Opportunities and limitations of patient choice:
the case of the Russian Federation

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While many countries have increased the opportunities for patient choice of provider, there is debate to what extent this has had positive effects on efficiency and quality of healthcare provision. First, some conditions should be met to exercise such choice, of which the most important is the provision of reliable data on providers’ performance to both patients and physicians as their agents, as well as increasing primary health care (PHC) providers’ involvement in realization of patient choice. Second, expanding patient choice does not always lead to efficient allocation of resources in a healthcare system. This article explores these controversial developments by using empirical evidence from the Russian Federation. It shows that choice indeed has value for patients, but there are many areas of inefficient choice, which leads to misallocation of healthcare recourses. Thus, health policy in this area should be designed to ensure a reasonable balance between objectives of expanding choice and promoting more efficient organization of healthcare provision. Political rhetoric about unlimited patient choice may be useless and even risky unless supported by well-balanced programmes of supporting and managing choice.

Keywords Patient choice, health policy, Russian Federation, primary health care

KEY MESSAGES

- Expanding patient choice in health care is justified by economic theory, but in practice does not always lead to efficient resource allocation if it is not accompanied by appropriate structural changes.

- The empirical evidence from Russia shows that certain conditions must be in place for consumer choice in health care to be efficient, with the most important being a strengthened co-ordinating role of the primary healthcare provider.

Introduction

In the last 15–20 years, many Western countries have expressed interest in expanding patient choice with the aim of improving the performance of their health systems, while trying to maintain the balance between equity, efficiency and cost (Maynard 1994; Bevan and Van de Ven 2010; Bevan et al. 2010). The main expectations of wider choice are shorter waiting lists, promotion of competition among health providers and the overall enhancement of quality of and access to care (Or et al. 2010).

Countries with transitional economies, such as the Russian Federation, have also placed this task as part of the health system reform agenda. The healthcare system in the Soviet Union historically developed in a way that had few opportunities for patients to choose a medical facility and the doctors who work there. The ambulatory sector was dominated by large multispecialty polyclinics that attended to patients based on the geographical assignment. Until recently, there were no independent physician practices that competed for patients with other practices. Individuals used to receive care in the medical
organisations located in their administrative area. The various levels of medical care were co-ordinated according to a rigid referral system (Davis 2010).

In the early 1990s, after the breakup of the USSR, the Russian healthcare system underwent significant changes: decentralization of government management, introduction of the mandatory health insurance system and permission for healthcare providers to charge for certain medical services in addition to or instead of free-of-charge services (Popovich et al. 2011). These changes created some opportunities for patient choice of the medical facility and the provider. However, these opportunities are primarily tied to paid services; the choice of free (‘at the point of use’) medical care is still limited.

The economic crisis and the reduction of government financing of health care during the transition period from the central planning to the market-based economy resulted in the lower quality of care (Andreev et al. 2003). The state began implementing policies that encouraged patient choice of both the practitioner and the healthcare facilities so as to increase access to medical organizations that provide higher quality of care as well as to promote competition among providers that will enhance efficiency of the whole healthcare system.

The recently implemented policies aimed at increasing patient choice (2010–11) have prompted a number of questions. What is the real span of the existing opportunities for choice of healthcare providers in Russia? Does greater choice always lead to higher quality of care and the increase in the effectiveness of resource use in the healthcare system? What are the conditions for increasing its positive impact on the performance of the system?

This article attempts to answer these questions by exploring the opportunities and limitations of expanding patient choice of health providers in the Russian Federation. The choice of payers is not considered here since in the context of the mandatory health insurance system in Russia such choice does not affect opportunities for the choice of providers, due to the absence of selective contracting (Sheiman 2007).

The first section discusses the conceptual issues of patient choice, including its limitations and its impact on the performance of the health system. The concept of inefficient patient choice, as understood in this article, is presented. The second section reviews the empirical evidence of the opportunities for patient choice in the Russian Federation and explores the areas of inefficient choice. The third section discusses the reasons behind the situations of inefficient choice in the Russian healthcare system. The final section presents health policy options to facilitate choice and enhance its positive impact.

**Conceptual issues in patient choice**

The process of choice can match patients to providers that best meet their needs, as suggested by the economic theory. It can also encourage competition of providers to improve quality of services as perceived by the patient. For this to work well, it must be based on patient’s knowledge and on a payment system that rewards providers for attracting patients. However, there are some barriers to patient choice, which can also hinder its positive impact on consumer utility and social welfare (Mooney 1994; Smith 2009).

The major limitation to patient choice and related access to high quality care is the informational asymmetry between the patient and the provider of medical services. A patient’s awareness of the expected product is limited, and the search for providers requires the costs of time and sometimes money (Hsiao 1995). The higher these costs are, the lower the potential for choice and competition among providers is (Dranove and Satterthwaite 2000). This limitation is further complicated by the special role of a physician as the agent of the patient. A physician, particularly a general practitioner (GP), not only provides care but also takes on the responsibility to organize and co-ordinate care at other stages of service delivery.

There are many challenges to implement the role of a perfect agent by the physician, one being the lack of information about alternative providers of care. What makes the physician–patient relationship even more complex is the presence of multiple sources of uncertainty that complicate decision making on both sides (McGuire 2000). Thus, additional information on the performance of alternative providers and the outcomes of services is needed not only for the patient but also for the physician as the agent of the patient. Information is a tool not only to increase the awareness of a patient but also to strengthen the function of a physician as the informed guide of his patient’s care process. This function is presumed in most health systems but is not always regulated and motivated.

Local monopolies, particularly in the hospital sector, and limitations to cross-border flows of patients also create barriers for patient choice (Gaynor 2006). The last factor plays out differently depending on how the health system is organized. The decentralized systems (e.g. the traditional Scandinavian health systems) tend to have closed networks of medical organizations serving primarily the local population. Rigid administrative dividers between territorial units limit the expansion of cross-border flows of medical services, and thus constrain patient choice. In countries with a more centralized system (e.g., France), the hospital capacity is planned regionally or centrally to serve the inhabitants of many regions. This enhances the interregional mobility of patients and widens their opportunities for choice. Therefore, an important condition for expanding choice is removing the obstacles for the flow of patients in traditionally decentralized health systems through the centralization of resources planning and regulation (Saltman and Vrangbek 2009).

Low capacity of providers may become another significant barrier for patient choice and access to the desired providers. When the capacity is limited, patients have to wait long even when they are formally allowed to access a preferable provider. To expand the capacity of the latter takes time and sometimes requires a redistribution of resources. The ability of the purchaser of health care (health authority, insurers, etc.) to plan and implement this redistribution according to patient preferences and providers’ performance indicators is another opportunity to enhance patient choice.

Related to the problem of limited capacity of the providers is the problem of the role and frequency of patient choice in various subsectors of the health system. Conceptually, we can assume that choice is more important in the areas with more substantial variance in providers’ capacity in terms of modern medical technology use. In relative terms, hospitals are more
The impact of patient choice on the performance of a health system is still a highly debatable area. There are two opposing approaches in the economic literature. The first approach is based on the neoclassical theory assumptions of individualism and rationality, thus acknowledging the unlimited choice as a positive characteristic of the healthcare market. Choice allows an individual to minimize new expenditures and to maximize utility, which leads to the optimal allocation of resources. Choice is also a driver of competition, which, according to the economic theory, leads to efficiency. Patient-driven healthcare models call for abolishing all network limitations of patient choice, including a general practitioner as a gatekeeper and other forms of managed care (e.g. Le Grand 2003, 2007; Porter and Teisberg 2004).

The second approach does not deny a value of choice but warns that it is costly and may be harmful for a healthcare system and social welfare if it aggravates the fragmentation of service delivery and creates new areas of inequity. The major advocate of this approach in the USA is Alain Enthoven who calls for selective contracting and closed systems of service delivery with the central role of primary healthcare providers funded on a capitation basis (Enthoven and Tollen 2005). In the UK, the reservations about expanding patient choice are usually based on the fear of aggravating equity problems (Le Grand and Hunter 2006) and emerging problems of implementation (Thomson and Dixon 2004; Fotaki 2006; Brereton and Vasoodaven 2010).

Another point of view on the controversial impact of patient choice is discussed in the literature on the organization of health care. Many WHO papers warn that the systems without general practitioner-gatekeeping function are more vulnerable to duplication and fragmentation of services, as well as the lack of the continuity of care (Ettelt et al. 2009). Empirical studies overwhelmingly show that primary health care (PHC) capacity significantly affects the demand for specialized care, and consequently the need for patient choice (see, e.g. Atun 2004). In addition, general practitioners in their role of guides of health care can make the choice more appropriate if it is based on their awareness of the best providers of specialty care.

The implementation of the policies to enhance patient choice in the Western countries brought about ambivalent results. On the one hand, these policies created new opportunities for patients to receive medical care and make providers more responsive to the patients’ needs. The most prominent example of this is the strategy of expanding choice implemented by the UK National Health System (NHS) from 2006 after a series of pilot projects. The data from the monitoring and evaluation conducted by the UK Department of Health show that in 2008 ~46% of patients were offered a choice of hospital for consulting with a specialist and undergoing the initial screening, while only 30% had such an opportunity in May 2006. When choosing a hospital, 48% of those surveyed use the recommendation of their general practitioner, and 13% used the information from the NHS brochures and the Internet (Dixon 2009). The NHS electronic referral service was created as part of the ‘Choose and Book’ programme that was launched in 2008. It gave patients an opportunity to choose hospitals that had beds for new patients and lower waiting periods (Brereton and Vasoodaven 2010). This programme significantly contributed to the reduction in waiting periods for some medical services, such as elective knee replacements, hip replacements and cataract surgeries (Cooper et al. 2010). About 76% of those who were offered the choice were satisfied with the waiting time to receive inpatient care (Brereton and Vasoodaven 2010).

The widening of the opportunities for patient choice of medical care providers led to the increased market pressure on the hospitals and thus to the development of the entrepreneurial culture among hospital management and marketing of hospital services. Hospitals are increasingly making available the information about the positive outcomes of their services, highlighting the aspects that are most understandable to the patients and especially the general practitioners who are the ones prescribing the hospital services. Hence, the hospitals’ marketing strategy is primarily targeted towards the general practitioners (GPs) (Greener and Mannion 2009).

On the other hand, up to date there is no evidence that policies of expanding patient choice have an effect on the creation of competition among hospitals on the basis of their clinical activity and on the reallocation of resources according to the consumer demand. In the NHS, these policies were initially affected by the internal resource allocation limitations. The purchasers of medical care did not have enough capacity and incentives to distinguish the signals coming from patients in the context of the centrally financed health care (House of Commons 2010). Moreover, there is evidence that a large portion of patients does not understand the substance of clinical indicators or does not trust that information (Bevan 2007) and, hence, does not evaluate hospitals according to the parameters of their clinical effectiveness. A survey of literature, conducted by a group of researchers from the University of Manchester, showed that patients are more likely to choose a provider in cases when this choice is motivated by long waiting periods at the local healthcare facilities. Thus, the information about waiting times is in highest demand (Fotaki et al. 2006). The complexity of individual patient choice is still underexplored and requires a multidimensional approach, including the use of psychoanalytic concepts of choice and patient–physician interactions (Fotaki 2006).

The opportunities for patient choice depend greatly on the GPs or referring doctors. There is evidence that some physicians do not offer patient choice because they either think patients are not interested or do not use the information available but rather their own networks (Rosen et al. 2007; Kings Fund 2010).

The policies of expanding choice may have ambivalent impact on access to health care and equity in the utilization of medical services. Better educated people are more likely to choose a provider. Families that are worse off often respond that they are satisfied with their local hospitals and are not likely to seek an alternative (Fotaki 2006). Dixon and Le Grand (2006) show that extending patient choice may increase inequity, decrease it or leave it unchanged, depending on various parameters of demand and supply of health care; they propose...
a package of supported choice whereby individuals from lower income groups would receive assistance in making choices (Dixon and Le Grand 2006).

It is worthwhile to note that not all Western countries have introduced choice, and some (Germany, France, Switzerland, Austria, i.e. the social health insurance systems) already had substantial choice of provider for patients and the inefficiencies that come with these. There is the evidence that the number of physician visits per capita, hospital admission rates and share of health expenditure in GDP are substantially higher in the countries with no GP gate-keeping function and no specialist care control (Sheiman et al. 2012). Some of the countries in this group, such as France, are gradually moving away from ‘too much’ choice as the way to enhance integration of care, make duplication of services lower, and, thereby, to curb cost escalation (Ettelt et al. 2009).

Overall, researchers are reserved in their evaluation of the programmes to expand choice. Their main arguments are that the population underuses the new opportunities for choice, the information needed for choice is limited, and the market incentives for hospitals are still weak. In our discussion of the contradictory results of promoting greater choice, we emphasize that patient choice can lead to the misallocation of resources emanating from three main factors.

First, such misallocation may be an outcome of what is described in economic theory as the specificities of the markets for medical care: highly differentiated product of hospital care and lack of consumer information about its characteristics. In addition, as mentioned earlier, patients are more likely to compare hospitals not according to their clinical outcomes, but by their service characteristics such as waiting times. Therefore, patients may end up choosing the providers who have higher costs of obtaining similar clinical outcomes. Empirical studies of the impact of competition and choice in the hospital sector in the USA and the UK note the weak capacity of patients to evaluate quality of services and to choose the optimal combination of quality-price-accessibility of providers. They are particularly relevant in the situation of unregulated prices [for reviews, see Gaynor (2006) and Sheiman (2007)].

Second, misallocation of resources may arise when a patient chooses a provider whose role in the multilevel system of care does not correspond to the patient’s severity of condition. For example, a patient who does not require hospitalization may use inpatient care while his illness could be successfully treated in an ambulatory setting. Another example is a patient with a relatively uncomplicated condition choosing a highly specialized tertiary care facility for treatment—such choice would necessitate the use of relatively costly resources.

Finally, the choice of providers made by patients independently may lead to the difficulty in co-ordinating the care received by the patient from different providers involved in treating his particular condition, and thus to the weakening or loss of the appropriate sequencing of care. The resulting breakdown in the order of treatment may cause greater resource use at the subsequent stages of treatment.

To identify the situations when patient choice may lead to the misallocation of resources, we propose a term ‘inefficient choice’. We can identify two types of processes that affect the expansion of the inefficient patient choice in health care:

- The rise in the specialization of medical care: it adds to the differentiation of hospital ‘products’ and increases the costs of obtaining information about these products and comparing them. This further complicates the multilevel structure of medical care and increases the probability of situations in which individuals choose a highly specialized tertiary care facility to treat relatively simple conditions. It also raises the costs of co-ordination between various specialized providers of medical care and lowers the opportunities for the proper sequencing of care.

- The weakening of the healthcare governance systems, accompanied by the expansion of patient choice—together, these processes may lead to the breakdown in the co-ordination structures that oversee the activities of various providers such as referral systems from one stage of medical care to another and information exchange between different medical specialties. Inefficient choice is more likely to occur in this context.

The first type of process, specialization, is a mainstream aspect of the healthcare system development and thus becomes a long-term factor that creates the areas of inefficient choice. The second type of process mentioned earlier is typical of transition countries, which in the 1990s were undergoing a complicated and not always successful search for new models of healthcare governance.

Finally, to conclude the discussions of the conceptual foundations of patient choice, we make one final observation. In the literature on this topic, choice is usually understood in the context of economic theory and assumes that the patient has information about two or more possible providers of the needed medical care so that the patient can make an informed decision when selecting a physician.

However, in reality there are situations when the patient does not know where he can get appropriate care and is forced to find a physician and medical organization that can treat his condition. Such a situation should be labelled as ‘patient search for providers’ rather than patient choice. A type of choice arises when a patient is not satisfied with the services of the physician or the medical organization he has been treated by in the past and would like to switch providers, but does not know which one to choose. The search can lead to choice when the patient obtains information about more than one possible provider that he can choose from. However, the search may end with the identification of the first provider who can treat him.

In this case, search and choice are different.

Situations that create patient search are often the consequence of the distortions in the organization of the healthcare system, including the deficiencies of informing the patients about the opportunities to receive the needed care. Can search lead to inefficient allocation of resources in the healthcare system? Yes—similarly to the situations of inefficient choice, during the search process a patient may use resources that are more expensive than are objectively necessary. The search process has a greater likelihood than choice to result in the loss of the proper sequence of care at different stages. The case of the Russian health system provides an illustration of the
Empirical evidence of patient choice in the Russian Federation

Context of patient choice

From the USSR, Russia inherited a multilevel system of health care with clearly defined roles for each level of providers. The key element of the traditional Semashko model is the correspondence of the level of treatment with a patient’s health status at each stage of care: primary healthcare providers refer a patient to a chain of hospitals of various technical capacities, intensities and levels of healthcare specialization (i.e. rural, central rayon, city, regional and federal hospitals, plus numerous specialty care facilities). Despite having to operate under poor funding conditions, this system was able to provide a relatively efficient allocation of limited resources. However, its downside was the limitation of choice. A patient could receive care only under a referral from a previous level provider (Davis 2010).

Reforms of healthcare finance and provision in the early 1990s were conducted in the context of a substantial decrease of healthcare funding. Even now when the economic situation is much better, the health sector is severely underfunded. In 2009, public health spending was only 3.5% of the GDP, complemented with 1.9% of private spending, which is much lower than the average for the Organisation for Economic Co-operation and Development (OECD) countries in 2009—6.9% and 2.7%, respectively (OECD 2011). However, the legislative acts and the white papers produced by the government in the last two decades have repeatedly emphasized the right of patients to choose a health provider. The law on health insurance enacted in 1991 states that citizens have the right to choose a medical organization and a physician in accordance with the existing contracts with medical organizations under mandatory and voluntary medical insurance programmes. As regional mandatory health insurance schemes include practically all local providers, the choice in theory is practically unlimited.

Apart from political slogans about the need to ensure patient choice, practically nothing has been done to facilitate such choice. There are plenty of formal and informal barriers to choice—quotas for admissions to more advanced federal hospitals, informal payments for admission, limitations of choice to local providers only, etc. After a large-scale decentralization of healthcare governance in early 1990s, each local community tried to build an isolated network of providers with limited opportunities for patient flows from neighbouring communities.

A referral system has survived but has been impaired in most of the administrative areas of the Russian Federation (89 regions). The referral system has become less clear for both the patients and the providers. Thus, in practice the specialists at the polyclinics began to accept not only the patients that were referred to them by the general practitioners, but those without referrals as well. Hospitalizations in non-emergency cases became possible without the referrals from the polyclinics that the patients are assigned to.

In the last years, there is a positive trend to move away from written declarations about unlimited choice to real attempts of making choice the instrument of health policy implementation. The law ‘On the fundamentals of health protection for the citizens of the Russian Federation’ adopted in November 2011 attempts to put into practice the parameters for choice of a healthcare organization and physician. The law establishes the right to choose a primary healthcare facility once a year and then to choose a district physician or a general practitioner within that facility. The choice of a specialist for ambulatory care is carried out under either a referral from the primary healthcare provider or by patients themselves with specific procedures yet to be determined.

Empirical evidence on the patient choice of physicians and medical organizations was collected under the research project conducted by the Higher School of Economics (Moscow) and the Levada Center at the end of 2009 (Sheiman and Shishkin 2012). The data used for analysis are based on a sample of 1600 individuals aged 18 and above who were asked about choice of providers. The sample is representative of the Russian population in terms of age, sex, education and rural inhabitants, and the size of local areas. The data on the choice of outpatient care providers were collected for the period of 2 years prior to the time of the survey, and the choice of inpatient care setting—3 years. The survey provides empirical data on the value of patient choice, frequency of choosing outpatient and inpatient providers, readiness to pay for chosen care and information for choice.

Value of choice

This research project showed that the right to choose a practitioner and healthcare facility is valued by the Russian population overall. The majority of those surveyed disagree with any limitation of patient choice in the system of publicly funded health care. In response to the question, ‘Do you agree that in the context of free medical care the right of the patient to choose a physician and medical facility can be limited?’, 64% of respondents answered ‘no’. However, a quite significant portion, 24%, agreed. The latter groups included the better-off respondents who more often than others use the paid services. The disagreement of the majority of the respondents with the possibility of limiting choice may be more indicative of the protest-like wish to keep the current parameters of choice rather than a real concern about limiting it.

Existence of situations of independent search and choice of providers

Despite the high value of the opportunity for choice, the practice of patient search and choice of a practitioner and healthcare facility has a small, but not a marginal, presence in the Russian healthcare system. It should be noted that in this research project there was no differentiation between the situations of choice and situations of search for a medical provider. Thus, in the description of results the term ‘choice’ is used broadly and encompasses the situations of search.

The survey results show that:

- 5% of respondents changed their regular outpatient facility (usually the local polyclinic) over the last 2 years;
- 12% of those who used outpatient care over the last 2 years selected an outpatient facility or a physician in its staff;
18% of those who used inpatient care over the last 3 years selected a hospital.

These findings indicate that the incidence of choice in Russia is much lower than the available figures on the incidence of choice for the UK (share of patients that was offered a choice of hospital), mentioned earlier from the Dixon (2009) study. The relatively higher frequency of choosing a hospital may be attributable to a higher variation in hospitals in terms of their technical equipment and the staff competence (compared with polyclinics). Patients tend to choose based on the available resources (rather than quality), which are easier to assess in a country with a highly hierarchical health system. Thus, the hypothesis of a higher frequency of patient choice in the hospital sector is confirmed for the RF.

**Out-of-pocket payment as a factor of choice**

Only 21% of patients who made some choice were looking for free outpatient care and 33% for free inpatient care. Accordingly, 22 and 9% were looking for paid health care. More often, the respondents were choosing a provider, looking for free care if possible, but willing to pay ‘if need be’—44% and 46%, respectively, for outpatient and inpatient care.

Thus, in the mind of most of the population choice is connected in one way or another with the need to pay for it.

**Choice under information constraints**

Among sources of information about physicians, recommendations from relatives, friends and acquaintances who are not part of the medical profession is the most common—40% of respondents use this source when choosing a specialist, and 20% when choosing a hospital.

Only 23% of respondents used the recommendations of their current physician or the urgent care doctor when choosing a specialist; over half (55%) used these recommendations when selecting a hospital. Publicly available information (media, flyers and other printed advertisement, etc.) was used only in 4% of cases of choosing a specialist and in only 0.5% cases of choosing a hospital. Thus, in most cases, the choice was based not on reliable sources of information, but on the informal channels of hearsay. Such informational base for patient choice may lead to inefficient choice and misallocation of resources.

**Areas of inefficient choice**

The results of the research have findings that provide indirect evidence on the inefficient choice of providers of medical care. About 19% of patients who had to search or select a specialist decided on their own that they needed a consultation or treatment by a specialist without a referral from the primary care physician. Such visits to the specialist without consulting with or a referral from a general practitioner creates preconditions for the inefficient resource allocation driven by the growth in demand for specialist services, a part of which could be satisfied by the GPs. The same proportion of patients (19%) of those who had to search for a specialist was referred to specialty care, but not to a particular doctor. The patients had to look for a specialist on their own, without the appropriate support from their primary care physician.

About 30% of patients who chose a hospital for an elective admission did not have a referral. Non-emergency hospitalization without a referral from a GP or a specialist results in treatment at the level that does not correspond to the severity of the treated condition. The choice of an inpatient care facility to a large extent is focused on getting into a regional or a federal hospital, which provide mostly tertiary care. Out of those choosing a hospital for elective admission, 41% ended up choosing a regional hospital and 9% went to a federal medical centre. The other half of the patients made a ‘horizontal choice’, i.e. chose a hospital with similar functions and capacity levels.

**Evidence of the impact of inefficient choice**

The inefficiencies in service delivery, which are closely related to the inappropriate patient choice, were revealed in the survey of healthcare providers conducted by the Higher School of Economics (Moscow) and the Levada Center (Kolosnitsina et al. 2011) at the end of 2009 in three regions of the Russian Federation. The sample included 1598 respondents, including 791 physicians, 761 nurses and 46 directors of health facilities of various types (polyclinics, local, city and regional hospitals).

The survey was focused on the performance dimensions of the healthcare providers and was not designed to identify the direct impact of patient choice on the increase in quality and efficiency of health care.

The survey responses give evidence of low continuity and coordination of health care. Primary healthcare providers were asked about the availability of information on their enrolled patients’ use of medical services in hospitals. Only 25% of district physicians respond that they receive information about all hospital admissions of their chronic cases; 57% receive this information only rarely and 18% do not receive at all. Thus, most of the primary healthcare providers know little about their patients and are not ready for the follow-up care after the discharge from a hospital.

About 51% of hospital physicians assess that at least 30% of admissions are inappropriate (i.e. can be treated in outpatient settings); 20% of physicians say that this share is more than a half. The reasons for these are manifold, including incentives for hospitals to admit as many cases as possible since in most regions of the country, a shift to performance-based reimbursement method has not been accompanied by setting a financial cap. Limited insurance benefits for outpatient drugs also create strong incentives for patients to be admitted. But unmanaged patient choice contributes to this, making the problem of inappropriate admissions very relevant. The average admission rate in the RF is 23.7 per 100 residents in 2009, whereas this number for the EU is 15.8 (OECD 2011).

**Reasons for inefficient choice**

The analysis of situations of inefficient choice of providers in the Russian healthcare system shows that the main cause for such choice is not the legal expansion of opportunities for patient choice, but the changes in the organizational structures of medical care and the quality of care that occurred during the transition period.

The cutbacks in the government financing of health care in the 1990s by 37% in real terms over the period of 1991–98 (Rozhdestvenskaya and Shishkin 2003) and the permission for medical organizations to charge for services essentially
led to the removal of the requirement for a referral from the treating physician when transitioning to a higher level of care.

The decrease in the financing also led to the reduction in the real wages of physicians compared to the Soviet times. These conditions weakened the stated requirements from the healthcare officials and managers of medical organizations about the level of qualification of medical personnel, the need for professional retraining, acquisition of new professional knowledge and the maintenance of the existing rules of co-ordination of care between various stages of care. The responsibility of physicians for the management of the transition of their patient to a different level of care when necessary as well as for informing the patient about opportunity of receiving this care was significantly weakened or even removed. This process was not a result of the official withdrawal of the existing standards guiding medical care, but was an unintended consequence of the decreased financing of the healthcare system.

First, there was a weakening in the requirements of professional qualifications of the primary care physicians and their co-ordinating role in the system of medical care. A shift to the general practitioner model, common for most Eastern European countries, has not happened in Russia. The number of general practitioners is only 0.7 per 10,000 residents in 2010 (Rosstat 2011) compared with the average of 8.2 for the EU (WHO 2012). The major provider of primary health care is a district physician (different doctors for adults and children) who works at the same polyclinic as certain specialists. The functions of district physicians are much narrower compared with a GP: they deal with a very limited scope of simple conditions and are not allowed to provide specialty care even if they can. The competency of such physicians is questioned by many residents, particularly in urban areas. According to the national survey conducted by Roszdravnadzor (an agency reporting to the Ministry of Health) in 2009, 63.4% of respondents were unhappy with their district physician, whereas only 14% were satisfied with their services (Seregina et al. 2009). The lack of trust in primary healthcare providers is a major factor of the growing patient search for specialists.

The findings presented earlier on the sources of information that patients use when selecting a provider indicate that there are serious deficiencies about the supply of information. The expansion of patient choice that happened during the post-Soviet healthcare system was not accompanied by the development of the appropriate information systems so that the patients can make an informed choice. Patients have lost the old benchmarks (what they were and were not entitled to) but have not gained new ones.

The expansion of consumer choice in health care acted as a catalyst of negative changes in the organization of medical care. They led to the loss of a structured approach to the clinical activities; the stages of care are broken down into unconnected episodes. For example, an individual with asthma can freely go to any physician, and each would treat the patient according to his specialty, while none is held responsible for the worsening of the symptoms and the subsequent hospitalization, which raises the overall medical care expenditures.

**Implications for health policy**

The empirical evidence presented earlier indicates that there is a substantial need for carefully managed patient choice in Russia. The opportunities for choice exist, but some forms of patient choice can hardly be considered appropriate in terms of impact on the health sector. New inefficiencies arise from duplication and the lack of co-ordination. Therefore, promoting patient choice by the Government should be accompanied by managing health care and making choice less enforced and more manageable. Described below are some important preconditions.

The discussion earlier reveals the limited opportunities for patients to make informed choices. This would include access to meaningful and reliable data, as well as information through the treating physicians and/or gatekeeping (i.e. when the physician chooses on behalf of the patient). There is also the question of where these data should come from and who should be responsible for providing them and for ensuring they are reliable. Would this be the state, some other authority, or the providers themselves? If this is to be the responsibility of providers, how can it be ensured that the information they provide is reliable and objective, given that providers have a self-interest and have every incentive to ‘tweak’ them? Thus, the supply of the easily accessible and reliable data is a special problem, which still has no clear resolution.

The studies of patient reaction to the hospital performance information in the European countries (Bevan 2007; García-La Calle 2008; Wubker et al. 2008; Brereton and Vasoodaven 2010) allow us to suggest that patients do not react strongly to the clinical information, but are more sensitive to the data on non-clinical aspects of hospital activity (primarily, waiting times) as well as the indicators of patient satisfaction with the results of treatment they had received. In the Russian context, it is reasonable to assume that the non-clinical indicators will play a greater role than the clinical information that is less trusted and understood. However, the availability of even the non-clinical data would make the choice more justified compared with the current situation revealed by the survey.

The survey indicates that patients choose providers without much involvement of their primary healthcare physician; this leads to inefficient choice and causes the redundancy in care and raising costs for both the government-funded care and the cases where patients choose to pay for care. In the Russian context, the involvement of a primary healthcare physician in facilitating patient choice is critical. This implies creating detailed legislative requirements for the provision of provider alternatives for patients by a physician. Recommendations about such alternatives should be based on the information on the performance indicators of hospitals and hospital doctors, which should be available to every primary care physician.

An example of the participation of the primary healthcare physician in realization of patient choice is provided by the British NHS strategy to expand choice. A patient can receive care at a chosen hospital based on a referral from a PHC doctor, but this doctor is obliged to offer alternative options, while the choice belongs to a patient. The latter can use this recommendation or make his own decision based on the available information. In addition, patients can choose only a clinically
justified provider, taking into consideration the correspondence of the nature and complexity of his condition to the profile of the chosen medical organization (Department of Health 2008a,b). In other words, the choice is realized through the traditional referral system, but in the context of the requirements for doctors to provide treatment alternatives. The references to the low competency of district physicians revealed in the survey presented earlier may serve as a warning that their gatekeeping function in a traditional meaning may be limited. In the initial stages of the implementation of the new role of primary care physicians it is reasonable to allow free choice of a certain category of specialists at outpatient facilities without a referral from a district physician. The list of specialists should be narrow and determined with consideration of the qualifications of the PHC physicians. Keeping in mind the relatively low trust in district physicians, it makes sense to allow open enrolment to specific categories of specialists working in outpatient settings (e.g. an endocrinologist for diabetes cases). This may serve as a transitional alternative—with the return to gatekeeping function of district physicians after gaining new competence and experience. The list of specialists with open enrolment could include the specialists who deal with specific chronic conditions. Another way to facilitate patient choice is to promote multispecialty chronic disease management programmes with the opportunity for patients to select this programme.

For the patient choice to become a significant factor in raising the efficiency of health care, it should be carried out in conjunction with other major structural and economic reforms, with the central change being the increase in the role of the primary care physicians and the intensification of the integration of separate stages of medical care.

Conclusions

Conceptual analysis indicates that patient choice may serve as an instrument of enhancing quality of and access to health care, but it might be ineffective, leading to misallocation of resources in health care. Empirical data on patient choice in the Russian Federation suggest that choice is popular with patients. Extension of patient choice is considered by people as a better alternative to state bureaucracy in assuring access to quality health care. However, there is no available data that might be used for verification of influence of patient choice on the increase of quality or efficiency of health care.

On the contrary, empirical evidence indicates that in the Russian Federation there are many areas of inefficient patient choice that lead to care given at a level higher than the severity of the condition being treated. The main factors contributing to the appearance of these situations are the changes in the structure of the medical care system and its quality that occurred during the transition period, as well as the lessening of the requirement for a referral from a treating physician when the patient is moving onto a higher level of care, and, finally, the weakening of the requirements for professional preparation of the medical personnel, and especially the primary care doctors. The 30% rate of elective admissions without referrals of primary care providers is a clear message that choice should be managed and regulated. If it is not done, new opportunities for choice can be counterproductive. They will lead to higher costs and inefficient care.

Thus, the challenge for healthcare policy is to ensure a reasonable balance between the value of choice and the requirements of efficient organization of healthcare provision. This is particularly true for the countries in transition where health systems are still being reformed. Political rhetoric about unlimited patient choice may be useless and even risky unless supported by well-balanced programmes of supporting and managing choice.

Endnotes

1 This article is an output of a research project implemented as part of the Basic Research Program at the National Research University Higher School of Economics (HSE).
2 The Semashko model was the primary structure of the healthcare system in the USSR, named after its founder, Nikolai Semashko.
3 Rayons an administrative centre of several rural areas.
4 See e.g. The Government of the Russian Federation (2008).
6 For more information on the Russian health system, see the recent Russian HIT of European Observatory health systems and policies—Popovich et al. (2011).
7 Federalniy zakon Rossisskoy Federatsii ‘Ob osnovakh okhrany zdorovia grazhdan v Rossisskoy Federatsii’ (2011).

References


