsibility and risk to individuals. It is supposed to increase, and make more transparent, the relationship between contributions and pay-outs, improving incentives for middle- and upper-income workers to contribute. In the economic sphere funded schemes create social insurance markets, enhancing the role and opportunities of the private financial sector. In

[49]Orenstein and others

[50] "Programma Pravitelstva Rossii: Osnovnyi napravleniia sotsial'no-ekonomicheskoi politiki Pravitel'stva Rossiiskoi Federatsii na dorgosrochnuiu perspectivy" at: www.akm.ru/rus/gosinfo/progr_gov/1_1.stm,. (hereafter, Gref Program) The Program is revised from a long draft generated by the Gref team: Proekt Strategiia razvitiia rossiiskoe federatsii do 2010 g.," (Tsentr Strategicheskikh Razrabotok, 2000) at: www.kommersant.ru/documents/Strat1.htm

[51]It is essentially a transition from a defined-benefit system in which the payout is established (though, as we have seen for Russia, economic instability and inflation can undercut its value) to a defined-contribution system in which the pay-out depends on accumulations; cite source

emerging markets, particularly those such as the Russian that badly needed investment, funding can serve as a source for deepening capital markets and financing economic development. Both the reduction of budgetary pressures and the potential for developing capital markets motivated the government, particularly the Economic Development Ministry, to prioritize pension reform.

From its inception pension reform proved contentious, provoking deep conflicts within the Putin administration. The most prominent division emerged between the Ministry of Economic Development and Trade on the one hand, and the head of the Pension Fund on the other. Reform threatened the Pension Fund with erosion of its virtual monopoly over pension provision and loss of control over the contributions that would go into private investment accounts. As in 1997, Fund administrators resisted privatization, pressing for continued state collection and distribution of contributions. The Economic Development Ministry favored a large funded component and reliance on private investment mechanisms, in order to minimize financial pressures on the federal budget as well as to maximize prospects for investment of funds in the economy. The 'Pension War' between these two government agencies, driven largely by differing institutional interests in the outcome, dominated negotiations over the reform.[52]

Business and financial interests, most prominently the largest organization of Russian business executives, the Russian Union of Industrialist and Entrepreneurs (RUIE), as well as the Inspectorate for Non-State Pension Funds, supported the accumulative system. (What about the private insurance industry??) Business and financial interests lobbied heavily as *Rossisskaya Gazeta* put it, "for participation in dividing up the big money," while the PFR leadership lobbied to exclude them.[53] Pensioners had no significant national organizations that could articulate their interests. According to a World Bank representative who followed the process, "Pensioners' organizations are small. They are not capable of strategic planning. . . Employers' organizations are more powerful, and participated in all the discussions."[54]

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[52]On pension reform and the 'pension war,' see *Rossiiskaia Gazeta*, 20 March 2001**;** Yulia Ulyanova, "Pension War – Between the Pension Fund and the Ministry of Economic Development" *Segodnia*, March 6, 2001, 1, trans. In CDSP, 53:10 (April 4, 2001), 11.
[53]*CDSP*, July 19, 2000, p. 12.
[54]Technical Specialist, Pensions and Social Protection, Moscow Office, World Bank, interview with author, Moscow, June 26, 2002. For one prominent of such a court campaign, , see Ilean Cashu and Mitchell

The pension reform process entailed very limited governmental accountability to Russian society. By this point the pro-presidential United Russia party dominated the Duma; its agenda and decisions were determined largely by the Presidential Administration. A National Council on Pension Reform, formed in early 2001, ostensibly provided representation to a broad range of labor, business and social organizations, including trade unions, veterans' and invalids' groups, but this constituted largely token or ineffective representation.[55] But the Council was heavily weighted toward governmental actors, and engaged in a process in which, "State agencies vigorously lobb/ied/ each other, crowding out /most/ non-governmental voices and constituencies."[56] According to an expert attached to the Duma Committee on Social Policy at the time, "The tone of the discussion is set by the ministries and the Pension Fund."[57] The trade unions and Labor Ministry, institutions that typically defend distributive approaches in pension reform negotiations, played minor roles, though the unions did support the Pension Fund. The Council managed to reach a compromise on all but the most contentious elements of the reform, i.e., the size and management of invested pension accounts. Council meetings also gave voice to a concern, among deputies, specialists, and others, that Russian markets remained too unstable and poorly-regulated to provide long-term pension security.

Conflict and negotiations over the investment mechanism continued for more than a year despite the government's strong promotion. Legislators resisted the more radical proposals for investment funds. The final legislation was a compromise: the new 3-tiered pension system retained a basic redistributive component, a guaranteed minimum pension that was slated to decline in real value over time. The reform initially re-directed to investment accounts a portion of pension contributions (2-3 percent of the total 28 percent wage tax) that was small by international standards, but slated to increase over time.[58] Pensioners could choose to keep this money in a state-managed fund or invest it privately.

Orenstein, "The Pensioners' Court Campaign: Making Law Matter in Russia," *East European Constitutional Review* 10:4 (Fall, 2001): 1-7.

[55] For the membership of the National Pension Council, see "Sostav natsional'nogo soveta pri Prezidente Rossiiskoi Federatsii pri pensionnoi reforme," (mimeo, 2001)

[56] Colton, n. 82 (quoting from intro to book?)

[57] Expert for the Committee on Social Policy of the State Duma, interview with author, Moscow, June 4, 2001.

[58] World Bank, *Pension Reform in Russia: Design and Implementation* (November, 2002) www.worldbank.org

Despite the absence of a direct role by World Bank officials, Russian privatization followed the multi-pillar model that the Bank had been promoting. Societal input was minimal, and social implications gained little attention. The reform reduced the re-distributive potential of the pension system and is likely to impose future costs on large groups of pensioners, especially women and lower-paid workers, who will be disadvantaged in a system of individual savings accounts. (Estimate of effect on women's pensions, from Women in Duma manu) Women's organizations did mobilize to a limited extent against the reform, but they gained a hearing in the Duma only from the Committee on Women's Affairs.[59] Concessions were made mainly to the Pension Fund, which was compensated by new legislation that consolidated its control over pension distribution. Re-negotiations of state and non-state roles were heavily dominated by institutional and financial actors with their own agendas, in which the interests of pensioners, the state's social security function, and any accountability to society, held at best a subsidiary place.

Pension privatization was implemented in a context of continuing labor market informality, evasion of income-reporting, minimal tax compliance, weak regulatory structures, and large-scale societal distrust of financial markets. In March 2001, when tax collections had already improved considerably from the low levels of the 1990s, Pension Fund head Zurabov reported that 60% of employers were paying minimal contributions that would make employees eligible for "subsistence-level pensions at best."[60] Survey evidence consistently indicates broad distrust among the Russian population, both of the financial institutions that will play a role in pension security and of the government's intentions.[61] Very few have elected to invest pension savings with private asset managers. In 2002 the World Bank itself, in a report on the reform expressed (somewhat ironically in view of the Bank's consistent promotion of privatization) a litany of doubts about the capacity of

[59] Expert on Women's Movement in the Russian Federation, interview with author, Washington, D.C., April 23, 2004.
[60] *Rossisskaya Gazeta*, , March 20, 2001.
[61] See, for example, "Russian Surveys on Pension Reform Support Examined," *FBIS Daily Report: Eurasia*, July 18, 2001, citing *Vremya MN*, July 18, 2001.

the Russian financial system to handle pension investments, and these were echoed in a 2006 OECD report.[62]

III. Consequences of privatization: access, exclusion, accountability

Health Sector

The formal, legal private sector in Russian health care comprises private insurance companies, private medical practices and clinics, and "chargeable services" at state facilities. About 300 private insurance companies operate in Russia, developed in the largest cities and wealthiest regions. But along with the much larger number of public insurers they are mostly passive intermediaries, neither risk-bearers nor active purchasers of health care. They have been stunted by the long opposition of regional governments to participation of private insurers in the system. In the private insurance system, employers frequently relying on 'pocket' insurance companies that are selected in exchange for kickbacks to managers.[63] The system is also affected by weak compliance with social taxes, specifically, chronic under-financing in many regions of OMS, as many workers under-contribute owing to 'grey' schemes for paying wages and salaries. In 2006, an OECD report judged as major challenges to an effective private and public insurance system Russia's "weak contracting environment and weak state regulatory capacities," and went on to argue that: "fostering the emergence of a truly competitive pool of medical insurance companies . . .will make considerable demands on the state's administrative and regulatory capacities, including the need for a regulatory authority with medical expertise."[64] Russin health care system expert Igor Sheiman points out that insurance works poorly in most regions of Russia and concludes "Russia is unlikely to be able to create a well-functioning competitive insurance system in the foreseeable future."[65]

(Need info on private medical practices and clinics and chargeable services; see WHO)

[62] 2002 WB(Colton, 136); "Reform and Challenges for Private Pensions in Russia," OECD, Paris, 2006.
[63] OECD *Economic Surveys: Russian Federation*, 2006, (Paris: OECD, 2006), p. 193
[64] OECD, 2006, p. 109; 206
[65] Sheiman 2005 or 2006, cited in OECD; chk cite.

Private medical practices, Clinics, Chargeable Services

Private expenditure on health care has grown rapidly in Russia, with the household share of expenditures continuing to increase, and overall private spending by some estimates equaling public, although officially the system remains overwhelmingly public. Out-of-pocket spending on heath as a % of total health expenditure by households has increased from 24% in 1998 to almost 30% in 2004.[66] Fifty to sixty-nine percent of respondents in the 2003 NOBUS survey across all income groups reported paying for medical services because there were no free providers or specialist available.[67] The largest share of household payments goes to pharmaceuticals, with 80% of patients paying part of the cost, and expenditures on drugs equaling 30% of total healthcare spending. The share of payments for legally-chargeable services has decreased steadily over time.[68] This pattern of high private and low public expenditure is associated with extremely poor public health outcomes, including high rates of excess mortality, communicable diseases such as tuberculosis, and rapid increase in the incidence of HIV/AIDS.

Corruption, informality, non-compliance

Efforts to regulate formal, informal, and quasi-formal private payment for medical services have been frustrated. Informal practices have become institutionalized and persistent, with administrators and providers forming a vested interest against governmental efforts at formalization or regulation. According to prominent Russian social sector experts, writing in 2003, ". . . central and local sociocultural authorities and the heads and employees of institutions resist privatization and any reorganization of their institutions, in part because they have already privatized most of the ownership rights. . . Keeping the services free serves the interests of both the bureaucrats and the employees of service-providing institutions, for it provides the former with grounds to have public funds placed at their disposal and the later with the opportunity to receive fees for their services directly from their customers."[69] The system includes private facilities as well as public

[66] Manning, Nick and Nataliya Tikhonova, *Health and Health Care in the New Russia,"* (Nacmillan, 2009)
[67] World Bank, *Russian Federation: Reducing Poverty through Growth and Social Policy Reform (Washington: World Bank, Report No. 28923-RU, February 8, 2005), 130-133*
[68] OECD, 2006, p. 195
[69] Irina Rozhdestvenskaya and Sergei Shishkin, "Institutional Reforms in the Sociocultural Sphere," in Yegor Gaidar, ed., *The Economics of Transition* (Cambridge: MIT Press, 2003), 606.

facilities that offer both legally free and chargeable medical services, but in practice patients often pay informally for all types

Intensive studies of out-of-pocket payments in Russia's health care system, based on interviews and public surveys, show that informal payments to health professionals are strongly prevalent. Norms and practices vary according to medical specialties, hospital departments, localities, patients' social and income group, in-patient and out-patient institutions, and arbitrarily. Hospitals rely on "diverse and complex income-sharing practices" to distribute informal payments among staff. Patients generally pay premia for access to advanced diagnostic technologies and facilities and for top specialists and surgeons, and collusion between doctors or hospitals and pharmaceutical companies over drug pricing and distribution are common. The pervasiveness of informal payments is driven mainly by insufficient public funding of state-guaranteed health benefits, low salaries among health workers, and . . . In addition, rank-and-file doctors and nurses benefit little from payments for chargeable services, which are mainly retained by administrators.

The size of medical professionals' "shadow" incomes can only be estimated, but negotiable 'shadow' price lists exist and surveys indicate that surgeons may exceed their official incomes by 5-10X, hospital unit heads by 3-4X, rank-and-file doctors in some specialties by 2-3X, nurses and others by one-fifth-2X, with many considering what they get as fair reimbursement.[70] Making legal payments does not protect patients against demands for additional informal payments. There is little support for more regulation among medical professionals. Experts conclude that these practices have become so deeply-entrenched and broadly-accepted among providers, health facility administrators and patients that they cannot be eliminated, and could perhaps be mitigated only by additional large increases in public expenditures on salaries and equipment. One analyst has characterized similar practices in postcommunist Poland as a system of 'welfare patronage' in which political authorities tolerate ubiquitous informal payments, and clients and providers

[70] S.V. Shishkin, et, al., *Informal Out-of-Pocket Payments for health care in Russia,* (Moscow, 2003), p. 24

collude to evade state regulation and taxation, a system that ultimately undermines the state's capacity to provide public services.[71]

Table 4

Abstinence from Medical Treatment by Household Income, 1997

(thousand rubles)

	< 400	401-800	801-2000	>2001
	% hshlds	% hshlds	% hshlds	% hslhds
Prescription Drugs	50	36	21	20
Laboratory Tests	36	26	18	18
Dental Care	43	32	19	13
Hospital Care	18	9	4	4

Source: V. Bobkov, et al, "Household expenditures on health and pharmaceuticals," Voprosy Ekonomiki, no, 10, 1998 in OECD, Social Crisis in the Russian Federation (Paris: OECD, 2001) 35.

Access and Inequality

Though basic and clinic-based care remain broadly available in Russia, abstinence from care or failure to complete treatment regimes because of inability to pay have reached substantial proportions.. Data from 1997 show that abstention from various types of medical treatment affected 18-50% of those in the lowest income declines, depending on type of service. (See Table 4) A 2001 World Bank study found a 'burgeoning underclass' with limited or no access to medical services.[72] The 2003 NOBUS survey found that 10-20% could not get access to care or complete treatment regimes because of cost.[73] **(Say more about effects across social strata)**

[71] Connor O'Dwyer, *Runaway State-Buildingg, p. 239*

[72] World Bank, *Russian Federation: Reducing Poverty through Growth and Social Policy Reform* (Washington: World Bank, Report No. 28923-RU, February 8, 2005), 26.

[73] NOBUS, 130-133; see also Mick Manning and Nataniya Tikhonova, eds., *Health and Health Care in the New Russia Table 63, p. 129* (Ashgate, 2009); see materials on access to medical care in YB Carnegie file and new WB materials.)

Pensions

The scale of investment and payment of pensions through the private market in Russia remains very limited. Voluntary private Non-State Pension Funds (NPFs), which were, as noted above, legalized in 1998, had some 5.8 million participants (8% of total employed) in 2006 and paid benefits to fewer than 0.5 million people. They number about 300, though decreased to 257 in 2001 after the cancellation of more than 50 licenses. NPFs have a "history of anti-competitive, monopolistic practices, with the four largest controlling 68% of private sector pensions assets."[74] They have experienced great volatility because of the 1998 financial crisis, and again in 2000, account management has been subject to high fees . . .[75]

The funded component of the second pension tier is also privatized, but most contributions remain invested through the Pension Fund. Few contributors have chosen private asset managers because of poor information as well as distrust. Moreover, participation in the funded component of the second tier has already been re-organized because of poor tax collections and resulting pension fund deficits, undermining popular confidence in both the reform and privatization. Pay-outs remain in the future, but experience in Latin American economies, with levels of inequality and informality broadly similar to the Russian, show that large numbers of workers accumulate little or no savings in individual invested accounts, and at retirement qualify only for minimum, state-guaranteed benefits.[76]

Introduction of a private component in the pension system and accompanying changes in Russia's tax system have limited access to pensions and contributed to inequality. The re-distributive feature of the system has been limited to the first, minimal tier. Women will no longer received pension stazh for time out of the labor force due to maternity and child rearing. Women and low-paid workers, who tend to earn less and have more interrupted work histories, will be disadvantaged in a system that relies on individual funded accounts, as will those working in the informal sector, where women are disproportionately represented. Pension privatization has been accompanied by reduction and regression of social taxes as well as the introduction of a flat income tax. While designed in part to draw higher-income workers back into the social

[74] Williamson
[75] OECD Pensions, 2006.
[76] Brooks,

security system that many fled in the 1990s, and to give employers incentives to report wages in full, regressive social taxes shift the burden disproportionately to lower-paid workers, and weaken the tax base of the Pension Fund, which has again experienced deficits since xxxx.

Finally, the introduction in Russia of the World Bank-promoted multi-pillar model is incompatible with the nation's policy legacy in that it requires well-developed financial markets and regulator institutions. Funded accounts are subject to many types of corruption, and the volatility that again affected Russia's markets in 2008-09 further illustrates the problems. According to one noted expert, "Even experts at the World Bank are now questioning how well their model is likely to work in nations with serious corruption problems and poorly-developed financial institutions."[77]

IV. CONCLUSION: A New, 'Informalized' Welfare Regime Model?

Both health care and pension provision have undergone limited privatization in Russia since 1990. The re-negotiation of state and non-state roles has in large measure not entailed a settlement with Russian society. Rather, privatization has been limited by the resistance and obstructivism of statist-bureaucratic actors at central, regional, and local levels who have vested interests in the maintenance of public financing and state administration of social sectors. Privatization efforts have also been hampered by the importation of market-based social policy models, diffused through international networks of social policy experts associated with the World Bank and other institutions, for which Russia lacks the necessary infrastructure and regulatory capacities, and by the continuing weakness of a range of compliance procedures in taxation and social security administration during the Putin/Medvedev administrations. Moreover, pervasive informality in the social sector as well as the broader economy obscure the distinctions between private and state-public. As I have shown, many formally public services require *de facto* private payments for access, while minimal compliance with state tax laws shields large "grey incomes" from health and pension insurance contributions. Thus, it becomes difficult to define or measure what qualifies as 'private.' My paper has attempted to sort out these realities as they affect contemporary Russia's health and pension sectors.

[77] Williamson, p. 24

Table 5

'An 'Informalized' Welfare State Regime Type'

Functions and Areas of Welfare State	*Informalized* (Liberalization +Weak State Capacities)
Financing	Mixed Public, Private, and Informal
Administration	Weak state and Market, regulation; Informal Private Controls over Access
Coverage	Fragmentary: Poorly- targeted and incomplete State Coverage of Eligible Poor, Partially corrupt Social Security Markets
<u>Welfare Policy Areas</u>	
Pensions, Social Insurance	Multi-Pillar PAYG and/or Capitalized Accounts; -low wage tax collections -low contribution rates to capitalized accounts
Health and Education	-mix of legal and 'spontaneous' privatization -informal control over access to subsidized services -poorly-regulated private services -prevalence of 'shadow payments'
Social Subsidies, Social Assistance, Poverty Relief	-residual subsidies; -poorly-targeted poverty relief
Labor Market Labor Code	Large informal sector with unregulated wages; No formal legal protections

The outcomes in the Russian case suggest a new or hybrid "informalized' welfare regime type, a product of inherited welfare state infrastructure, partial, contested liberalization, and relatively weak state taxing and administrative capacities. Informalized welfare regimes are distinct in their systems of financing, administration, and coverage: financing entails a non-transparent mix of public, private, and informal payment, with relatively low and regressive taxes and weak tax compliance.Administration involves both weak state regulation (i.e. endemic conflict among administrative levels and agencies of the states) and market regulation, and pervasive informal private controls over access. Benefit coverage is fragmentary, characterized by partially corrupt social security markets and, (though not discussed in this paper), poorly-targeted and incomplete state coverage of the eligible poor.

The paper has focused on the effects for health care and pensions. In health care (as well as education in different forms), a mix of legal and 'spontaneous' privatization, informal control over access to subsidized services, the prevalence of 'shadow' payments, and poorly-regulated private services. In the area of social insurance, including pensions, partial privatization, low wage tax collections and contributions to capitalized accounts, resulting in large-scale eligibility for 'subsistence' pensions. Social subsidies, including means-tested or poverty-targeted benefits, are poorly-targeted and relatively ineffective in reducing poverty. A large informal labor market leads to the exclusion of large parts of income, and some parts of the labor force, from eligibility for pensions and social insurance. The system overall benefits those at higher income levels, and progressively erodes the access pf poorer social strata to services, and produces feed-back effects on the state's capacity to tax citizens and employers, to distribute public goods, and to construct and implement national welfare programs and policies.

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