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MAXIMUM WAITING TIMES GUARANTEE IN RUSSIA: DOES IT IMPROVE ACCESS TO HEALTH CARE?

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The objective of the paper is to explore the role of maximum waiting times targets in improving access to health care in the context of the country with limited financial resources. The study indicates that most of targets in Russia are unrealistically low, while institutional and operational arrangements for their implementation have not been built. Some regions of the country have started waiting times monitoring, but its coverage of providers is still limited. The estimates of actual waiting times are fragmented and unreliable. The lack of waiting time regulation and monitoring encourages the opportunistic behavior of health providers to meet the targets. Uncertainty of patients regarding actual waits is growing. Thus a waiting times guarantee is not a remedy to avoid excessive waiting times. To make it really work, we recommend: 1) to develop realistic targets of waiting times that are based on a careful evaluation of the actual indicators for each type of care, as well as the capacity to meet them; 2) to strengthen waiting time monitoring, including pooling waiting lists/waiting times information in centralized information systems, introducing a unified pattern of waiting data reporting with the clarity on the initial point of waiting times, measuring both completed and on-going waits; 3) to build accountability procedures with the involvement of all actors of health care system.

Key words: waiting times targets, health care guarantee, health policy, health policy implementation

JEL Classification: Z

Introduction

The excessive waiting time for elective services is an important health policy concern in the majority of developed and developing countries. To cope with this, many countries have introduced a wide range of policies, including the establishment of a state guarantee of maximum waiting times in the form of targets that can't be exceeded (Hurst and Siciliani 2005; Kreindler 2010; Siciliani et al. 2013). The expectation is that the guarantee will strengthen the entitlements of citizens and improve access to elective health care.

There is a substantial progress in measuring and comparing actual waiting times in OECD countries (Viberg et al. 2013; Siciliani et al. 2014), but the role of the guarantee is a relatively new issue in health policy literature. The evidence of its successes and failures is fragmented and the number of studies is limited. The study of OECD makes a point that "waiting time guarantees have become the most common and effective policy to tackle long waiting times, but are only effective if enforced" (Siciliani et al. 2013, p.13). The enforcement relates to penalties for the breach of targets – in addition to supply and demand-side policies to increase capacity of health providers and promote competition. The policies of institutional and operational arrangements for the guarantees implementation are much less discussed in the literature, while the importance of these issues is growing. Some countries have introduced waiting times targets but failed to meet them. There are examples of cancelling unsuccessful implementation of targets, for example, in Sweden and Norway in the 1990s (Hunning 2005). The targets for cancer cases are currently debated in England with the major question: what is the point of waiting time targets if they can't be met? (Appleby 2019). Another option is when targets are introduced without accompanying a sound regulation and monitoring with the resulting failure to affect access to care.

Both options are particularly common in countries in transition and developing countries, where the problem of access to care is usually a burning issue, and the government seeks the ways to improve it by setting requirements to waiting lists procedures and maximum waiting times. Poland is an example of a post-communist country, where an attempt has been made to create a national policy for reducing waiting times with a waiting list package aimed at improving access to specialty care (Kowalska et al. 2018).

Russia is another post-communist country that has followed this line. The country has traditionally had a universal coverage of health care with constitutional entitlement of free care for all citizens. Social health insurance (SHI) was introduced in 1994 with the universal coverage. Federal and regional SHI funds accumulate and pool earmarked contributions, while purchasing care is the function of both funds and health insurers (medical insurance organizations). Private providers are involved in provision of free care, but state owned providers

still prevail. A new health funding model has not mitigated a traditional health underfunding. Over the last decades, public health expenditures have not exceeded 3.5% of GDP, therefore the country faces a serious problem of health care rationing – both explicit and implicit (Somanathan et al. 2018). Postponing elective care is a common form of rationing. To cope with excessive waits, the federal government has introduced a maximum waiting times guarantee and started a bold experiment with its implementation.

In this paper, we explore the process and the outcomes of the waiting times guarantee in Russia. Two major research questions are addressed: Does a waiting time guarantee always act as a remedy to reduce long waiting times and improve access to care? What should be done to make it actually work? These questions are discussed in the context of the recent developments in Russia. The conceptual framework of the study is based on highlighting three major dimensions of the waiting time guarantee – its regulation, monitoring and specific policy actions to meet the targets.   Regulation is a general area of designing the guarantee – the size of targets, the degree of their specification across types of care and medical interventions, the scope (national or local), possible deviations from targets, etc. Monitoring is aimed at receiving a clear picture of the guarantee implementation. It includes actors responsible for tracking waiting times, as well as patterns of their measurement and reporting. Policy dimension relates to the specific activities to reach targets and reduce actual waiting times. The focus of the paper is on regulation and monitoring. The rationale for choosing these areas is the assumption that the waiting times targets can work only when they are supported by a set of activities to measure actual waiting times and to link the targets to the capacity of health system to meet them. Implementation and management of waiting times is a relevant problem of health policy in any country.

Both positive and negative experience in Russia is reviewed, and international comparisons of institutional and operational arrangements are made. Physicians', health leaders' and patients' perceptions of the guarantee are addressed so that to compare official estimates of waiting times with the actual access to care. The paper is concluded with recommendations on building an effective system of maximum waiting times regulation and monitoring. They are relevant for any country looking for the ways to solve this problem, particularly those with substantial health underfunding.

Methods and data

To determine the scope of waiting times guarantees and the requirements to their monitoring, we explored all regulatory documents on the subject issued by the federal Ministry of Health and federal fund of social health insurance. These requirements were discussed with the officials of these bodies. Since the federal waiting times data is unavailable, the estimates

were collected through the review of official annual reports of health authorities (ministries of health) in each of 85 regions of the country. We also looked for the waiting times estimates in medical facilities of Moscow city by visiting their websites. The best regional practices of waiting times monitoring were determined through the review of regional regulation and literature, personal communication with the regional health leaders and IT specialists, as well as visiting the websites of regional health authorities and SHI funds in each region of the country.

Physicians' perception of waiting times guarantees was explored through face-to-face interviews with 20 hospital managers and physicians in Moscow city and Voronezch region (in Central Russia). The major questions were: "Who is the major actor of waiting times monitoring in your region and your hospital?", "Are the requirements to monitoring actually met?", "What is the initial point for waiting times measurement?", "What is your estimate of the actual waiting times?". The role of health insurers in waiting times monitoring was analyzed through interviews with four top managers of the biggest Russian health insurer.

Citizens' perception of waiting time was analyzed through the review of large-scale national surveys of public opinion. The survey of the Levada-center (the biggest poll company in Russia) was conducted in mid-2016 (two years after introduction of the guarantees) with the sample of 1600 adults (older than 18 years old). People were interviewed in 50 regions of the country, in 137 interview points (97 in urban areas and 40 in rural areas) (Levada Center 2016). Also, popular websites were visited to explore the actual problems with the implementation of waiting times guarantees. The list of these sources and the procedure of their choice are presented in Sheiman et al. 2019.

To compare waiting times regulation and monitoring in Russia and Western countries, international literature was explored. The special focus was on the OECD studies (Siciliani et al. 2014; Viberg et al. 2013). As such, a descriptive analysis was supplemented with surveys and interviews.

Results

Regulation of waiting times guarantee

The major regulatory act in Russia in this area is the federal Program of state guarantees of free care provision (further – Program). It is developed and issued by the federal government annually and establishes a list of medical benefits, the coverage of the population and conditions of access to services. Each region of the country[3] develops its own Program that practically repeats provisions of the federal Program. The package of medical benefits includes practically all medical services provided in state owned medical facilities and it is universal for the entire

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[3] The region is an administrative unit with the population ranging from half a million to 11 million. There are 85 regions in the country. Each region consists of municipal areas (communities).

country. Regions can add some benefits, but this is actually done only in a few regions with relatively high financial resources.

Starting from 2014, the Program has set waiting times targets for elective medical care: 24 hours for the visit to district physician (major provider of primary care, but not exactly general practitioner), 14 days – visit to outpatient specialist, 14 days – instrumental diagnostics and lab tests, 30 days – more expensive tests (CT and MRT), 30 days – hospital admission, including elective surgery. In 2017, a 14 days target for oncological care was added (Government of the Russian Federation 2017). These targets don't apply to the most expensive tertiary care, which is specified in Russia as a "high technology medical care". The Program sets a list of expensive medical interventions (hip replacement, knee replacement, CAPG, etc.), as well as a procedure of access to them without commitments on maximum waiting times. The exemption of high technology care from the general waiting times guarantee can be explained by the lack of resources for this care.

The size of the targets in Russia is lower than in developed countries with much more substantial health funding. For example, in England, the NHS Constitution established in 2010 a maximum wait from general practitioner referral to treatment of 18 weeks (Sicilliani et al. 2013). Finland introduced in 2010 a target of 3 days for primary care services, 3 weeks for outpatient specialists, 3 months for all types of diagnostics, 6 months for the elective surgery since the moment of assessment (Sicilliani et al. 2015).

International comparison of implementation/management of waiting times targets (table 1) indicates serious distinctions between Russia and OECD countries – 15 countries that were covered by the study of the OECD (Siciliani et al, 2014). This is a group of countries that face the problem of excessive waiting times and are particularly active in their regulation, monitoring and policy activities.

Table 1. Comparison of regulation, monitoring and policies to tackle the excessive waiting time of elective health care in Russia and OECD countries

Major characteristics	Russia	Developed countries of OECD with the problem of excessive waiting time
Regulation		
Waiting time guarantees (targets)	Available	Available
Degree of targets specification	Moderate: targets are set for primary care, consultations of specialists, tests, inpatient care, except for high technology care	High: targets are set for specialties, in some countries – for the specific medical interventions with the focus on high technology care
Availability of the reliable estimates of the actual waiting times prior to setting targets	Unavailable	Available
Involvement of political actors in setting targets	No	Yes
National vs. regional and local targets	National	Differs across country with the general tendency to set national targets
Availability of enforcement mechanisms	Week financial sanctions	Financial and administrative sanctions in England and Finland, no sanctions in other countries
Monitoring		
Clarity on the operational actor of monitoring	Not clear	Clear
Pooling waiting lists in the information system	Only for high technology care	Common
Unified pattern of monitoring	Only for high technology care	Common
Coverage	Only public providers, except for regional experiments	Mostly public, but in some countries private providers are also covered
Clarity on the starting point for measurement	No	Yes
Measurement of completed and on-going waiting times	Unavailable	Available
Accountability	No publicly open estimates	Available
Policy to reduce excessive waiting time		
Supply-side activities	Indirect activities	Clearly articulated activities in most of countries
Demand-side activities	Unavailable	Available in some countries

Sources: Siciliani et al, 2013; Siciliani et al, 2014; Viberg et al, 2013; Kreindler, 2010 for OECD countries. Evidence for Russia is presented below.

Regulation of the guarantee is available in all countries covered by the comparison. But the mode of its setting differs a lot. In Russia, the estimates of the actual waiting times prior the guarantee introduction were not available. The targets of the Program were not substantiated by the analysis of health systems capacity and funding, they have not passed through serious discussions with the involvement of political parties and civil society actors. In OECD countries, the targets were based on the reliable estimates of the actual waiting times. Various political and professional parties were deeply involved in their setting. In the course of targets implementation, the actual waits have been compared with targets. Their upward adjustment is not ruled out (Appleby 2019).

The targets in Russia are nation-wide, they apply to all 85 regions of the country, irrespective of their financial resources and the capacity of medical networks. OECD countries differ in terms of the geographic scope of the guarantee, but there is a general tendency to set national targets.

The major distinctions are in the area of waiting times monitoring. In Russia, there is no clarity on the operational actor of monitoring. The federal SHI fund sets the requirement of "information resource" that must be established in each region (Federal social health insurance fund 2016). This is an information system that provides data on health care utilization and actual implementation of all guarantees. But there is no requirement of pooling data on waiting lists and waiting times. Each hospital is supposed to manage waiting list and report data on waiting times. This means that hospitals are expected to make estimates themselves rather than to provide data on incoming referrals and actual admissions to the centralized information system. They can use their own procedures to estimate waiting list progress and average waiting times rather than to use the unified pattern of measurement. Thus regulation makes hospitals responsible for monitoring their own performance, while regional health authorities and SHI funds collect hospitals' estimates. The requirement of pooling waiting times data exists only for high technology care. The national centralized information system for this care utilization has been established.

In all OECD countries, there is an institution responsible for monitoring. Collection of data is conducted by the specific information resource, for example, the Health and Care Information Centre in England, the National Institute for Health and Welfare in Finland. Contrary to Russia, a single waiting list is established for all providers nationally or locally. Related to this, is a *unified pattern* of waiting data collection: all providers report data to the centralized information system according to the specified rules and procedures. The referrals of patients to specialists or hospitals and the actual utilization of services are fixed by this system.

Based on this information, it evaluates the indicators of waiting times (rather than providers themselves). (Viberg et al, 2013, Siciliani et al, 2013; Sicilianni et al, 2014).

The initial point for the measurement of hospital admission waits varies across countries. In Russia, the starting point for waiting times measurement, according to the Program, is the "referral of an attending physician" without specification of the level of service provision. Therefore, most of Russian regions have a substantial discretion to establish their own starting point for measurement. Only high technology care is better regulated. There is a formal procedure of selecting patients in every region by centralized regional clinical commissions and then by providers themselves. The decision of the latter is a starting point for waiting time measurement.

In OECD countries the most common approach is to measure from the moment of the diagnosis confirmation by hospital physicians. However, some countries (England, Scotland, Finland, Sweden) measure the time span from the referral of GPs to the actual treatment. In both cases, there is a unified understanding of the initial point, which makes estimates comparable for individual providers (regions and even countries) and clear for patients.

Most of OECD countries monitor completed waits and on-going waits. The former is evaluated retrospectively – upon actual utilization of elective care, the latter is the estimate of the current waiting time of patients on the list, which allows patients to track their movement to a hospital admission. Also, the distribution of patients according to the waiting times is estimated. For example, 80% of patients wait for the period which matches the target. The government develops activities how to make care more accessible for another 20%. In Russia, the measurement of on-going waiting times and the distribution of patients according to the waiting times are unavailable. Regulation sets requirements only for the completed waits, that is a retrospective estimate of waits.

In all OECD countries, waiting list and waiting time data is reported for individual hospitals and other providers. Patients can select providers according to both completed and on-going waiting times. In Russia, there is no requirement of making waiting time estimates public for each specific hospital. The notion "informing patients' relates to the reminder of the approaching date of admission rather than provision of regular information about the progress of waiting list and expected waiting times.

Control of the targets implementation in Russia is a function of medical insurance organizations (insurers) acting as contracting parties with regional SHI funds for provider payment and quality control. These organizations are supposed to collect data on the number of

patients that have been admitted to a hospital "with the breach of the waiting time target" (Federal social health insurance fund 2013). There is no specific provision about financial sanctions for this, but there is a general provision about financial sanctions (fines) for any breach of guarantees. Thus a week enforcement mechanisms is established by the regulation. In OECD countries, they don't exist, except for England and Finland (Viberg et al, 2014).

The policy to reduce excessive waiting times is not explicitly stated in the Russian regulation, but there are activities to improve access to care. Most of them are planned and implemented in the framework of large-scale national programs that cover specific areas of service provision. They are designed to strengthen the capacity of health providers, particularly in rural and remote areas. The focus of the current national program (for 2019-2024) is to enhance quality and access to care for patients with oncological and cardiovascular diseases. In most OECD countries direct supply and demand-side activities to cope with excessive waits are clearly articulated and implemented (Hurst and Siciliani L, 2005; Kreindler, 2010; Siciliani et al, 2013).

Waiting times monitoring

The federal regulation on monitoring does not clearly specify the requirements to: a) a major actor of monitoring, b) pooling the information on waiting lists/waiting times, c) patterns of measurement, d) accountability, e) statistical recording. Therefore, regions of the country have only "mild" commitments to building institutional and operational arrangements for monitoring. In the current political system with a highly centralized decision-making and vertical federal accountability, the lack of the federal regulation allows regions to avoid monitoring activities. Similarly, health providers are not committed to pool information on the waits in the situation when the federal regulation does not require it.

Our analysis of regional practices indicates that monitoring of outpatient care waiting times is based on electronic systems of a physician visit appointment that are available in most regions. The referrals of primary care providers to specialists and diagnostic tests are fixed by these systems, and the actual waiting time can be estimated (at least, theoretically). There is much less progress in the area of elective hospital admissions. We reviewed websites of SHI Funds in all 85 regions of the country and found out that the centralized information systems for admissions waiting times monitoring existed only in six of them in 2018. The rest relied on the estimates of individual hospitals.

Among these six regions, there are successful examples of building an effective monitoring system, the most promising - in Kemerovo region in Western Siberia (Zalesova

2017; Personal communication with health leaders). The centralized regional information system with the unified pattern of waiting time measurement has been established. It covers 75% of regional health providers. The regional regulation makes the referral of a polyclinic physician a starting point for a patient movement measurement. A physician chooses a hospital for admission using the data on the on-going waiting list in the community or in the entire region, offers this hospital to a patient and then presses a button "put on the waiting list and save". There is a requirement that the time of the referral and the time of putting a patient on the waiting list should be the same. Thus gaming with the starting point of waits measurement is ruled out. Also, the feedback of hospitals is presumed: a hospital worker, who is in charge of admission management, looks at the referral and fixes the date of admission. A referring physician can keep track of what happens with the referral.

The information system collects information on the referrals to outpatient consultations in hospitals, actual number of admissions, as well as cancelled admissions (mostly for medical reasons). A unified regional waiting list has been established. A share of patients who receive inpatient care within the guaranteed time is estimated for each hospital. The on-going waiting time is estimated and this information is open for patients. They can easily track waiting list progress.

The information system collects data on a vacant bed capacity across communities. This data allows to re-distribute patients from one hospital to another if they agree to change the place of treatment. Thus monitoring is used as an instrument of hospital admissions management.

The practice of this monitoring system provides insight into the issue of alternative starting points for waiting times measurement (Sicilliani et al. 2014). It refutes a common argument that an admission is usually preceded by a hospital doctor assessment, which justifies the date of this assessment as the initial point for measurement. The monitoring system in Kemerovo regions allows to take this into account without destroying the unified pattern of tracking patients' movement on the waiting list. The number of cancelled referrals to admissions (those that are medically inappropriate) is subtracted from the general waiting list, while the actual waiting time is measured from the point of outpatient physician's referral. Thus all stages of waiting time are accounted rather than the time elapsed from the moment of assessment in a hospital. The referral-to-treatment measurement reflects the actual waiting time for admission - what really matters for patients.

International practice indicates that pooling waiting lists is an important factor to use the existing hospital capacity more efficiently (Kreindler 2010). Some Russian regions provide additional evidence to this point. Centralized monitoring systems, where available, have allowed to avoid duplication of waiting lists and thereby made planning of activity more precise. Also,

this is a tool to encourage patients choice: patients have the necessary information on specific hospitals and can choose a provider with a shorter waiting list. The centralized system of cataract surgery monitoring in Saint –Petersburg is an example of such arrangements. It has contributed to the reduction of waiting time for this procedure (Information technology in health care 2017).

The lack of the federal regulation of waiting times monitoring does not allow to make this system universal. Even in Kemerovo region, some hospitals establish their own waiting time monitoring systems and don't report their data to the regional information system. This pattern does not account for the entire "route" of patients to admission, therefore the average waiting time estimate becomes much shorter and usually meets a federal target of 30 days. The regional information system fixed 90 thousand of referrals to admission in 2017 but only 58 thousand of admissions have been actually paid in the SHI system (Zalesova 2017). The reason for this gap is that the biggest hospitals are not involved in the regional monitoring system. They make their own estimates of average waiting time that are "doomed" to meet the target. The regional health authority does not oppose this practice, because it allows to report that the guarantees are met.

The official estimates of average waiting times in the country and regions are not available. The reviewed annual reports of regional health authorities on the implementation of the Program don't contain this information. Neither do any other governmental official documents. Some regions of the country provide fragmentary estimates. For example, Moscow city reported average waiting times in 2016: consultations of specialists – 4 days, diagnostic CT and MRT tests – 8 days, elective hospital admissions of therapeutic cases – 6 days, surgical cases – 7 days (Moscow City Health Department 2016). These estimates are based on the reports of the selected hospitals.

All hospital managers and doctors, whom we interviewed, indicate that they know about 30 days target for hospital admission, but don't see any problem to meet it. *"Admission is a matter of a few days"* is the most common estimate. The reason for this estimate is that hospital doctors don't see the "iceberg" of the waiting time – the waits for outpatient specialists' consultations and tests in polyclinics and hospitals. The country has a multi-level system of service delivery with local facilities in small rural and urban areas, city, regional and federal hospitals in big cities. Not tracking the movement of patients through these levels and accounting only the point of "destination", makes estimates meaningless.

Monitoring of outpatient care waiting times presents a similar problem of adjusting official estimates to the targets. Multi-specialty polyclinics as major providers of outpatient care are well equipped to track the referrals of physicians to consultations and tests through electronic systems of visits appointment. However, there is a substantial body of evidence in the media and

Internet of the actual waiting times falsification. People can make an appointment with a specialist only 14 days before the expected date of consultation (this is the target) but can't do it 15 or more days before.

The following is a very indicative correspondence of a patient and a civil servant in a relatively rich region of the country found in the website: Patient: *It is impossible to make an appointment for the test. The electronic system says "No appointments for the nearest days". I see this every day for more than two weeks.* Civil servant: "*According to the recommendation of the regional health authority, appointments with specialists are open for the time two weeks ahead, starting from the current date. It may happen that all specialists are busy. The appointment for the new time intervals is open every day after 7.30 am. The nearest date is June 26. You may sign up for July 10* (Sheiman et al. 2019). This pattern of making appointments minimizes risks of complaints on the breach of targets. They are always met. The fancy electronic systems of making appointments are 'tuned" to meet the targets rather than to create a waiting list and estimate the actual waiting time.

Insurance companies are supposed to reveal the cases of the guarantees breach and report to regional SHI funds on the number of such cases. But not having a pool of data on waiting list progress, they have to collect data on individual patients' complaints. When these complaints are justified, providers have to pay a fine for the breach of the guarantees. Paradoxically, such control stimulates providers' gaming with waiting times – this is a conclusion of all top managers of the medical insurance organization whom we interviewed.

A special case is monitoring of high technology care waiting time. Contrary to the secondary care (the bulk of hospital admissions), tertiary care is monitored through the centralized information system with a clear pattern of waiting list management. The Federal Ministry of Health has issued a special requirement for the regional health authorities to measure the average waiting time and to make the estimates public in the annual regional health reports (Ministry of Health 2013). Our search on the websites of regional health authorities indicates that only six of 85 regions sometimes provide this data (table 2).

Table 2. Estimates of the average waiting time for high technology medical care in some regions of the Russian Federation in 2011-2017, number of days

Regions	2011	2012	2013	2014	2015	2016	2017
Arhangelskaya oblast	114	140	148	121	n.a.	n.a.	n.a.
Vologodskaya oblast	n.a.	n.a.	n.a.	n.a.	45	45	45
Jewish autonomous region	n.a.	n.a.	n.a.	n.a.	30	30	30
Omskaya oblast	n.a.	n.a.	n.a.	n.a.	n.a.	60-180	30-180
Burjatia Republic	30–60	30–60	30–60	n.a.	n.a.	n.a.	n.a.
Republic of Chechnya	n.a.	n.a.	n.a.	53	n.a.	n.a.	n.a.

n.a. – the data is not available

*Source: A*nnual reports of the regional health authorities to the government of the Russian Federation on the population health status and organization of health care.

These estimates are very indicative. They are irregular, inconsistent with regions' general economic level (relatively poor Jewish autonomous region and Republic of Chechnya have the lowest waiting times) and, what is most important, the averages are heavily underestimated and are not available for the entire country. Additional information collected on the websites of tertiary care facilities discounts this information. For example, Saint-Petersburg Research Institute of ear, throat, nose and speech honestly reports that patients have to wait for a high technology surgery from 9 months to 3 years (Sheiman et al. 2019).

Our interviews with managers of medical insurance organizations and civil servants have indicated that there is no additional information on waiting times except for the one we collected. It is unavailable even for the unofficial use: "*The desks of managers and officials are as empty as public reports*". Thus waiting times monitoring system does not exist nationally and in the majority of regions.

Official estimates and patients' perception of waiting times

Not numerous official estimates of waiting times are low. Coupled with the "silence" of the government about the actual waits of many services, they create a misleading picture of a satisfactory situation in the implementation of state guarantees. Patients' perception is totally

different.   According to the survey of the Levada-center (a famous poll agency), long waiting time is reported as the major problem of health care by 43% of respondents. This problem is more important than the lack of modern medical equipment (reported by 37% of respondents), the short supply of physicians (29%) and their low salaries (21%) (Levada Center 2016).

Even a higher proportion of respondents (56%) reported long waiting times as the major health care problem under the survey of the "Platform" in 2018 (Centger of social projecting 2017).

The survey of the Accounting Chamber (the Court of Auditors), conducted in mid-2016, provided estimates of the actual waiting times for primary care and diagnostic tests. 71% of respondents had to wait for primary care physician (district therapist and pediatrician) more than 24 hours (as stated by the Program) and a quarter of them waited more than 10 days. 43% waited for the routine diagnostic tests (laboratory, functional, etc) more than the target of 14 days (Gavrilov et al 2017).

Patients have to pay rather than to wait for free care. According to the survey of the National Research University Higher School of Economics, 62 percent of patients who pay for diagnostic services have to pay because they can't get these services free of charge, 15 percent - because access to the service is difficult or impossible without paying (Somanathan et al. 2018).

Rationing by queuing is quite common internationally. The special characteristic of rationing in Russia is the lack of transparency of the waiting list progress and uncertainty regarding on-going waits. Below are the typical complaints of patients and their relatives regarding high technology care:

"The status of my case has been "under consideration" over the year and a half. The hospital reports that the queue is unavailable and there is no opportunity to fix an expected date of admission. Please, let me know how long I should wait. Can I be admitted by some other hospital, if my hospital is overburdened?».

«My mother was placed on the waiting list for knee replacement in December 2016. Physician said that we should wait for about a year. We called the information desk of the hospital in January 2018 and found out that our number of the queue was 194. Then we called in February and March, the number was the same – 194. Please inform us if the waiting list is available and what is the actual progress of the queue.

" I have the registration card No…… for knee replacement. The status of the card has been "Under consideration" and then changed to "Blocked". Please indicate what it means. Walking becomes more difficult» (Sheiman et al. 2019).

The major message of these letters is uncertainty. People are ready to understand that resources for high technology care are limited, but reject to understand why they are not

informed about the actual waiting time. They want to know when the service can be provided, why there is no progress in the waiting list, why the communication with health authorities is blocked, why there is no accountability for too long waits. This uncertainty limits the possibilities to look for alternative providers in other regions of the country or in the private sector.

Discussion

Setting waiting times guarantee is a serious commitment of the government in any country, particularly those with limited financial resources for health care. Russia has started this bold experiment without any public discussion of its relevance and feasibility. The targets are very low by Western standards, although the country face a serious health care underfunding.

Apart from the mere political declarations, the rationale for unrealistically low targets in Russia is the expectation that they can serve as an instrument to pressure providers to improve their performance with the resulting decrease in waiting times. But the evidence does not support this expectation. In the situation of declarative commitments, the first reaction of providers is to imitate the implementation of guarantees through the use of measurement procedures that ensure meeting the targets. The evidence supports the hypothesis of Hunning (2005) that unrealistic targets may result in a number of negative effects for health systems. They may cause opportunistic behavior of health providers with the focus on medical interventions that are included in the list of guarantees at the expense of others, as well as affect indications for treatment. We may add to this various options of gaming with appointments: medical organizations want to meet the targets, therefore impede the procedure of patients' appointment to specialists and tests.

Paradoxically, health authorities in Russia have to tolerate the opportunistic behavior of providers. Financial and administrative sanctions for the breach of targets, although theoretically possible, are not commonly used, because they can raise questions about the feasibility of the targets. There are no serious attempts to establish an effective monitoring of waiting times in most of regions and nation-wide. The available estimates of actual waits are fragmented and unreliable. There is no pressure on providers to make these estimates public. The balance of perverse interests of all actors involved in the guarantee implementation blocks the implementation of initial objectives.

Waiting times monitoring is in the initial stage in most of Russian regions. It lacks three major characteristics, which proved to be critical internationally. First, it is a unified pattern of waiting times data collection. Providers must follow this pattern to receive meaningful estimates of waits. Second, pooling of data for the start and completion of a waiting period – the universal procedure for all primary and specialty care providers. Without polling this data, it is impossible

to determine the actual waits, as well as to manage waits by re-distributing patients between providers with different capacity and waiting times. Third, there is no clarity on the initial point of measurement. Hospitals tend to ignore the long period of patient waiting for the contact with hospital doctors.

What should be the first steps to build an efficient waiting time guarantee in the country with limited financial resources? This question is relevant for any country in transition and some developing countries facing the problem of long waiting lists in public sector. The following are the recommendations that are based on the best practices of developed countries and some regions of Russia.

Develop realistic targets of waiting times. They should be based on a careful evaluation of the actual indicators for each type of care, as well as the actual capacity to meet them. This is common in developed countries. A special case is canceling the existing unrealistic targets - a hard political decision made by some European countries in the 1990-s (Hunning 2005). The current target of 400 days for hip or knee replacement in some OECD countries (OECD 2017) is not encouraging, but it is better than declarative low targets that are not met and therefore reinforce patients' uncertainty and opportunistic behavior of providers.

Build a waiting time monitoring system. The major requirement is clarity about the operational actor of monitoring. The preferable approach is to set up a special information system for waiting list/waiting times monitoring in the country/regions/communities. Another requirement - pooling waiting lists and waiting times information. A single waiting list is established for all providers nationally or locally. Related to this, is a unified pattern of waiting data collection: all providers report data to the centralized information system according to the specified rules and procedures. The referrals of patients to specialists or hospitals and the actual utilization of services are fixed by this information system, which makes estimates reliable (contrary to the practice of hospitals as the major actor of monitoring).

Specify a pattern of placing patients on the waiting list for hospital admission. We suggest the date of setting a diagnosis by primary care physician or outpatient specialist as a starting point for measuring waiting list and waiting times. The referral-to-treatment pattern allows to track the actual movement of a patient in multi-level system of service delivery. The study of Smith (1994) indicated that in Scotland 50% of the total time on the waiting list for hospital admission after the diagnosis was the time spent on the waiting list for a visit to outpatient specialists and the time between two waiting lists. Thus waiting for admission is only a part of the wait. The diagnoses that are not confirmed by hospital doctors (after the assessment) should be subtracted from the general queue and not accounted in the estimate of the average waiting time (as it is done in Kemerovo region). The exceptions from this unified pattern should

be clearly defined – according to the list of diagnoses that can be made only by hospital doctors. They will have a different procedure of waiting times measurement.

Measure both completed and on-going waits. The latter indicator is particularly important to determine the time already spent on the waiting list for the patients that continue waiting services. Coupled with informing patients on the progress of waiting list, this will allow to reduce the level of patients' uncertainty.

Measure the share or the number of patients who wait longer than the target. In England, the regulation states that 90% of patients admitted to the hospital for treatment and 95% of those not requiring hospital admission should be treated within the 18-week limit (Sicilliani et al 2013). In Finland, communities have the target of a number of patients waiting more than 6 months – not more than 5 per 10 000 population in 2010 (Sicilliani et al. 2015). These additional indicators allow to track actual deviations from the targets and receive a real picture of access to care. When these deviations are too high, the discussion on upward targets adjustment may start.

Make waiting times estimates public. This is the major way to ensure accountability of providers and the government for meeting targets.

Conclusion

Establishing waiting times guarantee in Russia is an attempt to enhance access to health care. The targets are expected to improve the performance of health providers and decrease waiting times. However, this study indicates that the country has not built institutional and operational arrangements for monitoring the guarantee. There is no clarity on the major actor of targets monitoring – centralized information systems or hospitals themselves. There are no clear cut rules and procedures of waiting times measurement. The estimates of actual waiting times are fragmented and unreliable. Providers are not required to make them public. Most of targets are low and unrealistic, therefore encourage the opportunistic behavior of health providers to meet them. The government has to tolerate gaming with appointments to specialists and tests, as well as reports of hospitals about very short waiting times. Uncertainty of patients regarding actual waits is growing. Some regions of the country have started waiting times monitoring, but its coverage of providers is still limited. Thus the waiting times guarantee is not always a remedy to improve access to care. The targets can really work when they are realistic, rely on the effective regulation and monitoring, have supporting policy activities and are coupled with accountability procedures.

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