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Russian Report

Personalalia and the current health crisis

Michael Ryan

Recent changes in the Russian government introduced by Boris Yeltsin include the appointment of Eduard Nechaev as health minister at the beginning of this year. The appointment received little publicity in the West, although his predecessor was sacked after only one year for failing to make any effort to improve health care. The challenges facing the new minister are enormous. Not only does he have to introduce a new medical insurance system but he has to tackle the problems of falling population, rising childhood illness linked to poor diet, and the spread of polio and diphtheria. It remains to be seen whether his experience in the military medical service has equipped him for the job.

At the start of 1993 the line up of Boris Yeltsin's embattled government included not only a new prime minister but also—virtually unnoticed in the West—a new minister for health. This post had been vacant for over two months, and the reason for this is easily found. The shortage of public money for this sector and its administrative disarray, plus appalling morbidity and mortality statistics, meant that the appointee was being offered what amounted to a bed of nails. Indeed, one potential incumbent apparently declined the job with the words: "Do you think that I'm a kamikaze?"

The person eventually appointed was the relatively unknown Eduard Aleksanrovich Nechaev, who had made his career in the military medical service. The fact that a doctor was chosen to head up the health service represents the continuance of a Soviet constitutional practice which recent political evolution has not yet modified. Indeed, it would be unrealistic to suppose that in the short term Russia will develop a British style multiparty system which makes possible ministerial careers for generalists who expect to move from post to post as they "climb the greasy pole."

Although Nechaev has not worked as a civilian medical administrator, he was presumably deemed to have shown high qualities of leadership and competence in running a large scale organisation during his tenure of senior posts. Before expanding on that point, though, it is appropriate to ask what happened to his predecessor.

A minister who failed

Some of the changes to the government team can be explained as an expression of compromise by President Yeltsin to a parliament in which reactionary forces need to be placated. The most striking example of such

a logic occurred in December of last year when the radical Yegor Gaidar, who had espoused shock therapy for the Russian economy, was removed as acting prime minister and replaced by the opaque but pragmatic Victor Chernomyrdin. That action was almost certainly calculated to avert heightened political instability. However, the same interpretation cannot be put on the sacking of health minister Andrei Vorobyov, who had been appointed only about a year earlier.

As the Russian newspaper *Izvestiya* reported in October last year, Vorobyov was dismissed by presidential decree the day after he had attended a meeting of heads of ministries. Coming under strong criticism for his report on health care, he had a heart attack, but the reasons for his dismissal were not divulged. In its report the newspaper implies a mystery by pointing out that "problems in the health care system are no more daunting than in, for example, the sphere of education."

A few days later *Pravda* published an investigative article which had been prompted by phone calls from readers. The gossip culture had linked Vorobyov's dismissal to the allegation made by one of his deputies that the parliamentary speaker (Ruslan Khasbulatov) had been under the influence of drugs. To discover the truth, *Pravda* approached an authoritative informant A A Askalonov, chairman of the Supreme Soviet's committee on health care, social security, and physical culture.

What Askalonov said added up to a damning assessment of the former health minister. During a year in office Vorobyov "took no constructive steps to improve the health care of the people in our state." From the start he had adopted the position of an observer on the sidelines, taking the view that work on laws concerning health care was the responsibility of parliament and nothing to do with the executive.

Insurance medicine

His position might have been partly excused by the fact that the division of functions between the legislature and the executive is somewhat blurred at the moment. Nevertheless, he was also inactive in an executive task that clearly fell within his remit.

In June 1991 President Yeltsin had signed a law which was intended to change the financing and organisation of health care fundamentally by introducing a system of medical insurance to complement the traditional publicly financed health care. Vorobyov had an unambiguous responsibility for detailed planning and administrative preparations but he adopted a

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Only about a third of infants remain healthy throughout their first year

grandly dismissive attitude towards the scheme. According to Askalonov, he had asked: "But what do we need all this for?" and had not lifted a finger to implement medical insurance.

The moment of truth came at the meeting of government ministers held on 22 October. Vorobyov presented proposals which, according to *Pravda*, showed "that he had not studied the law on medical insurance fully or had ignored it." Given these circumstances his dismissal seems a foregone conclusion. The title of *Pravda's* article was "The Minister who pleased no one" and that may turn out to be the political obituary of Andrei Vorobyov.³

A military saw bones

No doubt the new minister will be using his best endeavours to resolve the varied difficulties presented by the introduction of insurance medicine. He will also need to evolve and put in place emergency strategies if the health conditions in Russia are not to deteriorate even further. In that respect Nechaev's track record suggests that he could turn out to be the right man for the job.

After some years of clinical work as a military surgeon (his doctoral dissertation was on heart surgery) in 1985 he was appointed to a major medical-administrative post as chief surgeon of the Soviet forces group in Germany. He was subsequently promoted to chief of the Soviet army's central military medical board. In that capacity, among other things, he effected improvements in field hospitals and was responsible for the provision of medical care to victims of the disasters in Ufa and Armenia.

Igor Denisov, a former minister, collaborated with Nechaev during the aftermath of the Armenian earthquake, and he expressed his confidence in the new minister as a man of "disciplined determination." Furthermore, Nechaev has already shown an ability to

rise to current challenges by taking "a substantial role in the organisation of emergency medicine in leading medical schools."⁴ I will now attempt to convey some of the dimensions of the public health crisis which confronts him.

Population decline

The demographic situation alone provides cause enough for pessimism. The death rate is increasing while the birth rate is falling, causing a sharp slow down in Russia's population growth. Birth rates have fallen because there are fewer women in the most fertile age groups and because of less childbearing among these women. During 1987-91 the birth rate dropped by nearly 30%—from 17.2 to 12.2 per 1000 population (table). The death rate has risen from 10.7 deaths per 1000 population in 1989 to 11.3 in 1991 so that the natural increase was only 0.9 per 1000 population in 1991 (table). This picture is broadly similar for both urban and rural areas.

In November 1991 a natural decrease in population was recorded for the first time since the second world war. The number of people who died exceeded the number of births by 4000, and the gap continued to widen during the early part of 1992. Relatively high birth rates still persist in areas with a high proportion of indigenous ethnic minorities such as Dagestan, Tuva, Checheno-Ingushetiya, Kalmykia, Kabardino-Balkariya, Yakutiya and Buryatiya, where birth rates ranged from 26.0 to 18.3 per 1000 population. Nevertheless, the State Committee for Statistics predicted that in 1992 population would fall in 43 of Russia's regions. Together these regions account for roughly two thirds of the total population.

Matters of life and death

The average expectation of life at birth in Russia reached a high of 70.1 years (64.9 for men and 74.6 for women) in 1986-7. Since then it has fallen and in 1990 was 69.3 years (63.9 for men and 74.3 for women). Official statisticians have estimated that a 50% reduction in the number of people who die each year from accidents, poisoning, and trauma would extend the average life expectancy of the Russian population by two years; the increase in life expectancy for men would be three years.

Among other preventable causes of illness and

Births, deaths, and natural increase in Russia per 1000 population, 1980-91

Year	Total	Urban	Rural
Births:			
1980	15.9	15.8	16.1
1985	16.6	16.1	17.8
1986	17.2	16.7	18.6
1987	17.2	16.6	18.6
1988	16.0	15.4	17.6
1989	14.6	14.0	16.4
1990	13.4	12.7	15.5
1991	12.2		
Deaths:			
1980	11.0	10.0	13.4
1985	11.3	10.3	14.0
1986	10.4	9.6	12.5
1987	10.5	9.7	12.7
1988	10.7	9.9	13.0
1989	10.7	10.0	12.7
1990	11.2	10.4	13.3
1991	11.3		
Natural increase:			
1980	4.9	5.8	2.7
1985	5.3	5.8	3.8
1986	6.8	7.1	6.1
1987	6.7	6.9	5.9
1988	5.3	5.5	4.6
1989	3.9	4.0	3.7
1990	2.2	2.3	2.2
1991	0.9		

Sources: *Narodnoe khozyaistvo RSFSR* 1990, s.98; *Kratkii statisticheskiy byulleten* 1991, s.6.

death, environmental pollution features prominently in many parts of Russia. For example, in 1991 high levels of atmospheric pollution were recorded in the cities of Arkhangelsk, Amursk, Volgograd, Norilsk, Saratov, Gubakha, Bratsk, Volzhskii and Ust-Ilimsk, mainly due to the metallurgical, petrochemical, and woodworking industries.

The Soviet state has also left the terrifying legacy of contamination by radioactivity. In January 1992 it was officially stated that over 120 nuclear explosions had been conducted for so called peaceful purposes; over 20 occurred in the Volga basin and 12 in Yakutiya. The statement admitted that only fragmentary information exists about the serious radioactive contamination resulting from production of nuclear weapons in the "closed" cities of Chelyabinsk, Arzamas, Krasnoyarsk and Tomsk. Furthermore, it admitted ignorance about what is happening in the shallow waters of the Kara Sea, where the nuclear reactor of the vessel Lenin lies buried, and about other sites where nuclear waste was deposited.

The emerging trends in public health also seem frightening. For example, diseases linked to inadequate diet are increasing among children in the first year of life. The most widespread are those which were common during the war and immediately afterwards—serious rickets, diathesis and allergic dermatoses, stunted growth, functional disorders of the gastrointestinal system, and obesity. Even according to the official statistics, which ignore many symptoms previously categorised as diseases, only about one third of all infants remain healthy throughout their first year. In January 1992 the death rate for children under the age of 1 year was 9% higher than the figure for a year earlier. Neonatal mortality apparently started to rise from 1989.

As for disease-specific death rates, during 1980-90

mortality from malignant neoplasms rose from 163.5 to 191.8 per 100 000 population. Diseases of the circulatory system remain by far the largest cause of death and also help to explain the rising mortality. In 1980 they accounted for 579.5 deaths per 100 000 population but by 1990 the corresponding figure had jumped to 617.4.¹

Immediate menace

It is the threat of major epidemics, however, that is likely to demand the most urgent response from the new minister. An outbreak of polio seems just waiting to happen. *Izvestiya* recently reported that in Moscow only 31% of children under 1 year had been immunised—and a case of the paralytic form had already been notified.

The advance of diphtheria is already alarming. In the first 10 months of 1992, 732 cases were reported in Moscow (twice as many as in the previous year). During that period diphtheria claimed the lives of 20 Muscovites, five of whom were children. In Vladivostok, at the other end of the country, 40 cases had been recorded since the start of the year—twice as many as in 1991. In Russia as a whole, there were 2717 cases and 77 deaths, almost half the dead being children.² An appropriate conclusion would be that health ministers in the affluent West can and should give tangible help now.

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Lessons from Lithuania: rethinking public health training

Lucy Moore, Jennifer Dixon

Lithuania faces stark problems that are familiar to most countries in the former Soviet Union: high morbidity and mortality rates, pollution, an unstable economy, and rapid changes in the financing and organisation of health care. In this environment Moore and Dixon visited Kaunas Medical Academy to help identify how training in public health medicine could contribute towards improving the health of the population. Although over 200 hours are devoted to public health training for medical undergraduates, teaching is unfocused, fragmented, and includes little epidemiology—the core subject for public health physicians. Teaching is mainly through long lectures with few group discussions. Student participation and motivation are low. As well as recommending redesign of the curriculum, Moore and Dixon suggested training in teaching methods for teachers. They also suggested that postgraduate training in public health should begin and should be targeted at hospital managers, teaching staff, and existing public health physicians.

As the tiny Baltic state of Lithuania enters a third year of independence from the former Soviet Union its population faces overwhelming public health problems which are the legacy of the previous regime. As in western Europe, the major causes of mortality in Lithuania are cardiovascular disease, cancers, injuries, and poisonings.¹ But the prevalence of associated risk

factors and the incidence of premature death from these conditions are all much higher.

Lithuanians smoke more, drink more alcohol, eat a less balanced diet, and exercise less than their western European neighbours.¹ Pollution of air, soil, and water is greater, and an estimated 30% of the population are working in hazardous conditions.¹ Lithuania spends only 3.75% of its gross national product on health care per year (about 300 roubles, or £1, per head),² and despite the potential for primary care to control the demand for hospital services almost 75% of this budget is spent on inpatient care³ and less than 5% on preventative programmes.

More recently the devaluation of the rouble has led to sharply rising prices, increasing the costs of drugs and equipment, triggering staff demands for higher pay, and causing hospitals to run out of money. Policies introducing market forces into the health care system have caused further organisational turbulence. There are few people with the skills to manage such huge changes or to develop strategies to improve the health of the population.

Public health skills

In the United Kingdom concern about the management of public health problems led to the report by the Acheson committee in 1988.⁴ This report highlighted the importance of public health skills and set out

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