USSR Letter

The way forward in the Soviet health service

MICHAEL RYAN, GEORGE D FORWELL

The Russians have a saying to the effect that it is better to see something once than to hear about it a hundred times. For a visitor to the Soviet Union, however, the evidence of one's own eyes may prove far from easy to evaluate, as we discovered during a recent study tour. Organised by the International Hospital Federation, this tour included visits to a range of health service units in Leningrad, Moscow, Kiev, and Sochi on the Black Sea coast.

Although much that we saw and learnt from our hosts suggested interesting themes for discussion, there was an ever-present danger of generalising on the basis of inadequate or unverifiable data. So, rather than present an account based on observations of probably atypical units, we have chosen to use our impressions and existing knowledge of the organisation of Soviet health care¹ to supplement valuable documentary evidence that we obtained about the programmes and priorities of the Soviet health service in the immediate future. This evidence was provided in the equivalent of a circular, which the USSR Ministry of Health issued in April 1979 in order to announce the main guidelines for the development of medical care and biomedical science during the period of the next five-year plan (1981-5).²

It may be argued that the most persuasive justification for studying other systems of social service delivery, and of government in general, is to sharpen critical awareness of the corresponding institutions in one's own country. So, although this article does not offer a rigorous comparative analysis, we shall refer to the British scene to the extent that seems appropriate. This intention is implied in our title, which, as many readers will recognise, contains an allusion to the DHSS document in the series that came closest to presenting a five-year plan for the National Health Service.³⁻⁵ (Higher priority was assigned to preventive medicine, primary care, longer-term care, convalescence, and rehabilitation, while a limit was proposed for the expansion of acute hospital care.)

The first point of difference that emerges from a comparison of these documents relates to the scope of the British and Soviet health services. Unlike the position here in Britain, Soviet public health measures—what is termed the “sanitary-epidemiological service”—come under the same administrative aegis as personal medical care. Broadly speaking, this arrangement may be viewed as a reminder of how comparatively recent is the development of the Soviet economy, judged by conventional criteria such as urbanisation and industrialisation. (Even in mid-1978, according to the statistical year book, 37% of the total population fell into the category of rural residents.) It also serves to recall the massive discontinuities in the socioeconomic infrastructure caused by protracted civil war; at the start of the Soviet health service, these factors made it imperative to give

high priority to basic issues of environmental health and control of communicable disease.

This is not the place to embark on a detailed discussion of the success or otherwise of current environmental health programmes—although considerable room for improvement clearly exists, especially in rural areas. Evidence to support this view may be gleaned from health education posters, such as one that we saw which suggested that brucellosis is still prevalent among dairy herds: it showed a small boy holding up a glass of milk with the caption, “I never drink milk unless it has been boiled first.” It is relevant to add that—according to the circular—the Soviet Union plans further development of the network of local bases for public health activities—what are termed the “sanitary-epidemiological stations.”

Outpatient care

That leads on to another major difference between the British and Soviet planning documents; the USSR proposes to make massive additions to the capital stock of the personal health service. New buildings will provide extra accommodation for the outpatient service (care for patients who are not in hospital beds) in a range of units—policlinics for adults, paediatric and dental policlinics, women's consultation clinics, and dispensaries for single specialties such as psychoneurology and venereodermatology. The extent of additional capacity created for the outpatient service is measured not by the number of units but, more appropriately, by the number of patients attending each shift. According to a separate source, capital works due to be completed during the period 1981-5 will make possible an extra 630 000 visits per shift.⁶

We were interested that the planning document specified the higher work norms that are expected to be achieved in the outpatient service at the end of the decade—that is, by 1990. In that year, however, there will still be an appreciable difference between town and country in respect of access to a doctor. The figure proposed for the capacity of urban outpatient units is 250.0 visits per shift per 10 000 population, while the corresponding figure for rural units is 160.0. To put it another way, each town dweller is expected to have more contacts with an outpatient doctor than his rural counterpart. The predicted average number of contacts per person is 12.9 (towns) and 8.2 (country). Perhaps it should be added that these are all-Union data and conceal variations among the 15 republics. Thus, according to the circular, Latvia will have 14.9 contacts per urban patient per year and 10.4 per rural patient, while the corresponding figures for the Central Asian republic of Turkmenistan will be 11.9 and 6.5.

The high average level of contacts with a doctor is partly explained by what the Ministry circular calls “the further development of the prophylactic orientation of the health service.” One well-publicised element in this strategy is the periodic (apparently annual) health check for an ever-increasing proportion of the population. In 1975, according to published data, 50.8 million such examinations were carried out on adults

Department of Social Policy and Social Work, University College of Swansea, Glamorgan SA2 8PP

MICHAEL RYAN, PHD, lecturer in social policy

Greater Glasgow Health Board, Glasgow

GEORGE D FORWELL, PHD, FRCP, chief administrative medical officer

and 56.1 million on children,⁷ from which it may be calculated that 42% of the total population were screened in that year.

To judge from what we were told, the main content of the health check for adults appears to cover chest x-ray examination, examination of teeth and gums, blood pressure, tonometry (for glaucoma?), and organisms in faeces. An unknown, but obviously vast amount of staff time—especially medical—is allocated to this, but no valid data were presented on the yield. There was no local recognition of the criteria by which in Britain it is considered that any form of prescriptive screening should be examined.⁸ Even so, the importance of prevention or early treatment may thereby be raised in the public mind, and little actual harm may be done to patients. A possible exception is the exposure to radiation of young people—for example, students—by subjecting them to annual fluoroscopic examination of the chest. Incidentally, none of the radiographic staff we observed wore radiation monitoring badges, and they seemed to be casual about the hazard to both the patients and themselves. As regards other aspects of prevention, the passivity of the Soviet public in health matters suggests that changing behaviour would be difficult. Nevertheless, commendable effort is being made in health education by using various channels, including the mass media (especially television).

Hospitals

Another striking point of difference between the British and Soviet planning documents is that the expansion of outpatient services in the Soviet Union is not intended to be matched by any reduction or even stabilisation in the provision of acute and long-stay hospital inpatient accommodation. The Soviet Union already has an extremely generous ratio of hospital beds to population—120.8 per 10 000 persons in 1977, as against just under 90 per 10 000 in Britain. Nevertheless, it is intended that by 1990 a higher level of provision will be reached, with a ratio of 136.8 beds per 10 000. Although some of the additional beds will be accounted for by so-called “multiprofile” hospitals—similar to the British district general hospital—a substantial proportion will be in units for single specialties or for client groups, most notably for children.

Only part of the extra capacity (for both outpatient and inpatient services) will be located in areas of industrial development with rapidly growing populations—such as Siberia, the extreme north, and the Far East. Existing hospitals will also be enlarged, in keeping with the policy of concentrating resources in bigger units which can maintain more qualified staff and be better equipped with modern diagnostic and therapeutic equipment. The Soviet planning document specifically refers to the “district centre hospitals,” which provide most of the inpatient accommodation in rural areas: by 1985 their size is expected to increase to 250–400 or more beds.

Does the obligation to meet crude quantitative targets entail loss of quality in hospital construction? This question can be answered, at least in part, from personal observation during visits to what are evidently showpieces, such as Moscow's teaching hospital No 7, which has 1540 beds at present and will have 3000 on completion of the whole complex. Opened in 1976, the building already shows signs of deterioration, quite apart from various defects in the interior finish and a lack of flexibility in design.

Even if the authority of such comment is open to question, at least there can be no doubt about the effect of an enlarged bed complement on the annual rates of hospital admissions. One of the planning assumptions made explicit in the Ministry's document is that by 1990 24.9% of the population is expected to receive treatment as inpatients. That figure is an average for the whole Union, but it does not conceal wide variations because the lowest republican rate is 21.4% (Georgia) and the highest is 27.8% (Tadzhikistan). Incidentally, these figures tend to cast suspicion on the assertions that the British health service is excessively hospital-orientated; in this country the annual admission rate stands at only about 10%.

The data given above for the Soviet bed complement apparently exclude all accommodation in sanatoria which, predictably, are located in favourable natural settings such as the sheltered littoral of the Black Sea. Although these institutions represent a numerically sizable supplement to the hospital service, they provide “cures” whose therapeutic effectiveness is far from proved. Perhaps no harm is done by the mud therapy, hydrotherapy, and paraffin wax baths which we saw in Sochi, but, equally, the treatment with sulphuretted hydrogen is unlikely to benefit those patients who have gingivitis. Soviet endorsement of this type of physical medicine may well indicate the absence of a rigorous conceptual framework for assessing clinical practices.

Expenditure

Perhaps the most distinct contrast of all resides in the omission from the Soviet document of any figures for current and projected spending. Mention is certainly made of policies intended to enhance economy and effectiveness in the use of resources—for example, the passage about psychiatric services states that the network of day hospitals and night hospitals must be expanded. Nevertheless, there are no figures for global expenditure, let alone anything as advanced as the programme budgets and per caput spending on various types of provision that form impressive features of *The Way Forward*.

Should that omission be interpreted as indicating that no hard choices have to be made between competing priorities because the finance will be sufficient to develop on all or at least many fronts? In our view, part of the answer is that although choices do exist they have not been clearly identified and presented in print—as they would be in a pluralistic Western democracy. But it is probably more important to note that, for various reasons, many developments will be cheaper than they would be here. Moreover, comparable five-year plans appear to have been largely fulfilled in the past despite the fact that the percentage of government spending allocated to health has remained roughly constant.

In future years it seems highly unlikely that the long-established level of spending will rise because health care has been assigned a higher priority rating. In all probability, the expansionist programme has been predicted on the assumption that health care will continue to absorb 5–6% of government spending. Nevertheless, the plans may also presuppose that the growth of national income will continue at the levels achieved in the late 1970s. It is this assumption—if it was made—which could lead to substantial underfulfilment of the plan, for, at the time of writing, a reduction in the growth rate of the Soviet economy seems almost unavoidable. It may be concluded that the development of health services in Britain and the Soviet Union will have at least one basic feature in common—in both countries it will be directly related to economic enterprise and the creation of additional wealth.

Reprints of this article will not be available from the authors.

References

- 1 Ryan M. *The organisation of Soviet medical care*. Oxford: Basil Blackwell and Martin Robertson, 1978.
- 2 Ministerstvo Zdravookhraneniya SSSR. *Osnovnye ustanovki k sostavleniyu pyatiletnevo plana razvitiya zdravookhraneniya i meditsinskoi nauki na 1981–1985 gg.* Moskva, 1979.
- 3 Department of Health and Social Security. *Priorities for health and personal social services in England: a consultative document*. London: HMSO, 1976.
- 4 Scottish Home and Health Department. *The Health Service in Scotland: the way ahead*. Edinburgh: HMSO, 1976.
- 5 Department of Health and Social Security. *Priorities in the health and social services: the way forward*. London: HMSO, 1977.
- 6 Golovteev, VV, Korchagin, VP. *Ob effektivnosti ispolzovaniya osnovnykh fondov zdravookhraneniya*. Sovetskoe Zdravookhranenie, 1979;10:6–12.
- 7 Novgorodtsev GA, Demchenkova, GZ, Polonski ML. *Dispanserizatsiya naseleniya v SSSR. Meditsina*. Moskva, 1979:337.
- 8 Wilson, JMG, Jungner G. *Principles and practices of screening for disease*. Geneva; WHO, Public Health Papers, No 34, 1968.