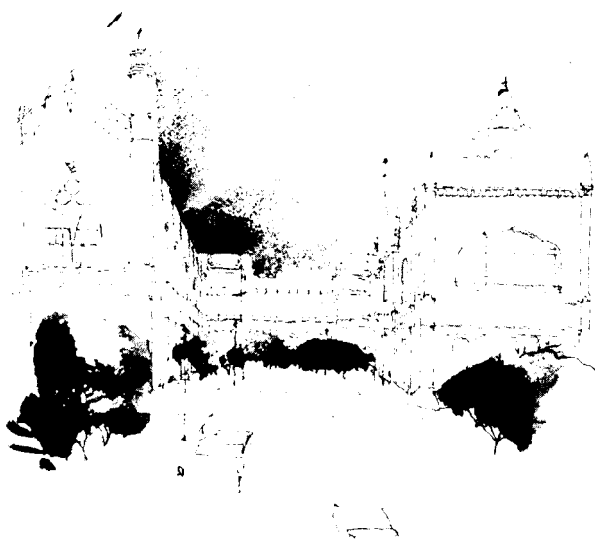


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# Health Services in the USSR

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## Health Services in the USSR

DURING the month of September, 1972, I was on an officially-sponsored trip to the Soviet Union, arranged under terms of the 1958 exchange agreement between the USSR and the USA. My companion on this trip was Dr. Robert Daniels, formerly of The University of Chicago and now at the University of Cincinnati.

The timing of the trip coincided fortuitously with the health exchange agreement which, among others, resulted from President Nixon's visit to the USSR in March, 1972. This particular agreement designated three research areas for collaboration between the two countries: heart disease, cancer, and environment. Dr. Daniels and I were told by Washington officials that we were regarded as the first wave of visitors after this new agreement who were interested in health services delivery systems. My particular interest was, and is, in long-term trend data on the health services indicators paralleling the data in my book on three-country comparisons.<sup>1</sup>

Both the USSR Ministry of Health and the American Embassy in Moscow were informed of our flight and arrival time, and from the moment of our arrival at the international airport in Moscow, at 6:00 p.m. on Sunday, September 3, we were the guests of the Ministry.

On Monday, September 4, we met at the Health Ministry with Dr. Andre Kischelev, the coordinator for official American visitors. On

<sup>1</sup> Odin W. Anderson, *Health Care: Can There Be Equity? The United States, Sweden, and England* (New York: John Wiley and Sons, Inc., 1972).

the basis of what and whom we wanted to see, we arranged to spend three weeks in Moscow and one in Leningrad.

We were primarily interested in the over-all health services structure and operation. This necessitated obtaining a great deal of data as to personnel, facilities, use of services, and financing-preferably long-term trends.

The arrangements were carried out by the Ministry, through Dr. Kischelev, in an exemplary fashion. We had conferences with all the people we wanted to see, and visited hospitals and polyclinics of the types which interested us. Our hosts were open, friendly, and gracious. We visited adult, pediatric, and maternity hospitals, a psychiatric hospital, and the Moscow medical emergency service. Somewhat parallel visits were made to facilities in Leningrad and arranged by the Leningrad Department of Health.

From my own standpoint, the most important visits were those made to the Semashko Institute, the enormous research arm of the Ministry of Health, which deals with research in the organizational aspects of the USSR health system, and which has immense data resources relating to the structure and operation of the USSR health system and research in progress.

We were given a great deal of oral information, whatever literature there was in English, some French publications, copies of the equivalent of the U.S. Statistical Abstract in Russian, and a set of forms used to gather data from the local, up to national levels and processed by a division of the Semashko Institute.

THE PHILOSOPHY, structure, and operation of the health services in the USSR can be understood as they are related to the social, economic, and medical development at the time of the revolution in 1917 and subsequent

plans to reconstruct the country. At the time of the revolution and into the 1920's, circumstances in the USSR differed considerably from those of the developed countries in Europe and North America, and these circumstances shaped a USSR health service system quite different organizationally and philosophically from those of the West.

In 1917, the USSR could be regarded as an undeveloped country relative to the West. Although there were the beginning of an industrial infra-structure and occasionally brilliant medical scientists, both the industrial base and the health services base were grossly undeveloped. The economy was still largely agricultural; illiteracy was high.

The disease picture was like that of Europe in the early 1800's, if not earlier—typhus, cholera, typhoid, smallpox, malaria, and diseases from malnutrition. Infant mortality was reported to be at about the 275 mark (per 1,000 births) when it was about 100 in Europe and North America; the average length of life was about 38 years when it was about 60 in Europe and North America. And, although there was a cadre of physicians, auxiliary personnel, and hospitals, these were hardly equal to the enormous tasks facing the country. It can be assumed that such personnel and facilities as there were, served mainly the small segment of the upper classes and urban areas.<sup>2</sup>

**SUCH WAS** the situation facing the new government when the Civil War ended in 1921 and the Bolsheviks under Lenin assumed full control over the economy and society according to the principles of classic communism. Lenin was sufficiently alarmed by the deplorable health status of the country to remark: "Either

<sup>2</sup> A much more elaborate and well-organized background can be found in Mark G. Field, *Soviet Socialized Medicine: An Introduction* (New York: Free Press, 1967).

the lice will defeat socialism or socialism will defeat the lice."<sup>3</sup>

All means of production, distribution, transportation, and communication and all private property, such as land, houses, and apartments, were appropriated by the state. All workers-professional, white collar, and blue collar-became employees of the state. Salaries were set low and within a narrow range relative to American and European standards, but above the subsistence level at the lowest range and above a bare-amenity level on the highest range.

The salaries of health personnel became, of course, part of this salary structure. Physicians were paid somewhat less than engineers. Skilled and productive workmen on piece-work could earn more than physicians.

The state-owned productive enterprises yielded their profits to the state and there was (and is) hardly any personal income tax in the Western sense. The Supreme Soviet, the legislative body of the government, together with the parallel party apparatus, determined the priorities on which the profits from the enterprises should be spent. Among these priorities, health services were high on the list. A generously proportioned health service, relative to concepts in Europe and North America, was visualized from the start.

Since health conditions in the USSR at the time of the revolution were analogous to those of Western Europe 100 to 150 years earlier, one can see why the state set a high priority on eliminating the scourges with the means that had become available. Public health medicine had lost its dominance to curative medicine in the West; in the USSR, it had higher priority. Curative medicine was not ignored-it received and receives much atten-

<sup>3</sup> Quoted in USSR Ministry of Health, *The System of Public Health Service in the USSR* (Moscow: The Ministry, 1967), p. 23.

tion-but there was and continues to be a pervading concept of prevention, or as it is translated locally, "prophylaxis," which is broader than prevention in the American sense of the term. Prophylaxis not only entails primary prevention by means of immunization, but also constant surveillance and follow-up of population segments and people in certain disease categories. The health system from the start was regarded as an active agent aggressively protecting the health of the people.

The USSR health system was, therefore, naturally established as a unified system combining the preventive (prophylactic) and curative systems under one administration. Although there is a division of labor between, for example, sanitary doctors and primary doctors for ill people seeking care, the system appears to be so interlocked with preventive and curative concepts in the same personnel that it is difficult to differentiate between the two types of activities operationally and financially.

FROM EARLY ON, the health of the people was regarded as a national asset to increase the productive capacity of the country, as well as a condition for a contented population. The health services were conceived and planned along rational lines according to the accepted planning precepts of the medical experts who shaped the system. All enterprises in the USSR are designed by the relevant experts-engineers, educators, physicians, and so on-and the USSR health service, accordingly, was designed by medical professionals.

Professional judgment, in the absence of formal scientific criteria, normally results in recommendations that are relatively generous in the use of resources. In view of the high priority given by the state to health services, professional medical experts were then ac-

corded rather wide leeway. As early as the 1930's, for example, a norm of 10 outpatient visits to physicians per person per year was established for the first five-year plan.<sup>4</sup> This goal was not attained during the first five years, but is now being exceeded. No health system then or now has set goals as high as the USSR. This goal, in 1930, was undoubtedly established by professional expert opinion of the time, since there were then no systematic criteria (they are barely being established now) for such a standard. Professional standards err on the side of safety.

Intertwined with the reliance on experts is the concept of targets and goals. Obviously, health conditions were such during the 1920's that through well-directed public health measures certain types of communicable diseases could be eradicated one by one. Teams of specialists for literally each disease were established. Specialization in health services and in all other fields of endeavor has been developed to an exceedingly refined degree in the USSR. Refined specialization facilitates a very high degree of accountability, a prime characteristic of the USSR economic and social system. It is a system which finds ambiguity and discretion uncongenial to its operations.

From the start, as indicated, the expert was on top rather than on tap, to reverse an old phrase. There was a vast country with vast resources to develop and it must have been and continues to be a heady experience for the expert specialists. There was no place to go but up.

The USSR has a very different social, economic, and political system from those of the liberal-

<sup>4</sup> I. D. Bogatyrev, ed., *Morbidity in Cities and Standards of Care* (Moscow: Meditsina Publishing House, 1967). From a translated manuscript to be published by the Fogarty International Center for Advanced Study in the Health Sciences, Washington, D.C.

democratic-welfare states of Western Europe and North America (or as the Russians call them, capitalistic states), and the health services system reflects in detail the characteristics of the larger system of which it is a part.

The core of the health services system is the polyclinic, the first point of medical contact for the general population. Within the polyclinic area of services there are further population subdivisions into *ustuchoks* (districts) for each first contact physician; i.e., each such physician serves a designated population. The polyclinics are staffed by primary doctors (analogous to internists). All are salaried.

Each polyclinic has its exclusive catchment area in some standard ratio to population. The primary doctors are backed up at the polyclinics by a range of specialists according to a specialist-population ratio. These doctors have no hospital affiliation. There are several types of polyclinics with areas that overlap geographically but not functionally: adult, pediatric (14 and under), and maternity. Each is staffed with its primary pediatric or maternity physician plus supporting specialists.

Hospitals are organized in some sort of gradation by size and complexity with established population catchment areas so that the population base is known and exclusive. Hospitals are staffed on a salary basis by a range and quantity of specialists, according to professionally agreed-on norms. There are specialized hospitals by age and/or disease: adult (15+), pediatric, and maternity; and special conditions, T.B., and mental disease.

In addition, there are specialized dispensary agencies for specific conditions, such as T.B., venereal and skin diseases, and mental disease; other diseases are being added. The dispensaries receive referrals from the polyclinics and/or the hospitals. The concept is one of long-term surveillance of patients with the

particular diseases. Again, the dispensaries have their catchment areas according to some measure of a population base yielding certain types of patients.

**AN ELABORATE SYSTEM** of emergency services has been developed for the larger cities, as a subsystem of the larger system described, but still autonomous as to staffing and operation. There is a central medical emergency service station in each city with a switchboard and operators who handle all calls. A standard number (03) can be dialed from all telephones, home and pay phones, free of charge. The reason for the call is screened by the operator, a trained medical auxiliary (usually a woman), who determines the nature of the call and advises on sending the ambulance or going to the patient's polyclinic, or even on a home call from the polyclinic. Substations are scattered throughout the cities. The emergency system has fleets of ambulances staffed by a physician, two assistants of the *feldsher*<sup>6</sup> grade, and a driver. There are also a few specialized ambulances, such as for heart attacks, with the appropriate equipment.

In rural and remote areas of the country there are district doctor stations staffed by doctors, when possible, with *feldsher* assistants; when doctors are not available, *feldshers* operate the stations and have contacts with the nearest hospital and polyclinic for guidance and supervision.

It is well to mention the psychiatric services. Although they are geared into the larger system described in the foregoing, psychiatric services are a separate service with separate staff and facilities. There are relatively few psychiatric beds (an estimated 10 percent of all beds as against 50 percent or so of all beds in the U.S.). However, the outpatient and

<sup>6</sup> A *feldsher* is better trained than a nurse, but not so well trained as a physician.

day-care services are well developed, catering to a large ambulatory patient population.

Finally, mention should be made of the services provided at the work place by factories, trade unions, and collective farms. There are first aid stations, physical screening stations, and also, apparently to some degree, treatment facilities, and personnel. The places of work finance rest homes, sanatoria, health clubs, and other amenities.

THE HIGH DEGREE of specialization makes the administration of this system seem complicated. On examination, this does not turn out to be so. The Ministry of Health in Moscow is the sole national administrative agency responsible for the entire health services enterprise-service, education, and research-and with its own national budget for the guaranteed basic services supplemented, as indicated previously, by contributions from industry, trade unions, and collective farms for nationally approved projects. The budget is distributed to the 15 republics, presumably on some sort of population basis and according to some criterion of need.

Within the republics the administrative areas are divided into for all governmental administrative purposes, and into regions for health service purposes (**rayons**) with population catchment areas of several hundred thousand people. Each republic has a central administrative agency reporting to the National Ministry of Health. Within the **rayon** each of the hospitals, polyclinics, and sanitary services reports directly to the **rayon** administrative agency for both urban and rural services separately. **Rayons** report to their **oblasts**. Below the National Ministry of Health the budgets are controlled by the Ministry of Health of each republic through the **oblast** level, down to the city level. Projections and planning for the future

presumably take place at all levels, but the over-all planning starts at the rayon level to the obblast, to the republics, and finally to the Ministry of Health.

The Ministry undertakes five-year plans, whereas the republics can engage in one-year planning within the national five-year plan. The ministries on both the national and republic levels are essentially directing and planning agencies; they do not administer services. The *oblasts* and their *rayons* actually administer the services.

All facilities and personnel are distributed throughout the system according to criteria established by expert opinion, guided, presumably, by the resources available and projection of such resources for the future.

AS IN ALL countries, the USSR health service has grown very rapidly, but the USSR growth has been particularly great because of the undeveloped base from which it started after the 1917 revolution. I would guess that along with the educational system (and likely the military) the health services have expanded more rapidly than the economy itself, even though the latter has also experienced rapid growth.

Perhaps 1950 can be regarded as the "take-off" point following the devastations of World War II and subsequent recovery, although there was considerable growth up to 1940.

Expenditures from the national budget (i.e., not including expenditures by collective farm, trade unions, and industry) increased from 3.12 thousand million rubles in 1955 to 7.4 thousand million rubles in 1967, and 9.2 in 1972; 10.7 is allocated for 1973.

The statistics indicate that the USSR spends relatively more than any other developed country on health care personnel, facilities, and use. If we in the United States provided as many comparable units of service as did

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		Per 1,000 Population	
		1950	Latter 1960's
H o s p i t a l	B e d s	5.6	10.0
Physicians*		1 . 6	2.4
M i d d l e - G r a d e	Staff	: . 4	7.3

Hospital admissions increased from 150/1,000 to 201/1,000 in urban areas from 1950 to the 1960's, and from 77/1,000 to 189/1,000 in rural areas for the same period.

\* Probably includes dentists who are regarded as technicians, approximately nine percent of total physicians.

t Includes *feldshers*, nurses, midwives, and lab technicians.

§ All foregoing data from *Public Health Services in the USSR, op. cit.*

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**the Russians, we would certainly have to double and perhaps treble our present \$80 billion rate of expenditure.**

**In urban areas of the Soviet Union (no data were published for rural areas) the number of physician visits per person annually was about seven in 1940, rising to about 10 by the latter 1960's. Visits to pediatric clinics were higher-12 to 15.**

**The number of hospital days per 1,000 population per year is currently about 3,000 in the USSR, as compared with from 1,000 to 2,000 in developed countries of the West.**

**Planned projections expand the current.**

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	Current	Projected
Number of Polyclinics	39,000	more
Polyclinic Population per Primary Physician		
A d u l t	1/2,000	
Child	2/1,000	
Maternity	?	
P s y c h i a t r i c	?	
Polyclinic Population per Polyclinic		
A d u l t	45-50,000	same
Pediatric	15-18,000	same
Hospital Beds/1,000 Population	10.8	13.2
Number of Physicians/10,000	28.3	34.6
M i d d l e Medical/10,000	7.3	10.4

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figures into the fairly indefinite future. Because it was sometimes difficult to differentiate between current data and projections, the above are current figures with future projections where I believed they were given as such.

The emergency medical care services have also been expanding. For a population of eight million in Moscow, currently there are 1,000 physicians and 4,000 middle medical personnel on the staff, plus drivers for 600 ambulances, of which 150 are in operation at any given time. There are five million calls a year, of which two million result in visits. There are 25 geographic posts.

The time interval between call, dispatch of ambulance, if indicated, and arrival of ambulance at site of call is very rapid. Ninety percent of the calls are completed within 15 minutes. More than 97 percent of the switchboard calls that require ambulances are communicated to the ambulance teams within three minutes.

Ambulance physicians are usually young (28-40), are trained for emergencies, and get 40 percent higher pay, longer holidays, and perhaps better housing arrangements. In Moscow most of the physicians are men, in Leningrad most are women, but all *feldshers* are men. They say men are needed for heavy lifting. Calls are increasing every year in both cities.<sup>6</sup>

As can be seen, the orderly assembling of data based on limited publications in English translation and translated interviews have their limitations, but certainly one gets a "feel" for the system which can guide future refinements of data if further research is possible in collaboration with USSR researchers and statisticians.

<sup>6</sup> More details are provided in *Medical Care in the USSR*, report of the U.S. Delegation on Health Care Services and Planning, May 16-June 20, 1970, by Patrick B. Storey, M.D. U.S. Department of Health, Education, and Welfare Publication No. (NIH) 72-60.

THE MINISTRY of Health bears the responsibility of supplying the USSR health service with both facilities and personnel (except rest homes, sanitariums, etc., financed by the collective farms, trade unions, and industry). Various levels of personnel are trained along specialized tracks and are divided into physicians, middle-medical *feldshers*, nurses, midwives, and technicians; the lowest level includes orderlies, maids, and other supporting and maintenance personnel.<sup>7</sup>

All levels are admitted to their various training tracks after 10 years of general education or about the age of 17. From the start, students accepted for training as physicians must commit themselves to one of five specialties, and subspecialties within the respective specialties. Those who go on for postgraduate training are selected later. Unless the students commit themselves to specialties as set up by planning quotas, they are not accepted.

There are 10 applicants for every post (as reported on this trip) and applications can be made to only one medical school. Shifts in specialization after commitment are rare and presumably frowned upon. The tracks are: (1) medical faculty, which includes internal medicine, surgery, obstetrics, and gynecology; (2) pediatric faculty; (3) stomatological faculty; (4) sanitary medicine and social hygiene faculty (public health); and (5) pharmacologic faculty (not to be confused with the training of pharmacists).

Medical training is provided in free-standing schools called Medical Institutes, unrelated to universities. Not all Medical Institutes have all tracks but the majority have the first three listed. Each of the tracks has separate facilities and curricula even though

<sup>7</sup> More detail on medical education in the USSR than being presented here is available in Storey, *op. cit.*, p. 30.

during the first two years the content is similar.

Currently, the training period is six years plus one year more or less analogous to the American straight internship or a "first-year residency." During the internship students potentially can be assigned anywhere in the country depending on openings, and there is stiff competition to get desirable spots which enhance future connections. The more specialized training takes place after the internship and usually after a three-year period of work in an assigned post. Again, I understand that securing the posts is highly competitive, and assignment to undesirable posts is more or less by default.

It can be seen, then, that Russian physicians are ready, in effect, to practice medicine at the age of 24. This is not to say they are general practitioners; there is no such classification in the USSR. All are specialists but, as the saying goes, some are more specialized than others. The more specialized physicians are ready for "regular" posts for which they can vigorously compete at the age of 27. Russian physicians are thus legally practitioners three to four years earlier than American physicians, an important consideration when investing in medical manpower.

The training period for middle-medical personnel varies from one year and 10 months to two years and six months. The pharmacist, nurse, and dentist (stomatologists are physicians) take longer. Thus middle-medical personnel are ready by  $18\frac{1}{2}$  years (nurse) or  $19\frac{1}{2}$  (general feldsher and midwife).

There is no tuition and for the most part there are stipends for subsistence support.

THE MEDICAL establishment-and it can be called that-has major influence on the criteria of supply and operation. As I said earlier, the experts run the economy and various

enterprises. Since high priority seems always to have been given the health services, the medical experts have had a great deal of room in which to maneuver.<sup>8</sup> Physicians may not be paid much in relation to American standards, but they certainly have been accorded professional incentives to build a generously proportioned health services system.

The Ministry of Health apparently formulates five-year plans by coordinating all the recommendations that bubble up from the local areas, particularly at the *oblast* and republic levels. The ministry then projects a plan according to norms set by experts. The norms are applied downward, as it were, but it is likely that the medical judgments on the local level are regarded respectfully if they appear to relate to conditions peculiar to the area such as rurality, disease pattern, and age structure. So much for the administrative level.

On the legislative level, medical judgment also comes into play. The Supreme Soviet of the USSR, like the U.S. Congress, works through appropriate committees. It was reported that there are 30 to 40 physicians who are elected members of the Supreme Soviet and, as a matter of course, the entire committee on health services (10 to 15 members) is made up of physicians! Recommendations from all committees are coordinated in the over-all plan for the country (Gosplan). In this connection, I was unable to elicit the view that there must be a great deal of hauling and pulling at this level among the various priorities. The answer invariably was, "No, we work by expert norms and everything falls into place."

<sup>8</sup>See more details on, at least, the formal aspects of the planning process in: I. V. Pustovoj, "The Training of Medical Staff in Health Planning in the Soviet Union," *International Journal of Health Services* 1:28-36, 1971.

The USSR, like Western countries, is a future-oriented society, but more so. Taking the standard of living of the West as its reference point, the USSR expects that its standard will eventually equal and possibly exceed the Western standard and that goods and services will be distributed more equitably than in the West. The USSR health service is naturally an integral part of this view, and it is expected that it will be "bigger and better." In this regard, it is of interest to note that the USSR health service is already bigger and better distributed than health services in the Western countries. Whether or not it provides "better" services than other countries deserves much more than an impressionistic judgment. Western observers (myself included) can observe that the USSR facilities and equipment are unit for unit (with likely exceptions given the vastness of the system) not up to Western standards. The Russian medical authorities who travel must certainly know this, and most certainly, also, I would assume that in their long-range planning they visualize improvements in facilities and equipment.<sup>0</sup>

So far, the future of the USSR health service is based on the desire for "more," an astonishing goal to Western observers who are now thinking in terms of rationalization, efficiency, cost-benefit, and retrenchment.

The criteria of need and use translated into facilities, personnel, and expenditures as established by professional judgment (or as translated by Russian expert medical opinion from high-level clinicians) have resulted in

<sup>9</sup> Note the statement by Dr. Venediktov who worked for four years in New York with the USSR Mission to the United Nations: "We know that the components of our health service must be strengthened, but we are satisfied with the general relationship among these components. In the United States your components are of extremely high quality, but the proper relationships are not established. We must improve our pieces; you must collect yours." In Muller, *op. cit.*, p. 694.

abundant resources and high use relative to Western experience. (I deliberately selected the word *rather than standards* because in the West there are no systematic standards of use and resources to accommodate this use.) The USSR medical planners, however, have a great deal of faith in the criteria set by experts. Future criteria, however-and already being projected-will be based on scientific findings flowing from a very large morbidity study in various sampling points of the USSR. Expert opinion will still be employed, but with reference to detailed morbidity data correlated with physician visits, physicians supply, hospital bed supply, and so on.

THE USSR GOVERNMENT is investing 17 million rubles (more than \$20,000,000) in a morbidity survey sample population in nine medium-sized cities in various economic areas. Some data have already been published.<sup>10</sup>

This elaborate and expensive survey will lay the factual basis for the indefinite future. Dr. Bogatyrev, the director of the Semashko Institute, is the apparent originator of this really stupendous study, which epitomizes the USSR reliance on and faith in systematic data and expert opinion. The population base in the nine cities is about six million, and a sample of 50,000 patients has been drawn from this base (from surnames beginning with *L* and *K*.)

In addition, 12,000 individuals from the

**10 I. D. Bogatyrev, "Establishing Standards for Out-patient and Inpatient Care," *international Journal of Health Services* 2:45-49, 1972. The survey reported in this article lists five cities in various economic areas. Since the results were publicized in 1968, this study must be a forerunner of the current study in progress costing 17 million rubles. See also: I. D. Bogatyrev and others, "L'efficience Economique de la liquidation de certaines maladies ou de la reduction considerable de leur niveau," *La Sante Publique, Revue Znternationale* 1:43-54, 1972.**

population were selected for physical examinations by teams of physicians. Thus, it was learned what proportion of the population had not sought services in a year, and what proportion had undetected symptoms and consequently untreated diseases. On these data the experts make estimates as to need and optimum demand were the people to seek services for all conditions found. The experts regard this as the proper norm, and long-range plans are being made accordingly.

There were also described time and motion studies of what physicians do which are expected to yield criteria for the number of physicians needed. It was learned that 40 percent of physicians' time is spent filling out forms. This high percentage was not expected. Accordingly, there are attempts to make the forms easier to fill out by check marks, codes, and so on, but apparently not to reduce the amount of information already being recorded. I gathered the underlying rationale was detailed accountability for everything done in the health system.

CURRENTLY, employed people and children have periodic physical examinations. Future plans are to give an annual physical examination to every citizen in the USSR and expand specialized facilities and personnel to enable follow-up treatment and prevention for the entire population. This is called the "dispenserization" movement, a nucleus of which already exists for heart disease, diabetes, and T.B., and possibly other diseases. There will thus be total health surveillance for the entire population leaving hardly anything to the initiative and discretion of the individual. There is a great deal of outreach now, but eventually there will be total outreach. Currently, when patients are asked to return for further treatment and review, records are kept and "malingerers" are checked

out by an automatic filing system daily, and they are followed up.

When the USSR has the resources it feels is necessary, there will and should be 16 visits per person to physicians a year (one-half of them prophylactic), 50 percent increase in physicians as well as other personnel, a 20 percent increase in general hospital beds, and so on.

The **feldshers** currently working more or less by themselves in rural areas will be phased out and replaced by physicians. **Feldshers** will continue to play an important part in emergency medical services, first aid stations, and other supportive roles to the physicians.<sup>11</sup>

I am convinced these projections are regarded seriously and have the support of the highest policy-making bodies. The Soviets have conquered more than lice, and they now intend to conquer disease, or control and manage it to the maximum extent. The intent is to make medicine and medical care so scientific that professional judgment will be drastically reduced. Precise accountability will then be possible and annoying subjective judgment, the bane of planners, will not be necessary. When all agree on scientific criteria, all are free of each other.

FROM A COMPARATIVE standpoint, what I find overwhelming is the seemingly lavish use of personnel-particularly physicians-and the great number of specialized hospitals, beds, and polyclinics, and programs. The result, of course, is a very high use of services compared with Western countries. I am sure that even if we standardized the types of services unit for unit, the extent to which the Rus-

<sup>11</sup> Patrick B. Storey, M.D., *The Soviet Feldsher as a Physician's Assistant*. Washington, U.S. Department of Health, Education, and Welfare, 1972. (DHEW Publication No. CNIH) -72-58, February, 1972.

stetrical-gynecological specialties and in internal medicine, as well as extremely open entry into other specialties.

**HOW DOES ONE** evaluate the health services in the USSR? Well, how does one evaluate any nation's health service? The USSR health services should be judged in the Russian context currently, and in the economic context historically. In those terms the health services come out rather well.

It is a plausible assumption that the Russian amenities in its health service compare favorably with the general amenities of Russian households and hotels. It also seems that the Russians can make dazzling exceptions if they so desire when one experiences their concert halls, operas, and ballets and their subways, airplanes, and express passenger trains.

The opportunity to compare USSR and Western policies and philosophies of health service is indeed fascinating. We in the West would say that the USSR is creating a dependent population by a relatively lavish health system where hardly any initiative needs to be taken by the citizen; the USSR critics would say that we capitalists (welfare state notwithstanding) are withholding services from the people in order to save taxes. It would seem that the USSR health service will give us an opportunity to study the operation and possibly the impact of a near-saturation type of health service. No Western model affords this opportunity.