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Formal and Informal Institutional Change: The Evolution of Pharmaceutical Regulation in Russia, 1991-2004

A thesis presented by

Alexandra Mary Vacroux

to

The Government Department in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the subject of Government

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Formal and Informal Institutional Change:
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ABSTRACT

Political scientists, economists, and practitioners have done much to clarify the ways in which formal institutions (codified judicial, economic and political rules) affect bureaucratic decision-making and policy outcomes. However the ways in which informal institutions influence politicians and officials have been more difficult to decipher. This dissertation investigates the role of informal constraints (defined as spoken or unspoken understandings that complement or contradict official procedures) on bureaucratic decision-making. It draws upon a case study of regulators in the Russian pharmaceutical industry to illustrate the policy impact of formal and informal institutional change during Russia's post-communist transition.

The thesis divides the Russian transition from 1991 to 2004 into three periods. Between 1991 and 1996 overall changes in the political and economic system and in the organization and financing of health care radically altered the formal constraints on regional health care officials. Uncertain of their new responsibilities and unprepared to take the lead in health care reform, civil servants relied heavily on Soviet-era informal rules to make decisions. From 1996 to 2000, regional health care officials became savvier about their role in health care reforms and the regulation of pharmaceutical firms. Informal institutions were adapted to new circumstances, with the use of *blat*, for instance, morphing into reliance on intermediaries for licensing pharmaceutical firms. In addition, some informal institutions were formalized into

regional rules that introduced administrative barriers for firms. From 2000 to 2004, President Putin has worked to reconstruct a powerful central government with enforced formal rules. The new rules have been implemented more effectively than those introduced under President Yeltsin because they bring the "rules of the game" back in line with informal constraints used by officials.

The dissertation provides specific examples of how informal constraints on bureaucratic behavior become more important in periods of uncertainty. It demonstrates that informal rules are both "sticky" and flexible, often adapting to changing conditions more quickly than formal regulation. Finally, it makes clear that reforms that fail to take into account widespread informal rules increase opportunities for corruption and are more vulnerable to failure.

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April 2005
Cambridge, Massachusetts

INTRODUCTION

Bringing the State Back In.

Bringing the State Back In.

Since coming to power in 2000, President Putin has been working steadily to bring the state back into the lives of Russian citizens. To some extent, the population has welcomed this reintroduction of oft-longed-for "law and order." The Yeltsin years immediately following the collapse of the Soviet Union in 1991 were a period of sudden freedom, and for many, chaos. Putin has worked hard to burnish his image as a stable, confident, and powerful leader. He has repeatedly assured his country that Russia can and should play a significant role in international affairs, has steadily reasserted the power of the federal government vis-à-vis regional governors, and has curbed the influence of so-called oligarchs on executive decision making in the Kremlin. In 2004 Putin was reelected to a second term of office with over 70% of the popular vote. Since then he has redoubled his efforts to consolidate the Russian state. Potential sources of opposition, including independent television stations, an independent and pluralist legislature, smaller liberal political parties, and elected governors have been squeezed out of the political process. The state, in Putin's view, is meant to be a highly centralized and effective instrument for implementing the will of the President.

Even the most cursory examination of how the Russian state functions, however, suggests that President Putin still has much work to do. The office of President ostensibly commands greater respect than it used to: the leading national television channels lead off news broadcasts with a report on the President's daily schedule; national and regional politicians praise his wisdom and prescience; other leading personalities from corporate, cultural and athletic milieus dutifully follow suit. Yet there is evidence that the reassertion of a strong presidential figure has not in and of itself improved the operations of the state. Moscow-based ministries are perpetually restructuring themselves to strengthen their internal hierarchies, but have not necessarily become more effective at implementing policy. Ambitious programs to reorganize and re-energize the Russian state have produced only modest successes. After four years of these administrative reforms, one of the architects of Putin's administrative reform program, Mikhail Dmitriev declared that only 15% of planned reforms had been implemented. Driven to dramatic oxymoron, he complained that "the paralysis of power has reached a hypertrophic scale" (Korchagina 2004).

Putin's attempts to recentralize political power must be seen in light of Yeltsin's initially deliberate, and later uncontrolled enfeeblement of the federal government. Both trends constitute changes in the structure of the Russian state—in the relationship between federal and regional governments, in the operations of federal and regional bureaucracies, and in the expectations of and for civil servants. Many agree that the "Russian state" has fundamentally changed in the past 13 years, but this unwieldy topic must be wrestled into a practical and insightful analytical

framework if we are to understand how the state has evolved since the collapse of the Soviet Union.

What Is the State?

Max Weber's pioneering work on the state still serves as the sturdy foundation for many studies of government and bureaucracy. The state is defined as "a set of organizations invested with the authority to make binding decisions for people and organizations juridically located in a particular territory and to implement these decisions using, if necessary, force" (Rueschemeyer and Evans 1985: 46-7). The organizations or bureaucracies that make up the state may act in concert, or may be in conflict with one another. Some studies, particularly those that consider the state as an international actor, unify the state into a single entity, but others see it as a diverse collection of interests, and consider the tensions between state organizations. Breaking the state down into separate organizations is but a first step in understanding state power. Particularly in a country undergoing momentous changes, it is wise to ask whether these bureaucracies themselves behave coherently, or whether tensions and conflicts within them might not be driving different parts of the organization in different directions, or into competition for resources and influence.

Descending into the corridors of a single bureaucracy, it is difficult to overlook the obvious: the "entity" in question functions by dint of its employees. The personnel within a bureaucracy, or bureau, subscribes in varying degrees to an overall organizational ethos, and may also be part of a regional, departmental, or office subculture. Unifying forces bring these people together— for example, a common

formal mission or professional background– while other factors lead their interests to diverge. To understand why certain individuals or groups act the way they do, one must appreciate the incentives that shape their decisions. A person undoubtedly strives to maximize his self-interest, but these interests are shaped by the organization and the society in which he lives. Attempts to assign universal interests to individuals and then extract their underlying decision-making methodologies flounder when they fail to consider the environment that defines and constrains available choices. This is not to necessarily imply that people behave irrationally. Rather, it is to place this dissertation in the company of those who believe that the institutional context for decision-making is as important to an individual as his or her individual beliefs. As Peter Evans noted in his detailed analysis of state bureaucracies promoting information technology, "state managers do not engage in disembodied maximization. Their decisions depend on an institutional context composed of complex, historically emergent patterns of interaction that are embodied in social structures and taken for granted by the individuals that work within them. These patterns have a reality that is prior to 'individual interests'." (Evans: 28)

The institutional context for state bureaucrats consists of formal and informal constraints *Formal constraints* include judicial rules (constitutions, laws, and regulations), economic rules (classically, property rights and contracts) and the political rules that define state structure (North 1990: 47). *Informal constraints* are the spoken or unspoken understandings that complement or contradict official procedures. In the words of Douglass North, they are "(1) extensions, elaborations, and modifications of formal rules, (2) socially sanctioned norms of behavior, and (3)

internally enforced standards of conduct" (40). In all societies, informal constraints are transmitted through socialization of the young and the learning derived from individual experience.

In a bureaucracy, formal constraints encompass the official relationships between organizations and sanctioned procedures within them. The formal division of supervisory or fiduciary responsibility among bureaucracies and bureaucrats is generally specified in the charters or legislation that define the functions of ministries, agencies, and other government bodies. However these formal rules do not fully describe how organizations work, and how officials within them make decisions. While officials may use formal rules as a starting point for their decision-making, they will also rely on informal rules to "get the job done." Organizational cultures will favor certain approaches or policies, even though these preferences are not specified in formal rules. Relationships among employees, and between employees and outsiders will influence the bureaucrat's attitude towards his work and responsibilities. While officials may not consciously notice that their behavior is bound by these formal and informal rules, on a day-to-day basis these constraints determine which decisions are made and what actions are taken.

The balance between formal rules and informal understandings changes over time. In the absence of radical changes in the overall environment, there is a rough equilibrium between the formal and informal. This does not mean that formal and informal constraints reinforce each other, or that they are equally important. In the late Brezhnev years of the Soviet Union, for instance, lip service was paid to ideological objectives while many bureaucrats used their positions to pursue more

personal goals. Organizations and officials understood that the façade of building communism had to be maintained, but they often made decisions on the basis of personal interests and informal understandings of what was permissible (see for example, Chazov 2000; Solnick 1998). Formal and informal constraints of Soviet bureaucracy were at odds, but officials were able to engage in behavior that answered to both the formal and informal constraints.

What happens in periods of rapid change? One theory of bureaucracy postulates that formal rules change more slowly than the environment requires. Officials confronted with inappropriate formal guidelines will rely on informal constraints to solve problems, and apply their practical understanding of organizational procedures.[1] Another approach to organizations emphasizes that the informal understandings rooted in actual experience and local political, social and organizational culture are "sticky" and slow to change, especially by design.[2] Reforms that alter formal institutions without taking into account existing informal constraints often fail to change bureaucratic behavior, producing results that are disappointing at best and dire at worst (North 1990 and 1993, Schiavo-Campo 1994). This dissertation investigates how the formal and informal constraints on bureaucrats have evolved during the post-communist transition as a means of understanding how the Russian state has changed since 1991.

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[1] Anthony Downs discusses the flip side to the point: formal rules for decision-making evolve the more often a bureau encounters a given circumstance. Thus, "the more repetitive or routine is the nature of the bureau's function, the more likely the bureau is to operate under elaborate, extensive, and inclusive rules. Conversely, the more unpredictable and variable are the situations faced by a bureau in carrying out its functions, the less likely it is to be governed by such rules." (Downs 1967: 61)

[2] Douglass North notes that "[a]lthough formal rules may change overnight as the result of political or judicial decisions, informal constraints embodied in customs, traditions, and codes of conduct are much more impervious to deliberate policies." (1990: 6) North leans on evolutionary theory when he describes the incremental adjustments that societies make in their informal understandings. (p.87)

This thesis breaks down the evolution of Russia's post-communist state into three periods: early Yeltsin (1991-1996), late Yeltsin (1996-2000) and early Putin (2000-2004). Until recently many took for granted that Russia would move from being a single-party, command economy system to a pluralist state. The attempts by President Putin to reconsolidate authority in the hands of the federal government, a single party (United Russia), and certain economic institutions (e.g. Rosneft and Gazprom) have led many to suspect that Russia's destination is not democracy, but a rather more authoritarian political system (McFaul and Petrov 2004; Sestanovich 2004; Shevtsova 2004). The shifting consensus is relevant here because it hints that the changes of the past 15 years have been not only dramatic in their magnitude, but also in their direction. How can the Russian state be at once sluggish to adopt reforms and yet flexible enough to reverse course in the space of a couple years?

Applying the institutional framework of formal and informal constraints, one can hypothesize that the three stages are characterized by a shifting balance of formal and informal constraints. In the early 1990s, reformers who rode to power with Boris Yeltsin were full of excitement over the possibility of applying Western treatments to the ailing Soviet economy to jumpstart entrepreneurship and growth. Egor Gaidar and his "young reformers" declared that the role of the state had to be minimized as quickly as possible for entrepreneurs and markets to fill niches poorly served by the command economy. Rows of elderly women selling kittens, knitted socks, and cheaply purchased foreign perfumes outside of subway stations suggested that market forces could be easily revived, if unleashed. The privatization of small shops and large enterprises was planned in 1992, and underway within a year. It thus appeared

that many formal constraints on individual activity were rapidly lifted as soon as the Soviet Union disappeared. And yet the results of the stabilization and privatization programs were not those anticipated. Criminal enforcement organizations began to demand protection payments from new businesses (Frye and Zhuravskaya 2000), and complaints about corrupt bureaucrats emerged simultaneously with the businesses they were meant to regulate. My hypothesis here is that while formal constraints on behavior (economic, political and cultural) may have been lifted, little attention was paid to the need to adapt informal "ways of doing things" to the new environment. As a result, many Soviet-era habits, including the reliance on personalized problem-solving through connections (*blat*), bureaucratic discretion and gift-giving persisted, blunting the impact of a new Constitution, new business legislation, and new opportunities.

The reforms of the early 1990s did not produce the anticipated results, and by the middle of the decade, resentment and cynicism began to take root. "Violent entrepreneurs" had cracked open the state's monopoly on violence, and by some accounts, criminal gangs played a large role in enforcing contracts in the absence of effective formal enforcement mechanisms (Volkov 2002; Khlebnikov 2000). A shrinking GDP, falling living standards, and rising mortality rates fueled opposition to transition measures, and by 1996, when an ailing Boris Yeltsin was running for re-election, a Communist resurrection was seen to be a real threat (Chubais 2000). The election campaign revealed that the top echelons of the executive branch had fallen under the sway of a small group of so-called "oligarchs."[3] These businessmen had

[3] Boris Berezovsky bragged to the Financial Times in October of 1996: "We, the seven wealthiest businessmen, have invested huge amounts of money in Boris Yeltsin's election campaign, we hired

successfully capitalized on the partial reforms of the early 1990s to build financial-industrial and media empires that were willing and able to organize a winning presidential campaign for a candidate who was barely ambulatory in the months preceding election day. The influence of businessmen over the Presidency and his family was indicative of the relationship between the private and public sectors in much of the Russian state. The new formal rules adopted in the early 1990s were skewed towards those who already had a foot in state's door and sporadically enforced. State officials, living amidst hyperinflation and uncertainty like most of the population, were poorly paid and poorly trained to operate in new democratic and market conditions. Many resisted new policies, while others succumbed to corruption. The state gained a reputation for being unwieldy and obstructionist, as evidenced by President Yeltsin's repeated calls for bureaucratic reform throughout his tenure.

By 1996-1997, however, many officials accepted the inevitability of Russia's transition, and had adopted appropriate coping mechanisms to deal with confusing rules, legislation riddled with inconsistencies or gaps, contradictions between federal and regional laws, and the feeling that they had been cut loose from the federal government. In the second stage of the transition, informal constraints appear to have played a more important role in determining bureaucratic behavior than formal constraints. This result would be expected by Douglass North and others who emphasize the importance and persistence of informal rules, particularly in periods of uncertainty. A close look at the actual formal and informal constraints facing a

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Anatoly Chubais to manage it and we ensured victory. Now, we must reap the fruits of our victory by taking key posts in the government."

selected group of officials, however, also reveals that the informal rules applied in a confusing environment were adapted to the circumstances confronting officials. Soviet-era habits were carried over into the post-communist period, but they were modified to fit the greater freedom of the capitalist era. Gift-giving, for example, became cash-based bribe-giving. Corruption, the abuse of public office for private gain, seems to have gained momentum in this period as a result. Identifying the changing patterns of corruption among petty and higher-level officials provides one indication of how informal rules adapted to circumstances and grew in import in the second half of the 1990s.

This dissertation thus argues that in the first half of the 1990s, as Russian policy-makers tried to hastily impose a new set of formal rules on a Soviet-era bureaucracy, the legacy of established informal institutions thwarted their efforts. By the second half of the 1990s, informal rules had been modified to meet the needs of the new environment. Communist Party controls over bureaucratic functions, the classic "check and balance" mechanism for the Soviet bureaucracy, had not been replaced with new supervisory mechanisms. Moreover, constantly evolving formal rules failed to effectively demarcate the role and responsibilities of officials, who were thus given leeway to expand their role and activities in directions not anticipated by reformers in Moscow. In stage 2, therefore, one saw ongoing reforms of formal rules blocked by the growing importance of more relevant, and more rewarding informal rules. Much of the comparative institutional literature laments the lack of research on how informal constraints change over time. I would argue that the

second half of the 1990s provides us with an interesting case study of this kind of evolution.

Close observers of Russia were taken by surprise when President Putin's efforts to recentralize and strengthen the Russian state began to bear fruit. While the introduction to this chapter pointed out the obstacles in Putin's path, few would claim that his efforts have failed to increase the authority of the federal government. Perhaps the strongest evidence of this is the fact that within two years of his ascendancy to the Presidency, regional legislation had, for the most part, been brought into line with federal law. Contradictions between national and local rules had been one of the most remarkable features of Russian federalism under Yeltsin (Mitchneck, Solnick and Stoner-Weiss 2001). How did Putin manage to neutralize the informal rules that had gained prominence during the Yeltsin years? Here again one can hypothesize that changes in the balance between informal and formal constraints tipped the scales enough to restore respect for formal rules. This seems to have occurred because the formal rules introduced under the administrative reforms launched by Putin better correspond to the informal rules that already exist. Whereas Yeltsin-era reforms in many cases attempted to push the bureaucracy into behaving differently from the way they had before, Putin-era reforms in many cases allow officials to revert to modes of thinking and behavior that correspond to Soviet-era tendencies. As a result, reforms sowed since 2000 fall on more favorable ground, and are able to take root more easily than those attempted under Yeltsin.

This is not to argue that President Putin had managed to accomplish all that he aimed for, nor to claim that the Presidential Administration's administrative reforms

are a direct return to the USSR. It is rather to suggest that closely looking at the formal and informal constraints on bureaucrats clarifies how the centralized Russian state could have disintegrated under Yeltsin (for better or worse), and have been resurrected under his chosen successor, Vladimir Putin.

A Case Study: Health Care and Pharmaceutical Regulation

An approach to the state that disaggregates government demands a great deal of information about the inner workings of a state bureaucracy. This information is not always easy to come by; and in Russia the anatomy and infirmities of state entities are often as closely guarded as private medical conditions. To ensure that one truly understands how bureaucracy works, it is necessary to focus research on a specific element of the bureaucracy, be it a specific policy area or region.[4]

This dissertation examines the post-Soviet Russian state by looking at health care. It concentrates on the key state organizations responsible for health care policy: the Ministry of Health (MoH), regional health care departments[5], and federal and regional public health insurance funds. Health care policy encompasses a wide range of critical issues, from maintenance of public health care facilities and medical personnel, to tracking health and mortality trends, to fighting local epidemics. Further narrowing the focus of inquiry to look at a single aspect of health care policy

[4] See for example Peter Evans' 1995 comparison of bureaucracies responsible for fostering domestic I.T. industries and Das Gupta and Mookherjee's comprehensive 1998 review of the Indian Tax Administration.

[5] The regional bureaucracy responsible for health care may be a health committee, department, directorate (*upravlenie*) or ministry (in the republics). While the former is the most common term, I will refer to these entities as "health departments" throughout the thesis, since "committee" implies collegial decision-making. I am grateful to Tim Colton for this suggestion.

allows one to investigate the interactions between and within government bureaucracies in greater detail.

My research concentrates on state pharmaceutical policy. It considers the evolution of drug distribution regulation (the rules used to control the sale and dissemination of drugs through distributors, pharmacies, and hospitals)[6] and drug procurement policies (the systems devised by regional health departments to manage the purchase of drugs bought with public funds). While this is but a single aspect of national health care policy, it is an important one, and it is illustrative of issues that extend beyond pharmaceutical regulation, including the shifting relationship between the Ministry of Health and regional health departments and the desperate struggle for adequate financing of health care. It also allows for a focus on a specific category of bureaucrats, namely those officials involved in regulating pharmaceutical distribution and procurement. Formal constraints are revealed by the perusal of laws and rules, but informal rules can only be discovered through conversations with the civil servants themselves. Focusing on a specific policy area allows for multiple interviews with similarly placed officials, as well as discussions with entrepreneurs who interact with officials in the course of their business activities.

Taking Stock of the State

The state is made up of many organizations. These organizations are made up of subunits that may or may not act in concert. To understand the state and its actions in a given policy area, one is advised to first identify the relevant bureaucracies,

[6] The thesis does not look into the fascinating and complex question of how drug production and testing is regulated.

consider whether or not these organizations behave coherently or incoherently, and in the case of the latter, analyze the sources of tension within the organization. This objective is best accomplished by considering the incentives facing different elements of the bureaucracy in question. These incentives can be categorized as stemming from either formal or informal constraints.

The balance between these constraints changes over time, though not necessarily in response to targeted reforms. Changes in the balance have an impact on policy outputs: the weakening of formal constraints, should they fail to answer the needs of a rapidly changing situation, may make informal constraints more important. Informal ways of resolving problems may favor personal objectives at odds with organizational goals, for instance by fostering corruption. Douglass North (1993) has argued that some of the failures of the post-communist reforms must be attributed to a failure to acknowledge that informal constraints on behavior, which, because they are often rooted in educational and cultural systems, may also be slow to change. Thus rapid formal reforms can fail to deliver their anticipated impact—or may have an unanticipated effect—because altering organizational rules or hierarchies is easier than changing the way in which superiors relate to their employees, or the way in which bureaucrats are used to personalizing their decision-making process.

Putting together these two understandings of bureaucratic behavior presents a negative hypothetical scenario about major transitions: rapid environmental change that makes formal constraints obsolete strengthens the role of informal constraints. These informal constraints become relatively more important to the decision-maker, and while "sticky," they may be adapted to answer new circumstances. Attempts to

alter formal constraints may therefore produce less fruit than expected if they fail to transform informal regulations as well, or if their essence contradicts that of well-established informal understandings (de Soto 1989). The longer one waits to make effective changes in the formal constraints on bureaucratic behavior, the less successful these reforms are likely to be. Stalled transitions are thus very difficult to revive, and are more vulnerable to reversal. This reversal is particularly likely if subsequent modifications of formal constraints bring them back in line with the informal constraints that are a legacy of the pre-transition period.

This dissertation uses an in-depth case study of state pharmaceutical regulatory practices to examine how the balance of informal and formal constraints has shifted over the past 15 years. Chapter 1 discusses the theoretical and methodological approach underlying this thesis in greater detail. Chapters 2 and 3 consider the evolution of formal and informal constraints on pharmaceutical regulators from 1991-1996 and from 1996-2000, respectively. Chapter 4 looks at how the Putin Administration has tackled reforms of the federal government between 2000 and 2004, again relying on pharmaceutical distribution and procurement regulation to highlight changes in the workings of the Russian state. Chapter 5 revisits the question of whether the changing balance of formal and informal constraints is an appropriate framework for understanding the evidence presented in the three empirical chapters. This final chapter also considers what the development of formal and informal constraints suggests about the Russian state as a whole, and about how it is likely to evolve in the future.

CHAPTER 1: Bureaucracies, Bureaucrats and Rules

Legally and actually, office holding is not considered a source to be exploited for rents or emoluments, as was normally the case during the Middle Ages and frequently up to the threshold of recent times... Entrance into an office...is considered an acceptance of a specific obligation of faithful management in return for a secure existence.

Weber 1958, "Bureaucracy"

Corruption exists and is dangerous because it is attractive and profitable for many people. For a civil servant it is a source of additional income—income which not only significantly exceeds his salary but also, in our cynical times, is covered with an aura of romance. For an ordinary citizen, a bribe given to a bureaucrat is the only way to force government to serve society, or more precisely, [to serve] this particular member of society.

INDEM 2001, *Diagnostika rossiiskoi korruptsii: Sotsiologicheskii analyiz*

Were he still alive, Max Weber's nightmares would be teeming with Russian officials. He recognized that the history of bureaucratic institutions is thickly lined with corrupt officials, but his ideal state administrative organizations were populated with officials who serve their government in exchange for the modest pleasures of executing professional duties, a decent salary, and public esteem. The civil servants in contemporary Russia, on the other hand, are typically depicted along the lines of the INDEM study quoted above: selfish, often incompetent, venal and petty.

What explains the gulf between these two images of the bureaucrat? The first possible interpretation emphasizes that Weber was generalizing from his theory of bureaucracy, not literally describing bureaucrats. He knew that each official has personal motivations for following rules, and indeed was a pioneer in his methodological reliance on the individual and the incentives driving behavior. He did not exclude the possibility of corruption, but his admiration of bureaucratic

organizations implied that the forces that facilitate the emergence of specialized "bureaucratic mechanisms" also favor the evolution of effective and objective civil servants.[7] Second, Russian bureaucrats may not be as bad as popular opinion would have one believe. True, there is a near consensus that Russian bureaucracy is far from efficient and impartial.[8] However, a more thorough look at particular bureaucracies and bureaucrats would lend more weight and give more depth to this flippant conclusion. A third alternative explanation is that bureaucracies display characteristics not noted by Weber in addition to those he did peruse. Weber's interest was in the formal nature of bureaucracy. He did not focus on the unofficial aspects of bureaucratic life—the unwritten rules, standard operating procedures, and interpersonal relationships among officials (Downs 1967, 59, 65-74; Crozier 1964, 179, 297). Yet theoretical and practical studies suggest that these informal relationships and rules are also crucial in explaining how people and organizations actually function (North 1990, 36-45; Shepsle and Weingast 1987).

This dissertation focuses on the complementary and contradictory influence of formal and informal rules on bureaucratic decision-making. It identifies the constraints confronting a specific set of bureaucrats, and then studies the formation

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[7] In Weber's view, a capitalist economy demands that non-market functions be "discharged precisely, unambiguously, continuously, and with as much speed as possible." Weber (1958, 215). "The more complicated and specialized modern culture becomes, the more its external supporting apparatus demands the personally detached and strictly 'objective' *expert*, in lieu of the master of older social structures, who was moved by personal sympathy and favor, by grace and gratitude." (Ibid., 216)

[8] Other studies concur in the assessment of Russian officialdom offered by the INDEM-executed, World Bank-funded project. This is reflected in the annual Transparency International (TI) Corruption Perception Index (CPI), which most recently ranked Russia as 86th out of 133 countries in level of corruption as perceived by businesspeople, academics and risk-analysts. The TI CPI calculation for Russia is based on 16 different surveys with a standard deviation among them of 0.8. This standard deviation is interpreted by TI to mean that there is "some agreement" among the polls they use to construct Russia's score (Transparency International 2003).

and evolution of these constraints in the post-communist transition period between 1991 and 2004. This chapter presents the theoretical underpinnings for this approach in more detail, following a brief overview of how the state has been treated in political science transition literature to date.

Focus on the State

While always respectful of Weber, political science as a field turned its attention anew to the state as an actor in the mid-1980s as Evans, Rueschemeyer and Skocpol urged scholars to "bring the state back in." The role of state bureaucracies and bureaucrats in policy-making was thoroughly investigated in comparative politics. Its role in post-authoritarian transitions, however, was often seen as secondary to that played by burgeoning societal forces freed from oppressive control. Ironically, the field of Russian area studies, once dominated by research on relations between Kremlin officials, ministerial control mechanisms, central planning, and political control, for the most part neglected to focus on how state institutions were transformed following the collapse of the Soviet Union.[9]

This problem is now being rectified (Colton 2004), but much work remains to be done if we are to understand how states evolve in periods of transition. President Putin's aggressive attempts to restore the power of the Russian federal state have taken some by surprise. It had been assumed that the Russian transition was a path

[9] There were of course notable exceptions to this rule. The Russian presidency has been tackled by a number of scholars (e.g. Breslauer 2002; Nichols 1999), though many tend to focus more on individual personalities than the executive branch as a whole. Research into the development of Russian federalism has highlighted the weakness of federal institutions (e.g. Bunce 1999). English-language monographs on contemporary Russian bureaucracies and bureaucrats have been few and far in between (again with a few exceptions, e.g. Ryavec 2003, Albats 2003, Mogun et al. 2004)—despite a legacy of similar studies in the Soviet era (e.g. Hough 1969).

from authoritarianism to democracy.[10] Mounting evidence that Russia's destination might lay elsewhere has led analysts to speculate gloomily on the "true nature" of the state in Russia and other post-communist states (e.g. Levitsky and Way 2004).

The state can be tackled with a number of strategies. It can be seen as a unitary actor, a simplification often useful for studies of international relations. A study of federalism may identify the national state as one body and regional states as coherent counterparts.[11] It can be seen as the blunt instrument of a single class of actors or interests. The advantage of reducing the set of bureaucracies that make up the state to a single entity is that it reduces the noise of internal conversations and conflicts and allows one to concentrate on policy effects rather than causes. It also affords more leeway to those who want to use game theory to understand state action.

The disadvantage to the reductionist approach to states is that the noise of internal activity that it stifles can provide important clues to how policy comes about, and to how it is likely to be implemented. Putting an ear to the ground, more pluralistic interpretations see the state as the arena in which interests struggle for control over policy. These interests may target specific people (such as Congressmen), bureaucracies (for example, regulatory agencies responsible for railroads or drug safety), or local governments (like those in Tiumen, the richest oil-producing region in Russia). But influencing people and policy is a subtle process involving cajoling, convincing, and occasionally more forceful methods. While one

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[10] The European Bank for Reconstruction and Development, for example, publishes an annual Transition Report ranking countries along measures that reflect democratization and "marketization" of national economies. See for example EBRD 1999.

[11] Authors employing such an approach recognize that this is a simplification, but their analysis is more focused on the negotiations and resulting relations between different levels of government, rather than on the fissures and alliances within governments (e.g. Solnick 2002, 175).

can easily see why a lobbyist might be interested in pushing his interests, it may be harder to understand why a given official favors one set of interests over another. For this we need to go even further to ground.

Bureaucrats in this study are assumed to be pursuing "set of goals including power, income, prestige, security, convenience, loyalty (to an idea, an institution, or the nation), pride in excellent work, and a desire to serve the public interest (Downs 1967, 2).[12] At work, bureaucrats determine their preferred course of action largely in response to the incentives presented to them by their immediate organizational environment (the bureau that employs them). This environment comprises the formal and informal aspects of their office. It is perceived by the bureaucrat through a cognitive filter formed by past experiences, and influenced by the society and culture in which he has lived.[13] While they may try to maximize their self-interest, officials define these interests in light of the incentives presented to them by the institutions around them.

Public servants in state bureaucracies, while often seen as worthy of contempt (if not attack by man-eating lions[14]), are responsible for implementing the bulk of state policies. While they may not be loved, they are essential for state operations, and dysfunctionalities in their attitudes or procedures can have a serious impact on

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[12] Scholars disagree on the extent to which self-interest is just selfish. Where Weber sees officials as motivated primarily by a deep sense of professionalism, Barbara Geddes argues that civil servants are mainly interested in their careers (Geddes 1994).

[13] Compelling proof of this assumption is provided by a study of Indian tax administration and the effects that the institutional and policy arrangements have on the behavior of tax administrators and taxpayers. See Das-Gupta and Mookherjee 1998, especially chapter 6.

[14] At least according to a Brazilian joke cited by Evans 1995, 3. Russian bureaucrats, however, need not fear lions.

state policies. If the law states that antibiotics should only be dispensed by prescription, but regulatory officials do not care to monitor pharmacies, then the law is unlikely to have any effect.[15] The consequences of widespread non-compliance with laws will vary by issue area, but they can, needless to say, be very serious.

This dissertation examines the state by examining its officials. It assumes that bureaucrats make decisions on the basis of their environment, and that a close look at this environment will yield clues into the formal and informal rules used by civil servants when they make decisions. Understanding the rules that govern bureaucratic behavior allows us to see why policies adopted may not produce the anticipated results—a key issue for those interested in understanding how Russia has weathered the years since 1991, and why the expected democratic convergence with Eastern and Western Europe has failed to materialize.

The Rules of the Game: Defining and Operationalizing Formal and Informal Rules

In his well-worn metaphor, Douglass North compared institutional constraints on individuals to "the rules of the game in a competitive team sport" (North 1990, 4). Players observe formal written rules as well as "typically unwritten codes of conduct that underlie and supplement formal rules, such as not deliberately injuring a key

[15] This is not an outrageous example. In Russia many drugs are supposedly dispensed only upon prescription, but it is easy to obtain nearly any non-narcotic prescription drug in any pharmacy. When asked why they do not enforce this law, local officials shrug their shoulders, say that doctors "are out of practice" when it comes to writing out prescriptions, and argue that they cannot be expected to do everything.

player on the opposing team" (4). When the rules are violated, the offending player is subject to punishment of some kind.

Formal rules are generally easy to identify—they are written, often in legislation, and they are understood by all players. Informal rules, however, are more difficult to work with, though no less important. While he recognized the vital importance of the informal rules – in fact, much of his seminal 1990 book considered the sources and effects of informal rules – North did not delve into the specifics of informal constraints. He made a few crucial observations, noting that culture and socialization, as well as the psychological and physiological nature of cognitive thought, are critical in the formation and transmission of informal norms (37). The fact that informal rules are embedded in a social context makes them resistant to change and difficult to identify (6). While a useful starting point for thinking about the constraints on individual behavior, this conception of informal institutions is difficult to operationalize. It also opens a trap door by tempting one into using informal institutions as a residual explanation for all actions not otherwise accounted for. In a review article on informal institutions, Gretchen Helmke and Steven Levitsky noted that "the term informal institutions has been applied to a dizzying array of phenomena, including personal networks, clientelism, corruption, clans and mafias, civil society, traditional culture, and a variety of legislative, judicial, and bureaucratic norms" (2004, 4).

Defining what is meant by "informal rules" is thus critical to this study. As noted in the introduction, Douglass North considers that informal constraints include all widely accepted modifications to formal rules, standards of conduct, and norms of

behavior. Helmke and Levitsky suggest a more narrow definition of informal institutions: "socially shared rules, usually unwritten, that are created, communicated, and enforced *outside* of officially sanctioned channels" (4-5, italics my own). This definition is useful in that it narrows the scope of these rules to those that are enforced. My conversations with Russian officials strongly suggest, however, that some of the most significant informal rules they follow are in fact enforced *within* officially sanctioned channels (albeit outside of formally endorsed rules). Consider, for example, hierarchically structured corruption, in which the "take" of a street-level official is shared with higher-ups; the "commission" paid by a low-level officer to his superior is enforced through officially sanctioned channels—the official state bureaucracy—although the objective pursued by the occupants of the bureaucracy in question is at odds with the organization's mission.[16] In this study of bureaucrats, therefore, informal rules will be defined as "socially shared rules, usually unwritten, that are created, communicated and enforced among actors." The enforcement of these rules may be sporadic, but those who fail to comply risk informal sanctions. Actors may be bureaucrats or "outsiders" who interact with them and who may be as familiar with the expectations generated by informal rules as the officials themselves.

How can this definition of informal rules be operationalized? It is one thing to theoretically discuss the importance of institutional constraints, but quite another to specify the constraints that actually impact behavior. To understand how state officials take decisions, one must get close enough to observe them and ask questions about why they have acted in the way they have. One must be prepared with a

[16] Susan Rose-Ackerman notes that while corruption in hierarchies may not be organized from above at the outset, "if payments are institutionalized, they become a condition of employment, organized by superiors for their own gain" (1999, 82).

reasonable understanding of the formal rules governing their activities to establish credibility and take the discussion beyond a banal recitation of laws and regulations. Language skills are critical in establishing the trust that will lead interviewees to expose their values and frustrations. Consequently, studies that look at particular state organizations in depth must often choose deep over broad analysis, thereby sacrificing some leverage in comparative work for the sake of developing a compelling case study of how a state operates in practice. As Helmke and Levitsky aptly note,

> Identifying the shared expectations and enforcement mechanisms that sustain informal institutions can be a challenging task. In most cases, such efforts require substantial knowledge of the community within which the informal institutions are embedded. Hence, there is probably no substitute for intensive fieldwork in informal institutional analysis. Indeed, it is not surprising that most studies of informal institutions take the form of either abstract theory (N=0) or inductive case studies (N=1). (18)

This dissertation adopts the case study approach to gain insights into Russian state bureaucracies that (unfortunately) cannot be gleaned without hanging around dingy offices and drinking bad instant coffee.

The inductive approach applied here involved collecting information from health care bureaucracies in four Russian regions and then piecing together evidence of institutional constraints. The methodology used is described below in the next section, and the procedure used to select regions is outlined in Appendix 1. Before moving to the bureaucracies examined, however, it is helpful to see examples of the types of rules or institutions that will be the focus of this dissertation. Table 1 provides a list of the basic formal and informal rules that guided the decision-making

of regional health department officials when an independent Russian Federation came into being.

It would be difficult to put together a comprehensive list of constraints on Russian civil servants, and it isn't necessary. The table below mentions only the most important constraints on the behavior of state officials in regional health departments. The formal rules summarize the basic structural constraints on officials in charge of drug policy; the informal rules listed focus on those that become the most important in later stages of the post-communist narrative. While I wouldn't want to reveal plot twists in advance, I must point out now that the emergence of biased pharmaceutical procurement policies in the 1990s led me to look back at the cultural foundations for such a phenomenon in the Soviet period. While there are many informal rules affecting the behavior of actors in all cultures, the emphasis in this study is on those that have a significant impact on drug firm regulation and drug procurement. Unfortunately, this means that one must focus on the underpinnings for corrupt exchanges.[17] Care has been taken to avoid using a functionalist approach to specifying the rules governing bureaucratic behavior. The constraints listed below are derived from observation, rather than an abstract idea of the types of rules one would "need" to make the national health care system more efficient. The way in which these rules operate in practice will be the subject of the following three empirical chapters.

[17] In this thesis corruption is simply defined as the "abuse of public office for private gain." This definition, used widely in the corruption literature, covers "two categories: the misappropriation of wealth for the benefit of a government official and the extraction of rents—whether in the form of bribes, kickbacks, or special 'favors' from private entities." (Kaufmann and Siegelbaum 1996, 422)

Table 1. Formal and Informal Constraints on Health Department Officials as of 1991

Formal rules

Systemic rules

- Bureaucratic structure: Regional health departments are officially subjugated to both the federal Ministry of Health and regional governments.
- Financing: Regional health departments are financially dependent on transfers from the All-Russian budget.
- Responsibilities of regional health committees: fulfill quantitative plans devised in Moscow, including allocating resources (money and medical equipment/supplies) transferred from the center to predetermined line-items in their regional health budget; monitoring spending of allocating funds; monitoring regional health facilities; supervising plan fulfillment by local health committees, and maintaining statistics on health indicators.
- Markets: Drug markets are completely centralized and state controlled. There are no private pharmacies or drug distributors.

Local rules

- Human resources: The regional health department follows personnel policies set by the regional government. (Most employees of health care departments have a medical education.)
- Regulation of pharmaceutical firms: The regional health department, in conjunction with the Sanitary-Epidemiological Service, monitors conditions in pharmacies.
-

Informal rules

- Connections: Public officials may use official resources to help their friends, family members, or contacts, though there are generally accepted limits to this behavior.[18]
- Gift-giving: Public officials can expect to be "thanked" by grateful recipients of their discretion with gifts ranging from chocolates to cash.
- Passivity: Expectations that health care reforms will die a quiet death means that one can ignore formal efforts to change procedures and policies.[19]
- Selective Implementation: Managers of medical facilities receive many unrealistic orders from above. They only implement those that are "realistic."[20]

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[18] This phenomenon, known as *blat*, will be discussed in more detail in chapter 3.

[19] Evgenii Chazov, Minister of Health under Gorbachev, noted in an interview that efforts to improve the quality of health care would be hindered by people "many of whom include administrators...[who] have become habituated to a quiet life, shrug off inadequacies, and note that previous attempts at reform petered out, leaving things very much as they had been before" (Ryan 1990, 149).

[20] A head doctor in Chernigov, Ukraine (which had an identical health care system to that of Russia in the Soviet period) reported that he sifted through many orders and recommendations from

Institutional Change

The rules that govern the behavior of players or actors may be stable, but they are not fixed in stone. Particularly in periods of transition, be it rapid or gradual, one will see the formal rules that govern the structure of the state modified to meet new circumstances or new goals. After the dissolution of the Soviet Union, Russia became a federal state in which, according to Riker's classic definition, at least two levels of government rule the same people, with each having autonomy in at least one issue area. This led to significant changes in the relationships between the federal government and regional governments, and between federal ministries like the Ministry of Health and their regional counterparts. Formal changes are usually easy to track because they are necessarily codified in Constitutions, laws, or regulations. They have also tended to be the focus of post-communist reformers in the early days of the transition.

Changes in informal rules are more difficult to follow. On the one hand, one expects culturally-based informal understandings to resist direct manipulation. In addition, because they are rooted in long-established patterns of behavior and socialization, it would appear that informal rules would only change incrementally. As Douglass North emphasizes repeatedly, "although formal rules may change overnight as the result of political or judicial decisions, informal constraints embodied in customs, traditions, and codes of conduct are much more impervious to deliberate policies" (1990, 6). On the other hand, there are examples of informal institutions

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organizations overseeing work at his hospital. His task every morning was to draw from them "a selection... of those which are 'realistic and capable of being implemented'." (Bogdan 1981).

changing very rapidly. The population of the Russian Federation, for example, for the most part stopped hoarding food within the first five years of the post-communist transition, although it had appeared that this behavior was deeply rooted in national psychology.

The sources of institutional change are mysterious but critical to understanding how and why actors change their expectations and therefore, their behavior. The advantage of the "thick case study" of a single policy area is that it allows one to examine how specific informal institutions emerge and evolve into accepted behavioral guidelines. Helme and Levitsky (2004) identify three possible scenarios that may alter informal institutions: changes in the design or enforcement of formal constraints may change the costs and benefits of applying certain informal rules (for example, by filling in gaps in legislation or by increasing the cost of obeying contradictory informal rules); societal values may evolve, eroding support for traditional, informal institutions; and the emergence of a new balance between political or societal forces may weaken those who benefit from the informal rules. By tracing the changing social, economic, and professional environment of Russian health care bureaucrats, one can find important examples of both persistent informal institutions, as well as new informal rules that emerge in response to changes in the political and economic environment. In both instances, the first scenario described above would appear to be the most relevant, an observation that will be supported by the empirical chapters that follow.

Suggesting that changes in formal rules alter the relevance of informal rules begs one to investigate the ways in which formal and informal rules interact. Turning

again to their comprehensive review of the literature on informal rules, Helme and Levitsky present a typology of informal institutions that attempts to qualify potential interactions with formal institutions. The way in which they grapple with the amorphous literature and subject deserves reproduction here.

Figure 1. A Typology of Informal Institutions

Outcomes	Effective Formal Institutions	Ineffective Formal Institutions
Convergent	Complementary	Substitutive
Divergent	Accommodating	Competing
Source: Helme and Levitsky 2004, 20.		

This table is useful in understanding the extent to which the incentives created by formal and informal rules act in concert or in conflict. While attractive in its parsimony, however, it threatens to lead analysts into three traps. First, by drawing attention to the nature of informal rules in relation to existing formal rules, it risks obscuring the fact that formal constraints may react to informal rules. In other words, it may not be the informal institution that is accommodating formal rules, but the formal rules accommodating informal institutions. Second, it tempts us to assume that the formal rules are all working towards the same ends, and with the same degree of effectiveness. This may not be the case. Consider, for example, Russian attempts to tackle barriers to entry for firms. Federal laws have been introduced to facilitate market entry, while regional bureaucracies have introduced administrative barriers. The divergence of federal and national legislation means that the same informal

institutions may simultaneously compete with some rules while complementing others. Finally, one is tempted to assume that effective formal institutions will be those that promote efficiency. Unfortunately, some of the most effectively enforced formal rules are the ones that open the door to corruption, as in the case of the aforementioned administrative barriers.

Refining the typology of formal and informal institutional interaction will be much easier once the case study has been presented, as it provides instances of outcomes in nearly all quadrants. Rather than focusing on static outcomes, I prefer to examine the simultaneous evolution of the formal and informal rules influencing bureaucratic behavior. The narrative presented in my study of the Russian state provides us with three useful examples of institutional change. In the early Yeltsin years (1991-1996), reforms of formal rules create conflicts with existing informal rules. In the late Yeltsin years (1996-2000), we observe informal rules adapting to new formal rules, and indeed being codified in additional formal regulation, particularly at the regional level. In the Putin years (2000-2004), further changes in federal rules bring them in line with dominant informal institutions. Russian pharmaceutical policy outcomes since 1991 illustrate the interplay of formal and informal institutions, and the mechanisms used to change informal rules. In bringing these results to light, this dissertation addresses one of the major lacunae in our understanding of the importance and function of informal institutions.

Methodology: Design and Execution of the Case Study

To study formal and informal institutions in a meaningful way, one is obliged to narrow one's research. The focus of analysis may be a particular economic sector

(Evans 1995, Radaev 2002), policies (Solnick 1998), a company (Hendley 1998), a region (Stoner-Weiss 1997, Fainsod 1958) or as in this case, a bureaucracy (Das-Gupta and Mookherjee 1998). One courts the prospect of meaningful analysis at the risk of drawing conclusions that are not generalizable beyond a targeted subject. Highly focused studies must therefore justify the principle used to narrow down the area of analysis, as well as the viability of extrapolating conclusions to other sectors, regions or issue areas.

Health care makes an appealing case study for a number of reasons. First, it is a critical aspect of state policy. Even in countries without a powerful welfare state, the provision of health care to the population is a question that mobilizes state and society alike. Post-communist countries saddled with a legacy of universal health care but insufficient funding find that reform of health care is highly politicized, which highlights the different forces and actors battling for influence. Second, the pharmaceutical industry is a particularly interesting case to study, as it is—and should be—highly regulated. Health care is an area in which the clichéd call to reform via sweeping deregulation is not appropriate as entrepreneurs left to their own devices are unlikely to satisfy the social objectives of state health policy.[21] The state must be involved in health care regulation, and will thus search continually for the formal institutions most likely to generate appropriate incentives for officials and entrepreneurs. Third, because health care can absorb such a large portion of a

[21]"As elsewhere in the economy, in the health sector—indeed especially in the health sector given the social character of its operating objectives--the strength of entrepreneurial incentives makes it essential to have in place adequate regulation to 'steer and channel' what would otherwise be only self-interested private decisions" (Saltman and Busse 2002, 6).

regional budget – in Russia or in a developed country[22] — it attracts cynics who want to skim public funds for their own benefit. The state must find a way to effectively control not only those involved in the provision of medical services and drugs, but also the regulators themselves. Informal rules that facilitate corruption should thus be more exposed in this sector than in others. Finally, health care systems depend on medical and pharmacological professionals. There is a distinct culture and ethic in health care that one may not find in a study of transportation or national resource ministries. If one wants to investigate the motivations of bureaucrats, concentrating on a sector with high standards makes it easier to identify the way in which a professional subculture may interact with a broader national culture. (Of course, this may jeopardize the extent to which one can generalize from conclusions.)

The Russian health care system is a particularly important subject to study in light of the deterioration of health experienced by the country since 1991. Life expectancy has recovered from the plunge experienced between 1990 and 1994, when it fell from 69.28 (for both sexes) to 64 years; however in 2002, the life expectancy was 65.10 years, below the CIS average of 66.95 and the EU average of 78.72.[23] This average figure for both genders masks one of the biggest gender gaps in life expectancy in Europe—one of over 13 years. It is impossible to determine the extent to which weaknesses in the health care system have led to a greater incidence of

[22] In a number of Russian regions, around a third of the regional budget is devoted to health care expenses. This is also true for a number of American states, including Tennessee (33%), Missouri (31%), Pennsylvania (30%), Maine (29%) and others (Lyman 2004).

[23] World Health Organization (WHO) "Health for All" database, "Total health expenditure as a % of GDP, WHO estimates – Both Sexes," available at http://www.euro.who.int/hfadb . Note that EU figure is from 2000, the last year for which data are available.

certain illnesses, and particularly of communicable diseases.[24] Problems with the health care system are not entirely to blame for the worsening of health conditions in Russia. But there is little doubt that transition-triggered problems in the health care system have had a negative impact on the quality of life in Russia (Tragakes and Lessof 2004, 19).

The Yeltsin and Putin governments have devoted more than a little attention to the problems of the health care sector, and yet appear unable to resolve the chronic problems of under financing and poor quality of care. A study of reforms in this area, with an emphasis on how the institutional context may have created problems in implementation of reforms, promises to shed light on why reforms have failed. The institution-based approach used in this dissertation reveals that failure to anticipate how reforms would be interpreted at the local level would probably have doomed even the best-intentioned efforts.

Health care in Russia is managed at three territorial levels: national, regional, and municipal. The Ministry of Health, based in Moscow, bears nominal responsibility for assuring the health of the country, but the decentralization process of the 1990s has shifted authority to the regions. Municipal health departments generally worry primarily about the medical facilities in their region, and are usually not involved in strategic decision-making (though they may have discretion over drug procurement). The regional level is thus the most critical to a study that examines health care policy-making and outcomes. Generalization is, however, greatly

[24] Efforts to pin down the underlying causes for the fall in life expectancy have been unsuccessful. "Indeed, if the effects of the postulated individual factors—environment, medical care, legacy of the past, economic impoverishment, social inequality, and political breakdown—were to be summed, they could together account for nearly twice the number of actual excess deaths" (Chen, Wittgenstein and McKeon 1996, 523).

complicated by the fact that upon decentralization in the early 1990s, each region developed it own health care bureaucracies and systems, with varying degrees of success. Looking at all 89 Russian regions is not realistic, so an attempt must be made to select regions that will permit some level of generalization to Russia as a whole.

The research underlying this thesis was done in four Russian regions: Samara Oblast, Volgograd Oblast, the Republic of Mari El and the Republic of Bashkortostan. The regions were selected to maximize variation in wealth and post-communist economic reforms, on the assumption that what distinguishes policy-making across the country is the extent to which leaders accept the principles of democracy and capitalism, and the resources available to fund policy. (A more extensive discussion of the process used to choose regions is provided in Appendix 1.) Although I was looking for the ways in which these regions differ from one another, in the course of field research it became clear that the bureaucrats and entrepreneurs I interviewed had much in common. This suggests that while each region may have organized health care in its own fashion, the institutions and incentives driving behavior are more national than regional, and more grounded in the common Soviet history shared by Russian citizens than in the regional sub-cultures that have blossomed since 1991. In addition, it suggests that there are imperatives driven by the health care and pharmaceutical sector that may override localized attempts at diversity. The formal and informal rules outlined in Table 1 reflect these findings.

The evidence underlying this thesis is drawn from over 70 interviews with Russian officials, pharmaceutical entrepreneurs, and journalists in the four selected regions and Moscow. The first round of interviews, conducted in the summer of

Table 2. Summary of Interviews

Interviews by region		*Interviews by profession*	
Samara	24	Bureaucrat	51
Ioshkar Ola, Marii El	25	Health Care	38
Ufa, Bashkortostan	17	Other[25]	14
Volgograd	11	Businessperson	22
Total	77	Other[26]	3

2002, targeted bureaucrats in state organizations that regulate drug distributors and retailers, as well as the entrepreneurs themselves. The people interviewed in the regional health departments, sanitary-epidemiological services, tax inspectorates and fire departments were mid or low-level officials responsible for interacting with businesspeople. This first round of interviews was intended to scout out the overall regulatory environment and regional drug markets. It provided an overall picture of the main firms involved in drug supply, and of the key bureaucratic players (both individuals and organizations) involved in health care policy-making and regulation. In addition, subjects were asked a number of personal questions about their motivations for working in state organizations, and on the internal operations of their bureaucracy.

[25] Bureaucrats from non-health care bureaucracies were drawn from the Sanitary-Epidemiological Service, the Tax Inspectorate, the Fire Department and the Anti-Monopoly Committee. All had done some work with pharmacies and drug distributors.

[26] Journalists and sociologists.

A second round of interviews in the winter of 2003-4 in Samara, Ioshkar-Ola (the capital of Marii El) and Ufa (the capital of Bashkortostan) involved mid and high-level officials in regional health departments and the anti-monopoly committees that have emerged as one of the chief opponents of administrative barriers. Leading players in the regional pharmaceutical markets were also interviewed. The focus of these conversations was on the evolution of regional drug markets over the past 15 years, and on changes (both real and perceived) since the inauguration of President Putin. Where possible, the conversations were steered towards a discussion of "how business really operates" and corruption.

All of those interviewed were told that the information was being collected as part of a doctoral dissertation. This explanation was not always believed, with the more suspicious subjects inclined to believe that a large western pharmaceutical company was planning to monopolize their local markets. The interviews were not taped, as it was obvious from the start that people would not discuss illegal procedures or questionable informal rules if a tape recorder was running. Both my research assistant (a mid-career Russian journalist) and I took extremely detailed notes during the course of our meetings. Given the sensitivity of the current political climate, I have rarely used the real names of my sources-- only when the information they provided can not potentially jeopardize them in any way. When interviewees provided information critical of regional government policy, I have used their real names only if I was able to find published evidence of them having made similar pronouncements in the local press. If the remarks were made in confidence, I have

given my sources an assumed name. In all regions I used local newspapers and businesspeople as an additional source of information.[27]

The original focus of my research was on corruption. I had hoped to get inside the regional health bureaucracies in four regions to understand why corruption varies from region to region and from agency to agency. However it proved impossible to schedule enough interviews within a single organization to really understand the particular incentives driving the behavior of individual bureaucrats. The intended initial focus of the thesis—on the individual official—proved to be unrealistic. Studying the formal and informal rules governing policy-making behavior within an organization was easier. Formal rules consist of published legislation and regulation, all obtainable with varying degrees of effort. I feared that the unwritten informal constraints would be more difficult to extract, but interviews revealed a relatively small number of "general principles" guiding behavior that were common across agencies, regions, and bureaucratic status. It was therefore possible to track the evolution of the formal and informal rules over time, and to identify political and economic forces that drove the changes.

I did not abandon the subject of corruption altogether. Many of the informal rules that guide government officials can be construed as facilitating the abuse of public office for private gain. Using a broader framework of formal and informal rules to understand the sources of corruption ended up being far more productive than analyzing the phenomenon of corruption in and of itself. Contrasting the formal and

[27] The use of many different subjective sources is common, and indeed recommended in studies that touch on corruption. Blundo and de Sardan (2000) emphasize the importance of "methodological triangulation," an approach that combines methods, approaches, and sources of information to maximize information where there appears to be none (Andvig et al. 2000, 68).

informal rules in operation at a given period of time highlights the gap between them, and the potential discretion and arbitrage opportunities available to policy-makers and implementers alike. In this final version of the thesis, therefore, corruption has become one of the observable implications of unsynchronized change in formal and informal rules.

The Rules and the Road Ahead

This dissertation will examine the changing formal and informal rules by breaking down the post-Soviet transition into three periods corresponding to Presidential terms of office. Each of the first three presidential terms has been marked by different permutations of formal and informal rules. This is due to the new momentum for formal reforms that is produced after each election, as well as the emergence of different winners and losers in early and later stages of the transition. The cutoff dates between stages are thus meant to be indicative rather than absolute.

The next chapter, Chapter 2, will examine changes in formal and informal rules for regional health care bureaucrats in the first Yeltsin Presidency, 1991-1996. The emphasis will be on how unanticipated rapid changes in Russian health care—especially the decentralization of the financing and organization of health care, the creation of new regional bureaucracies, and the need to regulate a new pharmaceuticals market—created uncertainty for regional bureaucrats. Doubts about the irreversibility of reforms and the substance of formal rules increased reliance on informal rules that had governed bureaucratic life in the Soviet period. The

contradiction between new formal rules and old informal rules greatly complicated attempts to reform health care in the first five years of the Russian Federation.

Chapter 3 looks at the second Russian presidency (1996-2000), and how bureaucrats adapted to the uncertainty discussed in Chapter 2. Formal rules and regulations continued to change, but officials came to rely on a variety of mechanisms to deal with the flow of legislative change. Some long-established informal rules continued to govern behavior, but other new informal institutions also emerged to meet the needs of regional bureaucracies. Some of these new rules were integrated into new formal legislation adopted at the regional level. The way in which health departments managed to finance their operations (and their salaries) in this period, and the methods they adapted to regulate firms in the lucrative local pharmaceutical markets, reveals much about the power of informal rules in transition.

Chapter 4 concentrates on President Putin's first term, the period from 2000 to 2004. Although many Russians and non-Russian observers had assumed that Yeltsin's chosen successor would follow in his predecessor's footprints, by 2002 it was clear that Vladimir Putin had his own ideas about where to lead Russia. Another round of reforms was launched, but this time they were intended to reconsolidate the power of the federal state and bring noisy regions to heel. Administrative reforms of the government bureaucracy, as well as changes specific to the health care system, represented new changes to the formal rules governing regional bureaucracies and bureaucrats. This time, however, the formal rules appear to have been well-understood and accepted by regional officials. Why did rapid modifications to the formal rules not create a new period of uncertainty as they had in the first Yeltsin

period? The answer seems to lie in the re-synchronization of the formal rules with the informal. Putin's recentralization of the federal state, and his reliance on control mechanisms familiar to Soviet citizens and bureaucrats, created a context in which new formal rules were more likely to be implemented than before because they did not seriously contradict existing formal or informal rules.

Whether or not Putin's reforms produced positive changes is a matter best left for later chapters of this thesis. The Conclusion of this dissertation will use the evidence from the three empirical chapters to draw out lessons from the Russian case study. These lessons have relevance not only for future attempts to reform health care in Russia, but also for our understanding of how states change during transitions, and of why corruption can be an unfortunate side effect of the transition period.

CHAPTER 2: Uncertainty

1991-1996: Radical Change in Formal Rules

The Soviet Health Care Legacy

Soviet health care has been the subject of intense criticism since Gorbachev's policies of *glasnost'* and *perestroika* exposed the shortcomings of an over-centralized, under-funded system of mediocre quality. While the Soviet Union was able to build impressive foundation – the number of polyclinics, hospital beds and doctors per population were among the highest in the world – its isolation from international medical and managerial advances ultimately inhibited its ability to adapt to the changing needs of a modern society. Soviet health care was designed to fight the infectious diseases that had afflicted the population during the Civil War and the early years of industrialization. By the Second World War, despite losses inflicted on the country and its infrastructure, the health care system was able to cope with massive casualties and avert major epidemics (Tragakes and Lessof 2004: 23). Increases in life expectancy through the 1950s and 1960s, in parallel with Western countries albeit from a lower baseline, reflected significant improvements in control over infectious diseases, treatment regimes and hygiene. Once these gains had been absorbed, however, the Soviet Union was unable to adapt its health care system to make a successful "epidemiological transition" (Field 1999). Since the 1960s, developed countries reduced mortality rates by attacking chronic illnesses (such as diabetes or cancer) and introducing preventative medicine. Meanwhile, the Soviet health care system continued to emphasize the universal provision of doctors,

hospitals, and beds. The result was an overextended system that aspired to insure comprehensive access to all citizens but which was able to do so only at substandard levels of care.

By the late 1980s, the system was in total disrepair. In 1987, Gorbachev appointed Evgenii Chazov, head of the "4th directorate" responsible for treating the political elite, to the post of Minister of Health. Familiar with the disparity between the medical care provided to Politburo leaders and their families and the treatment available to the majority of the population, Chazov minced no words in describing the shortcomings of the Soviet health care system. Doctors were woefully untrained, overworked and underpaid. Medical facilities were in deplorable condition, many lacking even running water,[28] because they had been built to fulfill plans rather than meet needs.[29] Soviet industry failed to produce enough basic supplies (e.g. disposable syringes and rubber gloves), let alone advanced equipment for ultrasound diagnostics or dialysis (Betlugin 1987). According to Chazov, in 1987 only 85% of drug demand was being satisfied in the Soviet Union—and this level dropped to 40-60% if one considered only critical life-saving drugs like antibiotics (Galaeva 1987).

The weaknesses in organization of the health care system were no different than those plaguing the economy as a whole. Chazov, himself a devoted child of the

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[28] "In only 35% of the rural district hospitals of the country is there a supply of hot water and in 27% there are no indoor lavatories and in 17% no running water." (Chazov 1987). This particular problem has proven to be stubborn indeed--- a 1999 study reported that 45% of Russian hospitals lack shower and bath facilities and 15% of rural hospitals still want for running water (Nursing Standard 1999).

[29] In a 1987 speech to the Ministry of Health leadership, Chazov "said that the Councils of Ministers of the Union Republics and local soviets, often with the acquiescence or positive agreement of health service organs, attempted to fulfill the plan by any means that they could employ. Thus, they opened beds in converted [apartment buildings] and hostels—as well as constructing units of unconventional design at significantly lower costs than those set by Gosplan." (Ryan 1990: 63-4).

Communist system, admitted that "It was clear that it was necessary to renew everything [in the health care system]: the principles of organization, financing, management, training and improvement of personnel, and finally, priority-setting. In fact, this was what the entire soviet system of economics, financing, and management required" (Chazov 2000:174-5). Centralization of all planning functions had robbed the system of any flexibility and had eliminated virtually all initiative from lower levels of government and medical facility administration. Trained to respond to often unrealistic orders from above, civil servants concentrated on meeting targets rather than solving observable problems.

Centralization of the Soviet health care system had occurred in 1936 when Stalin created the USSR Commissariat (later Ministry) of Health. Responsible for designing and coordinating all health programs for the USSR, the new bureaucracy was imposed over the republican commissariats already in existence (Kaser 1976). This move was to resolve inefficiencies created in 1921 when the new Bolshevik government's New Economic Policy (NEP) decentralized control over the economy to counter the effects of the painful Civil War. The regions were expected to assume responsibility for financing medical facilities in their jurisdiction from the republican government, but no effort was made to assess whether financial resources would be adequate. Unprepared regional leaders further delegated responsibility to similarly under funded lower levels of government, which had predictably negative results for the quality and quantity of medical care provided to the population at large (Davis 1983). The recentralization of health care was thus not unwelcome, particularly as it

had the additional effect of making health care more competitive for central financing and central plan allocations (Kaser 1976).

In the Soviet Union, the All-Union Ministry of Health was responsible for all health care planning, from calculating the number of doctors required in each Republic to allocating pharmaceutical products across the country. Health care spending was linked to the distribution of the population, with health care administrators encouraged to continually increase the number of hospitals, beds, and patients if they wanted to see their budgets increased (Chernichovsky and Potapchik 1999:120; Chernichovsky, Barnum and Potapchik 1996: 115). Regional health care officials and hospital personnel had little incentive to reduce hospitalization rates or use facilities efficiently. The Ministry of Health and Soviet Federal Ministry of Finance set and enforced the mandatory norms that incrementally increased spending on operating funds and supplies (human, equipment, and pharmaceutical) based on the number of hospital beds and the number of visitors treated the previous year. While nominally financed though Republican and regional budgets, health care did not reflect a federalist approach. In 1989, 80% of national health expenditures, 94% of ambulatory care services, and 96% of hospital beds were managed at the Soviet ministerial level (Rowland and Telyukov 1991:76).[30]

[30] The remaining 20% of expenditures were spent in medical facilities run by some 20 ministries and large enterprises for their employees—the so-called "parallel system." The amount spent to maintain these better-than-average facilities is unknown as the funding comes from the federal budget for 18 of the parallel systems, and from a combination of the federal budget and unspecified extra-budgetary resources for parallel systems serving the military. One estimate assigns 15% of all outpatient facilities and 6% of inpatient facilities to this parallel network. Some of these facilities are now accessible to non-employees willing to pay for private treatment. (Tragakes and Lessof 2003: 36-7)

Table 3. Inpatient Utilization and Performance in the Russian Federation, 1985-2000, and Comparable Average Figures for the European Union (EU)

	1985 EU	1985 Russia	1990 Russia	1995 Russia	1998 Russia	2000 Russia	2002 Russia	2001[a] EU
Hospital beds per 100,000 people	866	1298	1306	1187	1111	1089	1071	611
In-patient care admissions per 100 people	16.52	24.3	22.8	21.3	20.7	22.0	22.8	18.33
Average length of stay, in days	15.1	17.0	16.6	16.8	16.3	15.5	14.7	9.75

Source: WHO Regional Office for Europe "Health for All" database. [a] 2002 EU data not yet available.

By the late 1980s, it was clear that health care was deteriorating. Chazov's outspoken criticism generated momentum for reforms; in November 1987 a law was passed incorporating suggestions made in an August Central Committee of the Communist Party of the Soviet Union and the Council of Ministers document entitled "Basic Guidelines for developing protection of the population's health and for the restructuring of the USSR's health service in the 12th five-year plan period and for the period up to the year 2000." This law called for significant changes in many aspects of the health care system, from improved training of personnel, to increases in spending on facilities and technology, to improvement in the national drug supply. As part of the latter, industry was to be prompted to produce enough drugs to meet national demand by 1993, and the number of drug warehouses and pharmacies across the country was to be increased.

Decentralization of the health care system first started 1988 when health institutions were given the right to set their staff levels and salaries independently

within a fixed wage bill.[31] In 1989 the USSR Council of Ministers extended a reform program (the New Economic Mechanism, or NEM) from pilot regions Samara, St. Petersburg and Kemerova to the entire health care system, thereby initiating a transition from vertical to decentralized management (Chernichovsky and Potapchik 1999: 126).[32] Local councils of peoples' deputies were given control over most of the financial resources dedicated to health care, including the right to adapt spending and investment to local requirements. The NEM and reforming legislation gave more autonomy to local health authorities, but did not change the way in which the health care system was governed. The federal Ministry of Health, for example, still approved the candidacies of all local Health Department heads until 1992. As a result, while these changes represented a significant departure from the previous, highly centralized health care system, they did not have an enormous impact: "because of a lack of managerial capacity on the part of local authorities, these new freedoms were hardly implemented" (Tragakes and Lessof 2003: 60). Tacit admission of this failure came in 1991. One of the last legal initiatives of the Russian Republic legislature was passage of a bill introducing mandatory health insurance.[33] The bill "remained mostly a dead letter" until it was revived and revised in 1993.[34]

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[31] Head Doctors, the top administrators in hospitals, were also given the additional right to transfer funds across salary, food and pharmaceutical budget lines in 1991 (Chernichovsky and Potapchik 2003: 126).

[32] The NEM sought to address excessive hospitalization rates, a lack of innovation and management at the local level, and mortality rates. It eliminated the incentive for Head Doctors to inflate the number of beds and visitors to their facilities. Samara reported that the reforms reduced the number of reported visitors to hospitals by 3 million in one year! (Galkin 2004)

[33] Law of the RSFSR "On health insurance of the citizens of the RSFSR" (No. 1499-1) of 28 June 1991.

[34] The initial legislation was an extension of the New Economic Mechanism, and it required that new commercial and governmental entities be created to run the new system of financing health care. New

The Soviet Union bequeathed to Russia a rigid, bureaucratic, overly hierarchical health care system staffed with poorly trained and motivated personnel. Even before the demise of the USSR it was clear that the problems of over-centralization and under-financing required urgent redress. Both the government elite at large and civil servants in the Ministry of Health were aware of the depth of the problem (though few would have encountered it themselves, insulated as they were by the largesse of the 4th directorate). Legislative changes were obviously required, and more comprehensive changes in formal rules were expected—at least at the top of the health hierarchy. Officials at the republican and regional level, aware of problems that had festered for at least a decade, may have understood that reforms were required to fix the system, but little could have prepared them for the magnitude of changes that swept Russia from 1991.

Changes in Formal Rules between 1991 and 1996

This dissertation is not the place to summarize all the legislation that accompanied the transfer of sovereignty over Russia from the Soviet Union to the Russian Federation.[35] Here we will concentrate on the major changes wrought on the bureaucracies and bureaucrats of the health care system. However since some of the changes in health care policy, particularly those related to the decentralization of state

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private insurance companies and agencies were meant to accredit medical facilities and control settlements between the medical facilities and insurance companies. The 1993 amendments to the law created the federal and territorial (i.e. regional) obligatory medical insurance funds (FOMIF and TOMIFs, respectively), in part because regional authorities had been slow to implement the original legislation. These funds were envisioned as "independent state non-commercial crediting-financing entities" (Shishkin 1995: 28).

[35] This topic has been addressed elsewhere, perhaps most productively in studies of how state bureaucracies changed during perestroika and beyond (e.g. Solnick 1998, Hellman 1993; 1998) and of how federalism evolved in Russia (e.g. Stoner-Weiss 1997, Guboglo 1997).

authority to the regions, were the result of more general legislation, selected non-health specific laws will also be touched upon.

Between 1991 and 1996, the key changes in formal rules for health care officials were stimulated by decentralization and the opening of drug distribution markets. These two areas will be treated in the following sections of this chapter.

Decentralization

The dissolution of the Soviet Union was accompanied by the demise of faith in central planning. The reformers who came to power with Boris Yeltsin rejected the notion that the central government could effectively provide the people of a country the size of Russia with the goods and services it required.[36] The state and its bureaucrats were seen as obstacles to Russia's economic growth and integration into the world economy. Yeltsin's desire to shake off Gorbachev and the remnants of the Soviet state prompted him to encourage regional leaders to "grab all the sovereignty they could swallow."[37] Regional officials, most of whom had climbed the Communist Party hierarchy to reach high-level posts under the Soviet regime, were well-positioned to seize control over regional governments, and did not hesitate to establish themselves as the central authorities in their respective regions. The ideological and personal motives encouraging decentralization were overwhelming in the early 1990s, and produced momentum for corresponding reforms in many areas of policy-making, including health care. Decentralization triggered important

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[36] In the words of those who helped design the Russian privatization program, "...at least in Russia, political influence over economic life was the fundamental cause of economic inefficiency...the principle objective of reform was, therefore to *depoliticize* economic life." (Boycko, Shleifer and Vishny 1995, 11).

[37] *Nezavisimaya Gazeta*, 4 May 2003

modifications in the bureaucratic structure of the sector and the way in which health care was financed.

Changes in Bureaucratic Structure and Responsibilities

In the Soviet Union, each Soviet Republic (the predecessors to the countries now part of the Commonwealth of Independent States) had its own ministry of health. When the Soviet Union ceased to exist in December 1991, the Moscow-based Ministry of Health of the Russian Soviet Federative Socialist Republic (RSFSR) merged with the All-Union Ministry to form the Ministry of Health of the Russian Federation. This Ministry existed until March 2004, when it was merged with the Ministry of Labor (albeit with an interlude as the Ministry of Health and Medical Industry).[38] Since 1991, the Ministry has been in charge of the health care at the federal level.

At the regional level, of each of Russia's 89 regional governments has a regional health department headed by the equivalent of a health minister.[39] The

[38] The head of the new consolidated Ministry, Mikhail Zurabov, is one of 17 ministers in a government formed by the Prime Minister (who is chosen by the President and confirmed by the Duma). Prior to the re-organization of the government in 2004, the Ministry of Health was one of 30 federal ministries in the federal government. One would not expect to see major changes in the relationships described in this dissertation as a result of the consolidation of two ministries into one, as the potential overlap in their activities lies beyond the realm of pharmaceutical activity.

[39] The executive branch at the regional level may be headed by a Governor or a President (as in the case of the regional Republics). Within the regional executive branch, the body in charge of health policy may be called a health committee, department, administration (*upravlenie)* or ministry. It is not clear that the difference in titles makes any difference in the authority of the regional body. From 1 January 2004, for example, the Samara oblast executive branch has been a "government" (*pravitel'stvo*) rather an "administration" (*administratsiia)* with "ministers" replacing "chairmen." While this was perceived locally as increasing the prestige of the regional officials, there were no indications that renamed civil servants would get more respect in Moscow with their new titles. For the sake of simplicity I will refer to all regional leaders as governors and all regional health bureaucracies as health departments.

health department is typically responsible for liaising with the Ministry of Health; establishing priorities for health care; managing the regional health care budget; working with regional insurance funds; supervising municipal and private medical providers to maintain quality controls; organizing training programs for medical and pharmaceutical professionals; and controlling the quality of pharmaceutical products distributed in the region.[40]

Regional departments oversee their counterparts at the municipal and *raion* level of government, though the extent to which they directly manage subordinate administrations varies. In Samara, for example, the budgets of the municipal and district health committees are partially controlled by the Governor's office.[41] In Bashkortostan, the regional government has no authority over the composition and implementation of municipal budgets (Dmitriuk 2004[42]). The role of municipal governments is generally limited to oversight of municipal health care facilities.

The dissolution of the Soviet Union and rejection of central control launched a series of legislative changes that strengthened regional governments vis-à-vis the Ministry of Health. A law passed in 1991 freed local governments from the need to get ministerial approval for their budgets.[43] A law the next year gave *krais* and *oblasts* the same rights as Russian republics in the areas of social and economic

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[40] See for example the "Main tasks of the [health] department" for Samara oblast. Available at http://medlan.samara.ru.

[41] The oblast budget pays for the insurance policies of all non-working Samara residents, even though this is formally the responsibility of the municipalities.

[42] This format is used to indicate interviews as well as references. The references at the end of this chapter include a list of cited printed materials as well as a list of cited interviews.

[43] The Law of the RSFSR "On the budget process of raions, cities, city raions, towns, rural settlements and other administrative territorial units of the RSFSR" of 10 October 1991 (No.1734-1) confirmed that regional bodies could develop their own health budgets without Ministry of Health approval.

development, including health services.[44] Regional departments assumed primary financial responsibility for health care, including paying for regional hospitals; making contributions to insurance funds for the non-working population; paying doctors and medical staff; purchasing supplies, equipment and drugs.[45] The Ministry of Health ceased to finance regional health care budgets apart from the fairly small contribution of the federal government to cover federal disease programs and the operations of federally-owned hospitals.[46] Although the Ministry retained a few core functions (e.g. health policy formulation, training, and research) it ended up with very little actual influence over local planning, spending, and standards (Tragakes and Lessof 2004, 173).

The 1993 Constitution of the Russian Federation solidified the regions' right to "jointly coordinate" the health care system in their jurisdiction along with the federal government.[47] Since then, regional health committees have operated under an imprecise system of "dual subjugation" whereby they are directly subordinated to the regional government but also supposed to follow directives from the federal Ministry

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[44] "On krai and oblast council of peoples' deputies and [on] krai and oblast administrations," Law No. 2449-1 of the Russian Federation, 5 March 1992.

[45]Certain social groups and sufferers of particular illnesses are also entitled to free or discounted drugs, regardless of whether or not they are hospitalized; these people are referred to as "Entitled" or *l'gotniki*. Reliably supplying drugs to these groups (known as *l'gotnoe obespechenie*) at reasonable cost has been a major challenge to health departments. The rest of the population is entitled to (though not often supplied with) free drugs only when they are hospitalized; this creates a perverse incentive for patients to demand hospitalization in order to save on out-of-pocket pharmaceutical costs.

[46] In Russian the expression "medical treatment facility" (*lechebnoe-profilacticheskoe ucherezhdenie* or LPU) is used to refer to hospitals, polyclinics, and other medical facilities. For the sake of parsimony I will refer to all these facilities as "hospitals." Russian hospitals may be under municipal, regional, or federal jurisdiction, which determines the state budget responsible for covering the expenses they incur that are not covered by obligatory medical insurance.

[47] Chapter 3, Article 72 of the 1993 Russian Federation Constitution.

of Health. In an environment supportive of greater regional sovereignty, the Ministry's lack of financial leverage meant that it had no credible means of enforcing its directives throughout the 1990s.

It would be incorrect, however, to assume that it was impossible for federal bureaucracies to have any control over regional bureaucracies under Yeltsin. True, the Ministry of Health (MoH) found it difficult to maintain influence over health departments in regional governments. But other bureaucracies with stronger vertical hierarchies and clearly subordinated regional divisions maintained greater influence over the implementation of policies at the regional level, even in the 1990's. In the context of the current discussion, the best example of this is the Department for Sanitary and Epidemiological Supervision (SES) within the Ministry of Health. This paradox of a weak ministry with a single strong department brings to the fore one of critical areas of formal rules governing Russian bureaucracies: direct subordination ensures tighter control over personnel and operations. The vertically integrated SES appointed regional directors from above, demanded that subordinate offices report regularly to superior offices, and closely monitored statistical results generated by its offices for signs of looming epidemics or problems.[48] In contrast, the Ministry of Health did not have direct control over regional health departments, which gave the latter leeway to view the Ministry as a source of guidelines rather than directives. In

[48] The relationship between the Ministry of Health and SES has always been unusual. In 1991 a decision was made to pull the Sanitary-Epidemiological Surveillance Service out of the Ministry of Health and make it a separate federal service. This was supposed to insure independent health services monitoring but it in fact "reflected the outdated perception that the poor performance of the public health system was due to failures with respect to communicable diseases" (Tragakes and Lessof 2003: 30-31). In 1996 SES was reintegrated into the Ministry of Health, but not without resentment from within SES.

this instance, ambiguity in formal rules allowed regional health departments to take a more informal, ad hoc approach to ministerial orders.

Changes in Financing of the Health Care Sector

In the Soviet Union, health care was supposed to be provided free of charge to all citizens. Citizens' right to free medical care was promised in the Soviet Constitution, but the specific package of benefits to be provided was not formally defined.[49] Then, as now, "public commitments to the coverage, eligibility, and comprehensiveness of health care ... [were] too declarative and ... not based on an actuarial approach" (Shishkin 1998). Available resources cannot cover the costs of health care promised. The ideological legacy of theoretically universal health care placed a heavy burden on regional governments. Individuals have also traditionally picked up slack in funding. In the Soviet era, doctors and nurses would often take under-the-table payments to supplement meager salaries (Ryan 1990: 27), a practice that has continued to this day (Shishkin 2003). However the proportion of resources coming from regional budgets and individual contributions has evolved considerably since 1991 (see Table 4).

One of the earliest reforms of the health care system was the introduction of obligatory medical insurance. As noted earlier, the first stab at an insurance scheme was made in 1991, though it produced no tangible results. Revisions to the law in 1993[50] created an insurance scheme that reflected the overwhelming drive to

[49] Article 43 of the 1977 revision of the Soviet constitution promised citizens free and professional medical services though state medical facilities.

[50] "On the system for financing obligatory medical insurance of citizens for 1993." Decision [*Postanovlenie*] No. 4543-1 of the Supreme Soviet of the Russian Federation, 24 February 1993.

decentralize health care, as well as a rather naïve hope that markets would solve the problems government had not (Field 1999). The thrust of the law was that companies would be required to make a payment equal to 3.6% of each employee's salary into the obligatory insurance system.[51] 3.4% of the contribution would be made to the regional obligatory health insurance fund (the so-called Territorial Obligatory Medical Insurance Fund, or TOMIF) and 0.2% would be directed to the Federal Obligatory Medical Insurance Fund (FOMIF). The federal

Table 4. Main Sources of Financing for Health Care in Russia, % of Total

Source of finance	1992	1993	1994	1995	1996	1997	1998	1999
Federal budget	11.3	8.9	8.6	6.4	4.9	7.7	4.6	4.9
Regional health budgets	88.7	75.3	64.7	60.6	58.6	53.1	47.1	44.7
of which: regional budget contributions to OMS for non-working population	--	0.5	4.5	6.7	6.3	5.1	5.6	5.2
Employer contributions for working population	--	--	15.6	14.7	15.7	14.5	16.0	15.9
Private contributions to voluntary health insurance [(a)]	0	0.9	1.5	2.0	2.5	2.7	3.0	3.5
Household payments for medical services[(b)]		1.6	2.2	4.7	6.3	7.3	9.1	8.4
Household payments for pharmaceuticals			7.8	13.2	13.7	15.6	21.1	24.9
Corporate payments for medical services			1.1	0.3	0.7	1.7	2.1	1.2
TOTAL	100	100	100	100	100	100	100	100

Source: Tragakes and Lessof 2003: 98. Original sources are Goskomstat, Health Economics No. 7 (2001). Note that while this study was released in 2004, it failed to come up with more recent statistics, and I have not found enough data to extend the table to later years. (a) These contributions are included in the household payments for medical services and corporate payments for medical services; (b) does not include under-the-table payments.

[51] The 3.6% tax rate levied on firms reflected the political leeway available to the government in 1993 rather than the level of funding required to keep the health care system afloat (Shishkin 1998).

fund was to use its monies to equalize disparities between wealthy and poorer regions, fund research, and control epidemics. Local governments were expected to make contributions to the TOMIF for the non-working population, though the rate at which they were to calculate contributions was not specified.

The OMIF system was envisioned as a source of additional resources for the public health care system. Companies would fund the OMIF, which would cover the actual treatment costs incurred by hospitals, and regional governments would continue to cover other medical expenditures as part of their budgets. Market-driven insurance companies were to serve as quality and price-control intermediaries between the TOMIFs and the hospitals. The law's designers proved to be overly optimistic. For a start, not all regional governments made adequate payments into the fund.[52] Second, rather than supplement existing public financing, in many cases the introduction of insurance funds led regional and local governments to begin reducing the health care line-item in their budgets (Shishkin 1998, Mr. Pokhmel'kin 2002[53]). As a result, net regional health care spending did not receive the boost intended by the insurance reforms. Third, the attempt to divide responsibilities between regional

[52] Goskomstat reported that in 1994, only 40 regions (of 89) made payments to the OMIFs as required. Although the non-working population was 8% larger than the working population, regional and municipal budget contributions to the TOMIFs were equal to only 31% of the contributions made by firms. (Shishkin 1995). This problem proved difficult to solve; in 1996, only 67 regions made contributions to their TOMIFs to cover the non-working population (Shishkin 1998).

[53] Where necessary, to protect my sources I have changed their names and sometimes their gender. To indicate that the names are not their real ones, I will add Mr./Mrs. to the reference. The qualifications for these sources are given in the list of interviewees at the end of the dissertation.

health departments and the new TOMIF bureaucracies proved to be complicated and often acrimonious.[54]

One prominent Russian specialist in the field of health care reform, Sergei Shishkin, attributed the half-hearted implementation of the original insurance law to the fact that the Ministry of Health had recently been transformed into the Ministry of Health Care and Medical Industry. New managers of this ministry came from the field of military health, and were put in charge of taking care of "other people's children." For a doctor from the Soviet military, the idea of medical insurance would have been completely foreign to their personal experiences and views. After struggling to ensure that firms would have to pay for the policies of the working population through their premium contributions to OMIFs, the Ministry "stopped working on questions of developing the legal and regulatory basis for obligatory medical insurance. The execution of reforms was left on auto-pilot and began to be implemented in a decentralized fashion" (Shishkin 1995: 29). In other words, certain formal rules were established, but when it became clear that there were gaps and problems with the legislation, Ministry officials failed to introduce complementary formal rules, and relied on regional officials to "fill in the holes" with ad hoc decision-making and informal rules.

It is important to note that the OMIF system has not been a total failure. The health insurance system works, albeit unevenly, and largely (ironically) as a state-run

[54] Health committee budgets pay for certain items or expenses that TOMIFs will not. In most regions, the TOMIFs reimburse hospitals for treatment given to a particular patient. They will thus pay for a portion of salaries and equipment used, as well as the drugs required for inpatient care (though they often have minimal control over the procurement procedures and prices). Government budgets cover utility costs and major equipment purchases. In each region, the coverage of expenditures by TOMIFs and departments has been developed through a combination of trial and error and bitter negotiation.

program, as many regions decided that tax monies should not be spent covering the overhead of multiple, private medical insurance companies. Obligatory medical insurance may not have significantly increased the resources available for health care in Russia, but it helped sustain overall health care spending throughout the turbulent 1990's when other government-funded sectors, such as education, suffered much greater reductions in support.[55]

Table 5. Per Capita Spending on Health Care Relative to 1990, Deflated by CPI (in Stable 2003 Prices)

Year	90	91[56]	92	93	94	95	96	97	98	99	00	01	02	03
Budgets	100	--	89	105	94	65	61	71	48	42	51	53	63	63
Budgets + OMS	100	--	89	119	123	82	79	93	66	56	68	70	84	96
Source: Institute of Economic Analysis calculation based on annual Ministry of Finance budgets.														

Distribution Markets

Decentralization gave the regional governments responsibility for managing drug supply in their regions. While the national legislature is responsible for passing national drug laws, in the early 1990s there was little federal legislation to guide the work of regional health departments in this area. Focusing a bit on this aspect of health care policy provides concrete examples of changes in formal rules introduced

[55] Overall budget spending (i.e. federal, regional and municipal spending) on health care in Russia has gone from 2.46% of GDP in 1992 to 2.24% in 2003, with a few bumps along the way. If one includes OMIF monies, however, public health care funding rose from 2.46% of GDP in 1992 to 3.39% of GDP in 2003. Table 5 demonstrates that *per capita spending* in constant prices has been reasonably stable throughout a period in which GDP fell by 45% (1989-1998).

[56] The 1991 budget figures for the Russian Federation were never formally approved, so comparing post-Soviet financing levels with the latest Soviet spending levels in the RSFSR is difficult. In addition, the Soviet consolidated budgets do not allow one to break out the regional-level spending on health care, only spending by Soviet Republic (e.g. Russia, Ukraine, etc.).

in the early 1990s, while highlighting the shortcomings that strengthened the role of informal rules. Health departments were responsible not only for sourcing the drugs needed by hospitals and specially entitled segments of the population (e.g. veterans), but also for supervising the activity of firms who appeared as early as 1992 to work this market.

Since the Russian Revolution in 1917, drug distribution and pharmacies had been under the control of the evolving but unitary "Pharmacy Department" (*aptechnoe upravlenie*). Different entities had been formed within this bureaucracy, including local "Pharmatsia" organizations with regional warehouses, but management was centralized in Moscow and reasonably effective in spreading limited drugs across the country. In 1992 pharmacies, warehouses, and local producers within the Pharmatsia structure broke away and became independent actors on the nascent pharmaceutical market. The transfer of most pharmacies to municipal property, plus the adoption of early anti-monopoly legislation, further eroded any organizational ties even among state actors in the pharmaceutical markets (Karaeva 2001). The head of one of the quality control centers described this period as a "terrible (*strashoe*) time," when the structure of their organization was also totally unclear (*ne poniatna*) (Mrs. Bezotechestvo 2002).

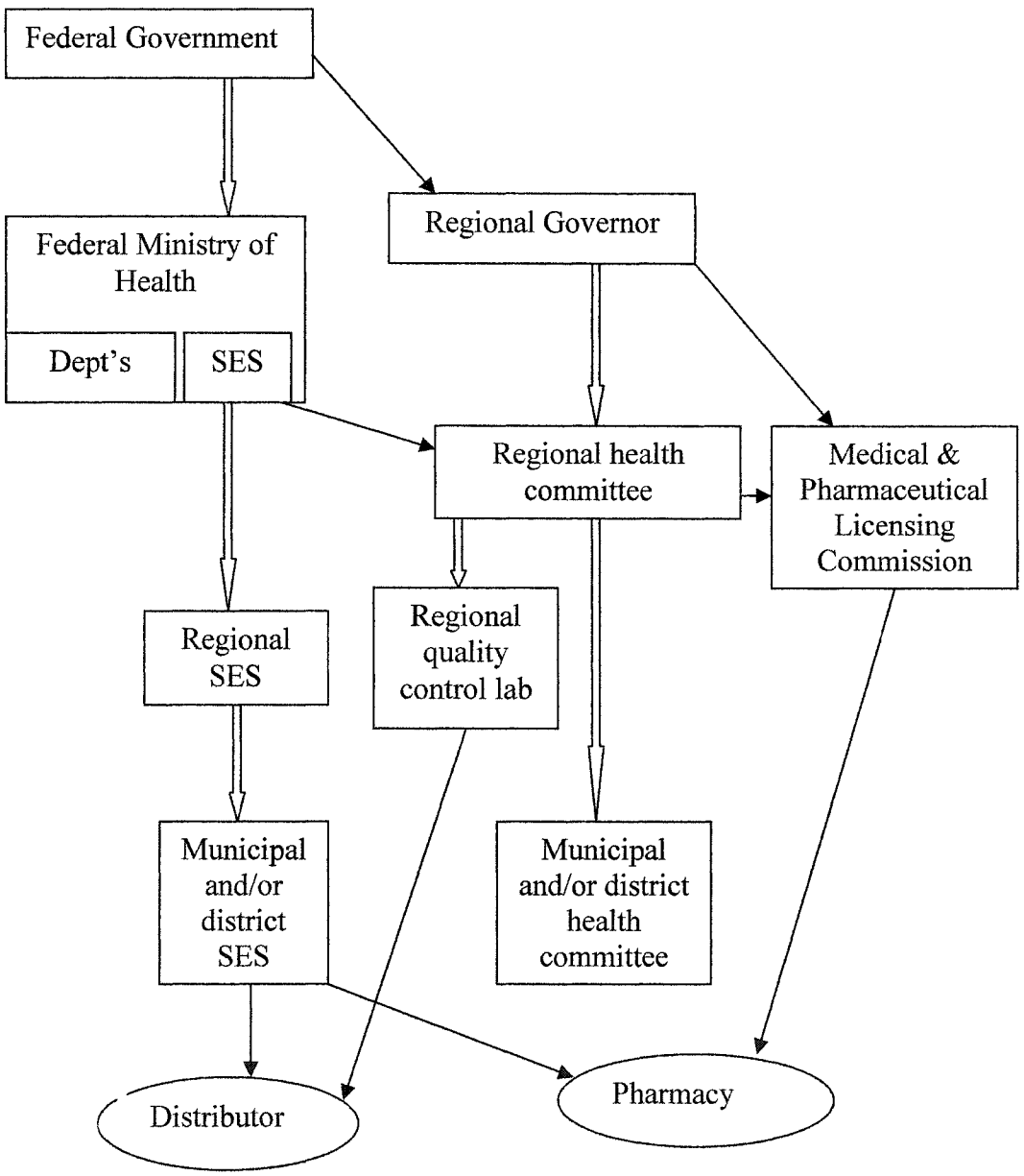
Until 1992, all drugs entering regional jurisdictions were distributed to drug warehouses in the regions by a central federal agency. Laboratories within the warehouses verified the quality of the drugs received when necessary. The health department determined how the drugs received should be allocated among regional hospitals and pharmacies. As Chazov pointed out in 1987, drug deficits were a real

problem in the Soviet Union. To alleviate shortages, the Yeltsin government cancelled the monopoly of the government distributor and allowed private drug distributors (often individuals with big suitcases) to travel around Eastern Europe and the C.I.S., sourcing drugs for Russia (Cherniavskyi 2002). These "distributors" would then bring their products into regional markets and sell them from the trunk of their car, at little tables in outdoor markets, or sometimes through pharmacies.

In regional health departments used to seeing drugs sold only through conservative state pharmacies, officials realized that some kind of controls were necessary, even if the federal government had not provided any guidelines. Bureaucracies were assigned different functions on an ad hoc basis, often in response to cases of medications spoiled by poor transport, storage, or sale conditions. Between 1991 and 1996 regions independently developed a system for keeping track of drug distribution firms. The system was different in each region, which complicated the work of distributors trying to serve a number of regions, but which reflected the organizational differences in health care bureaucracies. Figure 2 provides a schematic summary of the agencies responsible for overseeing distributors and pharmacies. It is intended to illustrate the bureaucracies involved without exactly replicating the system in any given region.

The development of a distribution market constituted a significant change in the formal rules for health care bureaucrats in the regions. No longer were they able to count on the regional "State Enterprise 'Pharmatsia'" to obtain shipments of drugs from Moscow for the region. On the one hand, this represented a potential improvement in drug distribution—the Pharmatsia warehouses had traditionally held

Figure 2. Schematic Summary of Key Regulatory Authorities for Retail and Wholesale Pharmaceutical Firms in Early 1990's



Note: Thick arrows indicate lines of direct subordination and control; thin arrows indicate that a bureaucracy has only partial influence over the subordinate entity. (a) The Ministry of Health has other departments besides the one responsible for licensing (formally entitled the Division for the Organization of Pharmaceutical Activity, Drug Supply, and Medical Equipment) and SES. The title and structure of these departments has evolved since 1991, but a list of those in operation as of 2003 gives an idea of how the bureaucracy is organized. Other departments include the Division for the Organization of Assistance to Mothers and Children, the Department for Professional Training and Development of Human Resources in Health, the Department for the Organization of Medical Assistance to the Population, the Department for Economic Development of Health Care, Management of Finances, and Material Resources, the Division of Scientific-Research Medical Institutions, the Division for International Cooperation, and the Department for Government Control of the Quality of Drugs and Medical Equipment. As of June 2004, the internal organization of the ministry changed, though its new structure has yet to be made public. The new ministry will undoubtedly retain responsibility for SES operations and oversight of wholesale licensing.

about 30 drugs in their reserves (a modern pharmacy holds an inventory of thousands of items) (TACIS 1997). On the other hand, officials in charge of drug supply not only witnessed the birth and growing pains of a completely new market, but were expected to control it. Interviews with public servants who worked in health departments at this time revealed the depth of their shock over the new direction drug supply was taking. Officials who joined health bureaucracies in Soviet times had never seen any private markets, let alone one that bore such high potential risks for consumers, and which flew in the face of deeply-held faith in the responsibility of the state to supply comprehensive health care. The effect that changes in the formal rules had on these officials is the topic of the next section.

Changes in Formal Rules Create Uncertainty

While the transition from Communism was initially imagined as a process of "decentralization from above," Moscow soon found itself responding to the demands of increasingly autonomous regions rather than directing a coherent transfer of power to lower levels of government. Beginning in 1990 and 1991, Republics had negotiated special relationships with the Yeltsin government. In 1992 and 1993 the Republics formed a coherent bloc to try to extract further concessions from the federal government. From 1994 on, the federal government began to conclude bilateral agreements with regions with special rights over natural resources or policy areas (Solnick 2002). Center-peripheral relationships between governments were far from smooth as both sides used the leverage they had to gain power—for instance Moscow sometimes delayed transfers to local budgets and the regions would collude

with enterprises to reduce federal tax payments (Shleifer and Treisman 2000: 124-5).[57]

In the area of health care, the decentralization of authority from the Ministry of Health to regional health departments also evolved spontaneously. A carefully planned and executed transfer of power from a central government to regional governments would have precisely delineated the authority of each, prepared for required modifications in policy, trained regional officials for their new roles, and perhaps have launched experimental pilot decentralization programs to identify problems ahead of time. The Russian decentralization of power happened somewhat differently, driven as it was by a total rejection of central planning, a collapse of the Communist Party hierarchy and its critical role in the monitoring of economic activity and training cadres, and an opportunistic grab for power on the part of regional elites. The result was that officials charged with implementing policy were given far more responsibility than they were prepared for. In the area of health care, the few years of partial reforms under Gorbachev from 1987 to 1991 had not made significant inroads in the education and preparation of health care officials. Regions ended up with de facto autonomy that could not be effectively exercised given their lack of managerial experience and dire financial straits (Tragakes and Lessof 2003: 60).

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[57] See Solnick 2000, 141 for a discussion of the content of these bilateral treaties. Note also that while the federal government was negotiating with feisty regions, regions were in some cases confronted with unruly municipal governments. Decentralization reached the municipal level in 1995 with the law "On general principles of organization of local self-government in the Russian Federation." Among other things, this law stipulated that municipal level governments did not have to report to federal or regional governments on health spending, though they were expected to comply with Ministry of Health orders. "This pose[d] a problem for health policy since *raions* [did] not have to comply with *oblast* level health reforms or other policies, and [were] only obliged to provide statutory health care services within their jurisdiction. In practice many regions and *raions* have developed a negotiating procedure so that the local governments remain with the regional [health committee] sphere of influence" (Tragakes and Lessof 2003: 36).

Health care bureaucrats in charge of initiating and carrying through reforms lacked the necessary management and technical skills, almost by definition. Largely drawn from medical or pharmacological educational facilities, they had been dutifully monitoring plan implementation and statistics—not making policy—for years. Budget and management in the Soviet era had been based on gradual increases on historical utilization patterns. As with the incremental increases in import and production quotas of state production firms, the number of beds in a region gradually rose, along with the number of doctors and funds spent. Regional health committees never independently decided how to efficiently organize health care in their region, and they were not at all prepared to reorganize their local system in an environment of severe financial constraints that invalidated the traditional input-based planning methods. Yet sovereignty meant that health departments were expected to develop strategies to deal with problems that had accumulated for decades, in addition to organizing the financing of hospitals under regional jurisdiction. The purchase of supplies, equipment, drugs, salaries for medical and support personnel, electricity, heat, water, and maintenance and/or construction charges became the responsibility of bureaucrats and hospital administrators who had done little more than watch funds trickle in and out of sub-accounts.

At the federal level, five uncoordinated administrations were now involved in different aspects of health care: the Obligatory Medical Insurance funds, the Ministry of Health, the newly-empowered Sanitary-Epidemiological Service, the parallel health care systems, and the Russian Academy of Medical Sciences. At the regional level, the Ministry of Health's emasculation left a loose set of quasi-autonomous

health care systems on their own. Attempts to formally divide authority among health care bureaucracies were ineffective. 1993 legislation entitled "Fundamentals of Russian Federation legislation for the protection of citizens' health" listed the responsibilities of federal, regional, municipal and district (*raion*) governments but failed to explain how the Obligatory Medical Insurance Funds and private insurers and medical providers fit into the health care system (Chernichovsky and Potapchik 1999:136).[58]

An extensive report on health care in Russia summarized the situation in the early 1990s:

> Planning, regulation and management functions are areas that were previously clearly delineated and subject to central control. Planning was the most highly centralized, but all three were carried out according to policies and standards determined at the level of the Soviet Ministry of Health. The post-1991 decentralization process has been so rapid and far-reaching, however, that there are fears that there may be a breakdown of core planning and regulatory mechanisms. ... Decentralization has occurred on a massive scale, resulting in a fragmented system of highly autonomous regions. ... Nominally the Ministry of Health has retained responsibility for oversight of the system (except for the parallel networks), oblast and raion governments own and monitor health care institutions, and [mandatory health insurance funds] deal with cash flows and insurance companies. However the respective role of the various players in planning, regulation and management has been obscured and the focus of the federal government on crisis management and systemic reform has left a leadership vacuum in many areas. (Tragakes and Lessof 2003: 44)

Officials in regional health care committees thus faced four major problems beginning in 1991. First, they had to assume responsibility for the survival and strategic development of health care capacity in their region once the "pyramid of command-administrative management and resource distribution organs had been

[58] Law of the Russian Federation No. 5487-1 of 22 July 1993, approved by Presidential Decree No.2288 from 14 December 1993.

liquidated" (Salikhov 2001). Second, they had to find sources of funds to pay doctors and nurses, and keep hospitals open, running, and supplied with vital inputs in conditions of hyperinflation.[59] Given the absence of a functional health insurance system, this task called for extracting money from skinny regional budgets and hoping that the funds reached the intended recipient fast enough. Third, they had to make the transition from input-based budgeting to more efficient mechanisms that would encourage cost-cutting by patients, doctors, and medical facilities. This required a grasp of profitability, a concept not widely understood even by the nascent private sector in 1991.[60] And fourth, these new problems could not be effectively addressed by existing health care bureaucracies and personnel.

Health care departments lacked departments for strategic planning, insurance programs, information technologies, and development of treatment standards (Mr. Krivopal'tsev 2002). Functionally unrelated units reported to a single manager, while functionally related units reported to different managers. It was not unusual for health committees to create both a Pharmaceutical Department (*pharmatsevtichesky otdel)* and a Department for Drug Supply (*upravlenie lekarstvennykh sredstv* or *upravlenie po obespechenie lekarstvennykh sredstv*). The former would deal with

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[59] Hyperinflation eroded the budgets that were approved, so that by the time purchases had to be made, there was little real money left. A pharmaceutical market expert in the Bashkortostan Anti-Monopoly Committee told me she had heard of doctors with "one ampoule left and three patients to treat. They had to literally decide who would live and who would not." (Mr. Orekhov 2004)

[60] When I worked in the privatization ministry (GosKomImuschestvo) in 1992-94, I spent much of my time convincing directors that private companies could be more profitable to their shareholders than state firms. Few directors were convinced that they would be better off, and that their enterprises would be better off, if they were forced to maximize profits. My later work at Brunswick Warburg, an investment bank, found me often trying to convince directors of now privatized companies that accounts that reflected real profits would be much more useful to investors than the pro-forma reports required by the tax authorities. Granted, in both situations the directors had their reasons to oppose changes that would potentially jeopardize their position, but the lack of understanding of hard budget constraints and the profitability motive was striking.

monitoring pharmacies and distributors, while the latter would make sure that the pharmacies and distributors were adequately providing drugs to the region. Later an additional licensing structure could be added in the region to license these same firms. Over time, each health department built its own organizational structure, usually in response to obvious gaps in policy coverage rather than as part of a strategic plan. A staggering diversity of bureaucratic structures still exists today.[61]

The leaders and staffs of health care bureaucracies were functionaries rather than visionaries, and had never been selected for their creative decision-making abilities. Many had minimal management skills—and of course no experience with the private sector. A recent study of young public servants explained that the problem in most of the post-Soviet bureaucracies was that

> [g]overnment officials in a transition society should have qualities that are to a great extent contradictory and even mutually exclusive. On the one hand, workers of ministries and regional administrations need the particular experience of government management which can be acquired only with years of work in this sphere... However this experience can, for natural reasons, come from the Soviet period, and can coincide with obsolete and seriously ideologically-oriented education, based on the normative ideas of the Soviet epoch (for example, the higher party schools). (Mogun et.al. 2003: 25)

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[61] As of 2003, the Ministry of Health reported that Russia had 17 regional Ministries of Health, 13 Departments (*department)* of Health, 11 *Upravlenies*, 10 Health Committees, 4 Main Health Departments (Glavnoe upravlenie zdravookhraneniya), and 3 Pharmaceutical Departments. (*Pharmatsevtichesky upravlenie*). All of these entities had their own organizational structure and relationships to other medical bureaucracies. After presenting this information, Natalia Podgorbunskikh, Head of the Department for the Organization of Pharmaceutical Activities, Drug Supply and Medical Equipment at the federal Ministry of Health added at a conference that it was a mistake to weaken federal unified control over health care organs. The result has been huge variation in the regional bureaucracies, some of which survive on 2 employees where others employ 39. Only 60.7% of these civil servants have a specialized pharmaceutical education. Source: Podgorbunskikh presentation at Apteka-2003 conference in Moscow, 29 October 2003.

The irrational structure of health bureaucracies can be gauged by subsequent efforts to improve them. In many health committees there are now ongoing attempts to improve the bureaucratic structure and effectiveness of spending. In Novosibirsk, for example, the oblast recently merged the Health and Pharmaceutical Departments. It also decided to devote more attention to the strategic planning, forecasting, and health care development department, and to the department responsible for organizing medical care. Even in 2004, this is considered extremely progressive (Sobolevskaia 2004).

In 1991, all of the bureaucrats in public service, and certainly all those at the top levels of regional hierarchies, were people who had served as officials in one capacity or another in the Soviet period. The turnover within regional bureaucracies in the early transition period brought few new technocrats into government service—over 30% of regional bureaucrats working in 2001 joined the civil service between 1991 and 1995. 45% of all officials working at the regional level in 2001, and 72.5% of those at the highest levels of the civil service (*vysshie dolzhnosti*) had begun their careers under Gorbachev or Brezhnev, and these proportions would have been 100% in 1991.[62] These people were not only ill-equipped to promote reforms under conditions of capitalism and democracy, but in many cases were skeptical, if not actually hostile, about the need for these changes.

Russia's transformation from a monolithic communist-run state was overseen by bureaucrats who were either supporters, opponents, or opportunists. Reformers in the small, first category were convinced that Russia had to change in order to survive, and were ready to throw themselves into the implementation of reforms. Opponents (including the majority of officials that I encountered in the privatization agency in 1992 and 1993) were openly resistant to the policies they were supposed to be implementing, and hopeful that the democratic interlude would be short. Opportunists, meanwhile, positioned themselves to profit personally from new economic rules. Even during *perestroika*, well-placed bureaucrats were already

[62] 27% of officials serving in 2001 joined the regional civil service between 1991 and 1995, most at the bottom rungs of the pay scale (*mladshie and starshie dolzhnosti*) (Mogun et. al. survey, 2003: 38). Using Goskomstat data the authors identify the entry dates of category "V" officials still working as of 2001 in the federal government, in federal offices at the regional level, in regional administrations, and in municipal government. Turnover has been lowest in the federal government, where 60% of current civil servants have been employed since the Communist era.

"stealing the state" and making the most of their access to valuable government assets (Solnick 1998; Hellman 1993).

Regardless of their personal loyalty to the reform process, Russian bureaucrats in the 1990s found themselves overwhelmed by change. The loss of their motherland as a country, the abrupt termination of the Communist Party's monopoly on economic and political power, the rapid devolution of power to regional governments, price liberalization, hyperinflation and privatization created an atmosphere of great uncertainty for all. Bureaucrats had relied on official orders and plans to guide their work. They had known to whom they and their departments were accountable, and understood how their activities were judged. The Soviet bureaucratic system may not have been efficient, but it was predictable. Officials below the Politburo and Ministerial level accepted that they were responsible for "strictly controlled functions... [with] limited capacity for decision-making" (Kotchegura 1999: 19). That predictability vanished in the early 1990's. In describing the transformation of health care in the early years of the transition, this chapter has highlighted the magnitude of the changes witnessed in a single policy area, and the degree to which new legislation failed to help officials cope with an increase in their authority and responsibilities. Uncertain of what was expected of them, and of how to meet these expectations, officials turned to informal rules for guidance. The next chapter examines how decentralization and the resulting uncertainty affected the working environment for bureaucrats in regional health departments, and analyses the coping mechanisms they applied as they struggled with the effects of the post-communist transition.

CHAPTER 3: Adaptation

1996-2000: Informal Rules Change and Influence Formal Rules

The Impact of Uncertainty: Increased Reliance on Informal Rules

A bureaucracy relies on formal rules to direct behavior and reduce inefficiencies. These rules are designed by actors who benefit from their application, and evolve in response to recurring events to coordinate the actions of actors and departments, and to increase the predictability and objectivity of bureaucratic behavior. Anthony Downs theorized that

> "...whenever an organization's environment is changing rapidly in an unpredictable fashion, its formal rules of behavior normally lag behind the conditions in which it finds itself. As a result, it must extend and adapt those formal rules so as to make practical and efficient responses to actual conditions. This means that organizations operating in rapidly changing and highly uncertain environments tend to rely heavily on informal structures and procedures." (1966, 64).

We must keep in mind that informal rules may not be at odds with formal rules; in the typology presented in Chapter 1, two of the quadrants allow that informal rules may complement or accommodate effective formal institutions. In the absence of effective formal institutions, informal rules may be an acceptable substitute for officials charged with implementing an incomplete or flawed piece of legislation (Galligan 1998: 486). In this dissertation, however, I focus more on informal rules that dilute the power, or at least the intent, of formal regulations.

This chapter looks at how officials in regional health departments coped with the rapidly changing environment described in the previous chapter. The chapter is structured as a narrative to bring out the evolution of responses by bureaucrats to decentralization and greater responsibilities. In order to extract the nuances of

behavior, the focus here is on the formal and informal rules that governed the licensing of drug distributors and pharmacies in Russia's regions.

Old Rules Are Applied to New Conditions

The 1993 law on medical insurance funds provoked the creation of licensing commissions across Russia. In the Soviet days, a single national distributor was supervised by the Ministry of Health and state-owned pharmacies were part of the pharmacy division of the regional health department. In the new Russia, private firms would not be part of a state structure, and it was felt that their access to pharmaceutical markets should be controlled. Licensing commissions were opened for business, but they lacked guidelines on how to discriminate "good" from "bad" firms, and on how to issue, extend, and withdraw licenses.[63] In the absence of a comprehensive federal law on licensing pharmacies and distributors, the Ministry of Health issued directives (*prikazy*) to fill in regulatory gaps[64] and regional governments introduced their own rules. In the Republic of Bashkortostan, for instance, legislation adopted in July, October, and November 1993 developed the

[63] Incomplete or contradictory federal legislation was hardly unique to the pharmaceutical sector. In the area of privatization, presidential decrees (used when the national legislature began resisting Yeltsin's reformist measures) outlining auction procedures for industrial enterprises contradicted earlier rules drafted by the same team at the State Property Committee (GKI). The basic requirements for the newspaper ad announcing a voucher auction, for example, were repeated in two decrees, but the list of required details that had to be included was slightly different. To be safe, regional officials included all the details listed in both decrees.

[64] For example, Ministry of Health Directive No. 93 "On measures for implementing the Russian Federation Law 'On Medical Insurance of Citizens in the RSFSR'" of 20 March 1992; Directive No. 16 "On measures to implement RF Government decision No. 970 from 11 December 1992 'On procedures for formulating prices on drugs and medical equipment and provision of measures to socially defend citizens'" from 20 January 1993; and Directive No. 148 "On licensing and accreditation of medical facilities" from 28 June 1993.

legal base required for the new Licensing Commission to operate.[65] A comprehensive federal law, complete with deadlines for considering licensing applications and list of required documents, was issued only at the end of 1994.[66]

Street-level officials in charge of regulating firms in the pharmaceutical industry were put in an awkward position. In the absence of new rules, many initially continued applying Soviet-era legislation, despite the fact that it was obsolete (Mrs. Chesnokova 2004). Standard operating procedures were applied to new situations, regardless of whether or not they were appropriate. "Before 1995 or 1996, officials just signed papers as they always had, just changing the date at the top of the page. All drug purchases in the republic had gone through Bashpharmatsia before [1993] and everyone assumed that this must be the best way to do things" (Mr. Orekhov 2004). In the face of the tremendous personal, political and economic changes experienced in the early 1990's, local officials apparently found it comforting to sustain the illusion that "the legal base was pretty well-balanced (*stroinnaia*)" (Mrs. Smetannaia 2003). "Even in 1993," explained a former head of a regional licensing commission, "there were rules for pharmacies and orders that could be followed" by those looking for concrete policies to implement (Mrs. Chesnokova 2004). An initially conservative approach is what one would expect from bureaucrats born and

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[65] Decision [*Postanovlenie*] No. VS 18/41 of the Supreme Soviet of the Republic of Bashkortostan "On procedures for licensing and accreditation of medical activities" of 14 July 1993 (pharmaceutical activities were included in this document.); Decision No. 422 of the Council of Ministers of the Republic of Bashkortostan "On activities of the Republican Licensing-Accreditation Commission of the Ministry of Health of the Republic of Bashkortostan" of 7 October 1993; Decision 478 of the Council of Ministers of the Republic of Bashkortostan "On the introduction of a unified system of state licensing of different types of activity in the Republic of Bashkortostan" of 29 November 1993.

[66] Decision No. 1418 of the Government of the Russian Federation "On licensing different types of activity" of 24 December 1994.

bred into the Soviet bureaucratic apparatus, even as the conditions supporting the state apparatus disappear.

Informal Practices Emerge to Fill Regulatory Gaps

Issues that were not clearly outlined in old or new federal legislation demanded local interpretation. While the application of obsolete Soviet rules may have kept bureaucrats busy in the early transition years, it was not an acceptable way to manage new firms and encourage improvements in drug supply. By 1993-94, health department officials were under pressure to support yet control the rapidly expanding retail and wholesale markets that were springing up like "mushrooms" (Mrs. Nekhoroshaia 2002). The lack of federal licensing rules, lax supervision by the federal government over implementation of other federal laws, the incompleteness of Ministry of Health guidelines, and the inability of the Ministry of Health to insure compliance with the directives it did produce led regions to devise their own rules for pharmaceutical firms seeking licenses. Where the health department was capable of showing initiative, it lobbied for regional licensing regulations. In other regions, officials took it upon themselves to introduce informal rules for evaluating license applications. The legal environment was so unstable that firms often did not know if the requirements they were asked to fulfill represented formal or informal rules.

Ministry of Health rules dating from the 1960s had stipulated the minimum amount of real estate required for urban and rural pharmacies. In addition, to ensure that pharmacies were spread out across the country, they were not allowed to be

closer than 500 meters apart. Non-binding 1994 standards produced by the Ministry of Health[67] specified that stores selling drugs had to be at least $12m^2$ big.

In the absence of modern rules that would allow anticipated consumer demand to determine the size and location of pharmacies, health department officials often concluded (not entirely unreasonably) that the old criteria for pharmacies should remain in force.

When entrepreneurs challenged the relevance of old rules, licensing officials resorted to other, less formal criteria to allocate licenses. The Marii El official in charge of licensing in 1996, Galina Otmakhova, had come to her post as the former director of one of the capital's (Ioshkar-Ola) largest pharmacies. She didn't believe in private health care, and tried hard to find problems in the license applications of private pharmacies. She would only approve new pharmacies that occupied space previously held by a state-owned pharmacy, as only then could she be confident that the facility met old Soviet requirements for the size of the salesroom, drug preparation rooms, staff dressing rooms and restrooms. The problem was that few state-owned pharmacies were being closed, which meant there was virtually no acceptable retail space available for the new pharmacies that were very much in demand. The replacement of Otmakhova by a new official freed up entry into the local market, strongly suggesting that she was personally responsible for enforcing

[67] Deputy Minister of Health V.K. Agapov produced two sets of non-binding standards in 1994. One from March 1 noted that the size of drug warehouses "should depend on the volume of goods stored," and can vary from 30 to 100 m2. The standard from September 1 of the same year stipulated that "pharmacies" (apteky) should be at least 90 m2, should be no closer than 500 meters from one another, and should be distributed at a rate of 1 per 9,500 urban residents and 1 per 6,500 rural residents. Pharmacy kiosks should be at least 10-12 m2, and pharmacy "points" should be 12-22 m2, depending on whether or not they were serving the Entitled population. These standards were not formalized in a Ministerial directive, not signed by the Minister of Health, and not confirmed by the Ministry of Justice (as a directive would be). Consequently, they were largely ignored.

these restrictions on licensing (Mr. Krivosheev 2003). In Orenburg the head of the licensing committee has a similarly personalized approach—she insisted on personally inspecting all proposed facilities herself, even though the banana-shaped oblast is over 750 kilometers long and bigger than Austria.

Although Ministry of Health policies and directives did not articulate a preference for state firms over private enterprises, in practice ownership structure affected the way in which pharmacies were regulated. Municipal or regionally-owned pharmacies were considered "loyal"; they would stay open on weekends, produce unprofitable solutions and crèmes in their laboratories, and out of a sense of moral obligation, ship saline solution to children's hospitals knowing they might not be paid on time (Otmakhova 2003). Private pharmacies, however, were seen as more aggressively concerned with the sustainability of their operations. They did not deliver drugs without credible promises of payment, and were less susceptible to pleas that they should "help out" the municipal government by selling at low prices. Regulatory officials in the drug supply divisions of health departments often felt that they were thus entitled to treat private pharmacies more harshly (Mrs. Smetannaia 2003).

Formal Rules are Replaced by Informal Practices

The leaders of regional health departments fought political battles to increase health care allocations in regional budgets, keep hospitals open, and avert noisy protests by doctors about wage arrears. Their subordinates tried to spread money for drugs across pharmacies and hospitals, ensure that hospitals were providing

minimally satisfactory care, prevent protests by invalids and the elderly, and cajole firms into supporting their efforts. The responsibilities of bureaucrats at different levels of the health care departments varied, as did their response to a lack of supervision from the Ministry of Health.

In the Soviet Union, all levels of authority were strictly subordinated to the level above, with no need for independent decision-making below the top levels of a ministry or party regional committee. Party officials were present in all offices to ensure compliance with directives sent down from higher authorities.[68] In Russia after 1991, health department heads were subordinate to governors (who selected them), but generally not subject to close supervision by other bodies. The regional legislature supervised overall implementation of health programs in the region, and could interrogate department heads on their performance. But it was extremely unlikely that a department head chosen by a governor would be removed as a result of legislative hearings. Mid and lower-level bureaucrats within health departments were ultimately subordinate to the chairperson of the health department.

In a few fortunate oblasts, innovative leaders emerged with a vision of how to reform local health care and the management skills required to pull it off. Samara, which had been at the forefront of the New Economic Mechanism reforms of the late-1980s, continued to lead the way in the areas of medical insurance (the national program having been based on a Samara pilot scheme); efficiency gains (replacing expensive hospital care with ambulatory treatment where possible); and modernization of staffing (emphasizing the training of General Practitioners rather

[68] As noted in Chapter 1, careful monitoring by party officials did not exclude the use of informal rules that contradicted or accommodated formal rules.

than specialists).[69] In most regions, however, the bureaucrats at the top, middle, and lower levels of health care bureaucracies lacked the qualities needed to salvage the crumbling health care system.

The tasks confronting leaders of health departments as policy-makers, and facing their subordinates as policy-implementers, were different. The former had to compete against other department heads for funding from the regional budget, liaise with the Ministry of Health, negotiate the ongoing relationship with the TOMIF, develop a plan to allocate scarce resources among hospitals funded by the region, figure out how health facilities shed by privatizing state enterprises would be absorbed into the regional infrastructure, and supervise the operations of the various divisions of the health department. Division (*otdel*) heads and their officers were expected to implement policies formulated in cooperation with the department head, monitor their policy area (e.g. licensing[70], pharmaceuticals, maintenance of health resorts) for problems and results, liaise with firms involved in that policy area, and collect data related to activities in their area. Health departments also had divisions with street-level officials that would participate in the inspection of pharmacies or handle the complaints of citizens who received unsatisfactory medical treatment or had problems with medications. As in most hierarchies, leaders concentrated more on

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[69] One might well ask how a Professor Galkin (head of the Samara health department from 1987 to 2000) burst out of the Soviet period with the vision and skills required to thrive and lead reforms in a complicated transition. The study of leadership, and particularly of leadership in transition, has generally been focused on presidents and oligarchs. Unfortunately we lack good research on the conditions that promote good leaders in lower levels of government, particularly among non-elected officials.

[70] In some regions the licensing commission was integrated into the health department, but in many (until 2004) it was an independent agency that worked closely with the Pharmaceutical Division of the regional Health Department.

maintaining political support for the bureaucracy and overall policy design, while lower-level officials worked on policy implementation.[71] Consequently, the problems confronted by bureaucrats at different levels of an organization are different, as are their responses.

The rest of this chapter will focus on two areas in which the absence of formal rules encouraged informal rules. In each area, the initial discussion looks at the pressures and opportunities confronting officials, and at how the informal rules gain importance. In some cases they are codified into formal constraints, but in others they remain important as unwritten guidelines for solving problems.

The Creation of Administrative Barriers

Officials in regional bureaucracies in the early 1990's were not only lacking a solid formal legal base with which to work—they also lacked funds. Regional budgets were stretched thin, and even federal ministries found that they didn't have the money needed to sustain their field offices. Rather than close down regional offices, however, federal agencies encouraged their local divisions to become "self-financing" by finding ways of collecting money from the firms they regulated (Radaev 2002). The regional offices of federal agencies began offering consulting services (some mandatory) to firms requiring their permission to operate. They also often set up new administrative barriers, for example by requiring that firm employees receive official training in fire safety, in order to collect rents in the form of official fees from those subscribing to the newly-required services, and informal bribes from those seeking to circumvent the requirement (Radaev 2000).

[71] In the words of Herbert Simon, "the actual physical task of carrying out an organization's objectives falls to the persons at the lowest level of the administrative hierarchy" (1945: 1-2).

Illegal rent-seeking based on corruption has been extensively described in the corruption literature. "[C]orrupt officials, seeing the financial benefits of accepting bribes, frequently have the discretion to redesign their activities. They may create scarcity, delay, and red tape to encourage bribery" (Rose-Ackerman 1999: 26). What is unusual in the Russian case is that not all of the rent-seeking behavior of the regional offices was illegal—in fact, it was encouraged by the head offices of these bureaucracies as a means of surviving strained economic circumstances. This provides us with an illustration of how informal constraints can be formalized. Fundraising from regulated businesses was not foreseen in formal regulations, but it became critical for local offices when they had no other means of funding their operations. Over time ministerial regulations governing regional offices were written to specify which services could be provided for a fee, and to set limits on the fees that could be charged. (By the late 1990's much had been said about the slow growth of small and medium businesses in Russia; part of the problem was attributed to expensive regional administrative barriers, which the federal government tried to reduce.)

The evolution of licensing fees for pharmaceutical firms in Bashkortostan provides a useful demonstration of this phenomenon. A 1994 federal decision allowed licensing commissions to charge firms on the basis of expenses incurred by the regulating agency in the course of reviewing the application and issuing the license.[72] The agency itself was allowed to assess its costs. In 1998 a Republican law specified that the licensing commission could not accept a fee greater than the

[72] Decision [*Postanovlenie*] of the Government of the Russian Federation No. 1418 "On Licensing Different Types of Activities" from 24 December 1994.

equivalent of 100 average monthly wages (known as *MROTs*) for the review of documents and issuing of new, duplicate, or extended licenses.[73] A federal law passed 2 months later significantly reduced the acceptable fees: review of an application could cost only 3 MROTs, issuing of a license was to cost 10 MROTs. The price of obtaining information about a licensee from the official registry was to reflect the costs incurred by the licensing committee in the course of preparing a registry extract.[74] In the next year a government decision recognized that the cost of generating a registry extract could not possibly be very large, and limited such fees to 1/10 of a MROT.[75] In sum, the fees charged for licensing were initially determined by the local office, then subject to a regionally set ceiling, and finally reduced by federal regulation. No one would argue that charging a fee for licensing is inappropriate. What is interesting here is that the originally informal mechanisms used for setting the fee were gradually set down in formal rules and reduced over time.[76]

The regional offices of federal agencies ultimately report to their headquarters in Moscow, while bureaucracies that are part of regional governments report to the governor's administration. On the ground, officials in regional bureaucracies are well aware of how their counterparts in federal bureaucracies are financing their

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[73] Law of the Republic of Bashkortostan No. 166-3 "On Primary Licensing of Different Types of Activities in the Republic of Bashkortostan" from 13 July 1998. In 1998 a MROT was equal to 83.5 rubles, or about $13.50.

[74] Federal Law No. 158-FZ "On Licensing Different Types of Activities" from 25 September 1998.

[75] Decision of the Government of the Russian Federation No. 387 "On Licensing Pharmaceutical Activities and Wholesale Trade in Drugs and Medical Equipment" from 5 March 1999.

[76] The actual cost of obtaining a license may not be reduced, of course, if the "unofficial fees" charged by the licensing agency increase in response to falling official fees. But generally speaking, reducing the official cost of a service should bring down the unofficial surcharge as well.

operations. If federal offices are getting away with charging fees for routine services, then local bureaus are more likely to start introducing similar rent-generating administrative barriers. Officials involved in licensing introduced restrictions on acceptable real estate, increased the number of signatures and approvals required to open a firm (Mrs. Chesnokova 2004, Sobolevskaia 2002),[77] carried out more unplanned inspections for existing firms, raised the fines imposed for violating rules, and demanded that firms "help out" state agencies with free goods or services. Receiving permission to renovate an office building, for instance, not infrequently involved promising to clean up a neighboring park and install a playground for local children.

Street-level inspectors acquired a reputation for squeezing firms for bribes, goods, and services (Frye and Zhuravskaya 2000; INDEM 2001). It was not uncommon for police inspectors to visit all the storefronts on their beat before major holidays to ask for "contributions" to the local orphanage. Or to ask firms to provide their goods and services for free-- the maker of steel doors would be ill advised to refuse a polite request by the local police division to replace the doors of the precinct station for free. Inspectors from the sanitary-epidemiological service, trade inspectorate, or tax inspection (to name just a few) routinely visited firms in their

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[77] Requiring applicants to submit additional paperwork is not a novel response to inadequate legislation. On 2 July 1999 the Ministry of Health issued a directive (Prikaz No. 266 "On procedures for taking decisions on allowing clinical testing of drugs") that required applicants to submit more documents than had been earlier stipulated in the Federal Law "On Drugs." In this case, applicants were required to provide evidence of insurance. In addition, the directive broadened the list of reasons that could be used to deny an application, and allowed for considerable discretion on the part of the MoH Department for Quality Control. The directive was never registered with the Ministry of Justice (as required), and was cancelled after the International Confederation of Consumer [Protection] Societies, KonFOP, (on behalf of the League for Promotion of Clinical Trials and Defense of Patient Rights) questioned the Ministry of Justice about the validity of this rule (Zavidova 2001).

jurisdiction to collect informal contributions to their pocket or their organization. This casual extortion usually followed an established pattern: A fireman would walk into a pharmacy, jiggle the handle on the door, pointing out that it was loose—a violation of the fire code—and then ask for the antibiotic that the doctor recommended for his son (Mr. Neliubin 2003).

A 1997-98 study that asked Russian entrepreneurs how they overcame administrative barriers confirms that informal rules were important in setting the actions of officials and entrepreneurs in the 1990s. In the absence of effective formal rules governing market activity, officials and businesspeople relied on informal agreements and relationships in their interactions. They employed one or more of the following three strategies: petty corruption, political connections, and the use of intermediaries (Radaev 2000). While all strategies are based on informal understandings of how bureaucrats relate to the constituency they regulate, only the use of intermediaries can be formalized into official requirements. The abuse of one's position to collect money or obtain favours for contacts are destined to remain informal institutions, while the introduction of intermediaries can be formalized.

Petty corruption, or bribery, encompasses private payments to low-level officials responsible for implementing laws, rules and regulations.[78] Although it is inherently impossible to analyze thoroughly, there is a near consensus that bribery is endemic in nearly all Russian bureaucracies although its incidence varies from organization to organization (INDEM, etc.). Firms reported in the 1990s that corruption among inspectors and officials was a constant hassle. More recently, the

[78] This is sometimes also referred to as "administrative corruption" (Hellman, Jones, and Kaufmann 2000).

relative importance of corruption as an obstacle for firms has fallen as other problems—such as competition from other firms—has increased (CEFIR 2002). My impression from interviews is that corruption is no longer a major obstacle to doing business not because inspectors have become honest. Rather, Russian entrepreneurs have come to understand what a peaceful relationship with their inspectors requires, and they go into business expecting to pay a certain amount in bribes. Larger pharmacy chains usually have a "fixer" among their employees who is in charge of the delicate negotiations that ensure that corrupt demands are kept within acceptable limits (Mr. Krovopustov 2000). Informal conventions with these inspectors and their agencies have made low-level bribery predictable and manageable. Although they are important in guiding the behavior of officials, because they are overtly illegal, rules governing corrupt transactions are not formalized into official regulations.

The use of political connections allowed certain entrepreneurs to circumvent administrative barriers thrown up to firms. "If an entrepreneur has good connections with civil servants, or with higher political officials he/she could get a license without wasting time in the lines and paying bribes for accelerating the formal procedures" (Radaev 2000). In Bashkortostan, a region allegedly run on the basis of "telephone law" (under which officials call each other to help out their contacts), a mid-level official reported that he once got a call from a bureaucrat highly placed in the republican ministry of health asking him to "favorably consider the application of a certain firm." My contact allegedly replied, in overt violation of telephone law, that he would be happy to review the application of the firm mentioned by the contact—just as soon as the firm submitted a complete dossier.

The use of intermediaries (*posredniki*) to circumvent administrative barriers can be advantageous to both bureaucrats and firms. In the early to mid-1990s, firms relied on "experts" to help them register or license their firm.[79] Intermediaries worked their connections in regional and municipal bureaucracies to obtain required permits and approvals, often paying an accepted "unofficial fee" on behalf of their clients. Officials were comfortable working with people who understood how to apply for licenses and whom they had come to trust from repeated interactions. By the end of the 1990's, the informal use of intermediaries had become more institutionalised in some bureaucracies. Their use was not strictly proscribed by law, and thus these informal arrangements could be integrated into formal rules. Government agencies set up special companies whose services a firm had to use in order to apply for permits or licenses. These firms frequently were conveniently located in the same building as the referring agency (Mr. Krovopustov 2000). In Moscow, for example, the city architectural commissions would only review blueprints prepared by an "approved firm" in granting permits for apartment renovations. The favoured firm did not do original work—it merely recopied the plans of other architects, as original client blueprints were not acceptable to the permit commission. At the beginning of 2001, a study of 2000 small and medium-sized businesses in 20 regions found that 18.5% of firms that needed licenses were told that their applications would not be considered if they did not use an intermediary. For 21% of surveyed firms, a specific intermediary was recommended (CEFIR 2002).

[79] These services cost from "several hundred dollars for registration to several thousand dollars in the case of sophisticated licensing" (Radaev 2000).

The Abuse of Conflicts of Interest

The advent of capitalism in Russia presented both problems and solutions for health care. While getting enough money to finance the regional health care system was always difficult, the fact that drugs and equipment were available through markets rather than administrative allocations facilitated their acquisition once money had been obtained. For officials in charge of health care budgets in hospitals or local governments, the careful spending of public funds was critical. Unfortunately, these bureaucrats were often prone to exploiting conflicts of interest. Old control mechanisms like the Communist Party and the Ministry of Health, while not always effective at curbing abuses (Roeder 1993; Solnick 1998; Chazov 1991), had provided some form of institutional accountability under the Soviet system. In post-Communist Russia, Head Doctors and Heads of Health Departments appear to have misspent their budgets with little fear of reprisal. Legislative controls on regional spending were ineffective. Formal constraints did not make them accountable to auditors who could effectively identify improprieties and punish transgressions.

Tracking the way in which public monies have been spent on drug procurement reveals much about how old informal rules have been applied to new situations and institutionalized into new formal rules. Looking carefully at the process of informal rule change also reveals instances in which attempts to institutionalize informal rules were thwarted or reversed.

In the early 1990s, drug procurement went from being completely centralized in Moscow to being completely decentralized to Russia's myriad hospitals and pharmacies. Regional and municipal health departments responsible for ensuring that

Entitled citizens had access to promised drugs trusted doctors to write needed prescriptions, and state pharmacies to honor those prescriptions. Pharmacies then submitted an invoice to the appropriate department requesting reimbursement. There was virtually no system for forecasting the volume and type of drugs that would be distributed, and no reliable budgeting for these expenses in advance. Many doctors abandoned the practice of writing prescriptions (and pharmacies often stopped asking for them) (Mr. Belokurov 2004). When hyperinflation hit Russia, any trace of budgetary planning evaporated, and health departments were powerless to cover the cost of even the most essential drugs. Some "loyal" state pharmacies continued to release medications to desperate clients over the years, even as arrears of state budgets to these pharmacies mounted.[80]

Several mechanisms were used by unscrupulous officials to siphon off a portion of the scarce funds intended for medical and pharmaceutical procurement. Drug distributors participating in tenders were asked to provide kickbacks to the tender commission[81], tenders were rigged to favor a preferred firm[82], and overly

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[80] When reimbursement periods dragged on for too long and they ran out of working capital to buy drugs from suppliers, these pharmacies counted on emergency infusions from the budgets. The loudest complainers—or those that stopped releasing narcotics to Entitled customers for a day—would get bailed out first. While the pharmacy might receive a cash infusion, employees were hardly rolling in cash. The director of one of Ioshkar Ola's largest pharmacies told me that she personally received her salary twice in 1998 and 1999 (Otmakhova 2003).

[81] A scheme allegedly widely applied in one Volga region exploits the tenders used by the regional administration for purchases of drugs such as insulin. The winner of the competitive tender is told to double his bid in all paperwork. The region pays the doubled price and then half of that sum is returned in cash to procurement officials. "Everyone there needs for everything to be done in the shadows," (*vsem vse nado v chernoe*) said my entrepreneur-contact. "And when we ask the organizers of the tenders why they aren't interested in the price list and why things have to be done like this, they tell us that this question is not for us"—implying that this system has been imposed on agencies from the gubernatorial administration (Mr. Cherepakhin 2002).

[82] One of the more common schemes is to dispense with open tenders altogether and rely on rigged bids rather than open tenders to source equipment and supplies (*zapros kotirovok*). Legal under a Yeltsin decree on local procurement, officials use the system to solicit a prearranged winning bid from

expensive purchases were made to mask commissions paid to purchase officers.[83] Head doctors, for their part, were also able to milk the funds intended to cover the cost of supplies for their hospitals. Many developed a reputation for taking kickbacks from drug distributors.[84] In these instances, the formal rules governing procurement were manipulated to allow contracts to be allocated according to informal rules of gift-giving and connections. The informal rules were not, however, formalized into new procurement regulations.

Moreover, in the second half of the 1990s, attempts to formalize illegal practices did not go entirely unnoticed. As the inevitability of the transition process became more certain, officials with initiative began to understand how to advance health care in those trying times. In 1995 some regions moved to improve the procurement systems for drugs purchased with budget funds. Several regions studied how their drug funds were being spent and found that the prices paid by different hospitals and pharmacies for the same drug varied widely. More proactive municipal governments reacted by recentralizing some drug purchases. In Samara, for example,

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their favorite vendor while collecting a few unattractive proposals from prearranged losers for cover. One of the officials I met in an anti-monopoly committee illustrated this technique. Her husband is the director of a school. He needs to buy something, and is told to use firm X. When he complains that he can source the materials more cheaply from someone else, he is ordered to use firm X, and to collect a few more expensive bids as well to make X look good.

[83] Procurement officers in health departments can also exploit the tried-and-true method of purchasing expensive medical equipment for regional medical facilities. Although many hospitals lack for the most basic medical supplies, many have acquired sophisticated equipment they could have done without. Some of this expensive equipment cannot even be used as it requires trained specialists that the hospitals lack (Ushakova 2004). One source claimed that the wide distribution of ultrasound machines across Russia is a good illustration of suspicious over invoicing.

[84] When the already inefficient centralized deliveries of drugs ceased in 1992 and 1993, hospitals bought supplies wherever they could. Drug distributors, former doctors or traders looking for profits in any industry, would visit hospitals trying to sell whatever drugs they could haul around in their care. Over time, these sellers established relationships with the head doctors, usually be offering them commissions on drugs purchased or even stakes in their firms. Some hospital administrators even created "pocket distributors" that would source drugs from one firm and sell a portion out the back door for a profit.

the mayor issued a decree that established a system of municipal tenders. These were, according to market participants, open and fair, and allowing the city to purchase more drugs at better prices.[85]

In addition, other counterbalancing forces were massing to fight illegal administrative barriers. The Anti-Monopoly Committee (AMC) began to apply new federal legislation to confront local restrictions on market entry. In Bashkortostan, new federal laws and professional associations of pharmacists helped the AMC strike down local rules designed to favor certain market participants over others. The republican Ministry of Health, for example, was forced to cancel directives requiring state pharmacies to buy their supplies from the state-owned drug supplier Bashpharmatsia.[86] Attempts to impose barriers to entry often ended in court cases and sanctions from the anti-monopoly committee (Mr. Netak 2002). An official in Volgograd complained bitterly that attempts to keep pharmacies from being opened next to one another had resulted in "bacchanalia." By the close of the 1990s, companies discovered that the courts and anti-monopoly committees in progressive regions were increasingly willing to help them fight discriminatory and discretionary practices. Regional administrations under the sway of more dictatorial governors were, however, still able to neutralize the power of these institutions.

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[85] The director of a large local distributor stated in 2002 that these municipal tenders were indeed fair and well-run (*prilichno*).

[86] Note that regional AMCs could afford to be aggressive with local authorities because they were part of a federal verticale, and therefore independent of local governors. I should also mention that the reputation of the AMC is not unequivocally positive. The AMC has been accused of being used as an instrument by firms against each other. (Source: Conversation with Ksenia Yudaeva, CEFIR, Moscow)

One of the effects of Russia's uncoordinated decentralization of authority was that in the 1990's regional governors had a lot of leeway to run their region as they pleased with little effective interference from the federal government. In one of the most reported cases, the Governor of Primorskii Krai in the Far East, Evgenii Nazdratenko, was able to stand up to Yeltsin's government throughout the 1990's despite mismanagement of local resources that reduced Vladivostok residents to rationed water and electricity. Residents of regions unlucky enough to fall under the control of unscrupulous governors saw regional policies explicitly designed to benefit the friends and family members of the governor, and public funds directed towards the same beneficiaries. While the drug industry was usually too small to attract the attention of local "oligarchs," there were regions in which attempts were made to consolidate the sector into "friendly hands." In Kursk, for example, it was rumored that the son of Governor Rutskoi was able to consolidate control over nearly all pharmacies in the capital city. In the Republic of Marii El, the insalubrious President Vyacheslav Kislitsin also tried to seize control over the local drug distribution industry. The methods he used are worth describing briefly, as they illustrate the power of informal rules in situations where formal rules are ineffective.

Kislitsin ran the republic as his personal fiefdom 1997 to 2001. Described by a wide range of the political spectrum as "odious" (Literaturnaya Gazeta 2001; Zavtra 2000), Kislitsin had a management style of arbitrary incompetence that put petty dictators to shame. Firms complained that he would wake up at 4 am and call licensing officials to tell them to close down certain pharmacies. At 10 am the officials would pleadingly call the pharmacy, begging them to close down of their

own accord, so that the bureaucrat could keep his position (Mr. Krivosheev 2003). Entrepreneurs with connections to Kislitsin would threaten regulating officials with calls "higher up" if they carried out inspections (Mr. Nezhdanov 2003). Kislitsin apparently wanted to consolidate the retail pharmaceutical market into family hands by bringing all the state pharmacies under the aegis of Marii El Pharmatsia, the inheritor of the large regional warehouse that had been half-privatized by his relatives in the mid-1990s (49% of shares were held by commercial interests, 51% remained with the regional government). Competing pharmacies were to be closed down.

The local anti-monopoly committee fought a "big war" to keep this from happening (Agapitova 2003). But in the meantime, private firms experienced "full-press inspections, and were closed with a wave of the hand."[87] One firm had so many visits from SES, the Pension Fund, the Tax Inspectorate, the VAT Commission, the Income Tax Commission and other agencies doing the bidding of the presidential administration that they took to leaving all their documents out on a table where they could be examined at a moment's notice. The businessperson who described this "incredible administrative squeeze" emphasized that these visits were not about lower-level officials looking for bribes—they were part of a broader effort from higher-ups in the regional government (Mr. Neliubin 2003).

[87] Interview with Mr. Miasoedov, a large regional distributor, Ioshkar Ola, July 2002. This source said that while Kislitsin did his best to close down the private pharmacies, in the end they all survived this period of intense pressure. Another entrepreneur, Mr. Bezfamilnoi, the director of a local pharmacy chain, said that the attempt to close down private pharmacies was due to Kislitsin's personal interests (2002).

Unenforced Formal Rules Open the Door to Corruption

This chapter has fleshed out the working environment and issues that surrounded employees of regional health care bureaucracies in the second half of the 1990s. The focus has been not on the particulars of organizational structure, but rather on the way in which the urgent problems of the day were addressed and resolved by officials at the bottom, middle, and top of these hierarchies. The examples given have, for the most part, been drawn from the experiences of officials in licensing agencies, and from problems relating to health care budgets and specifically, drug procurement. Nevertheless, the narrative has been structured to bring out a broader issue in the Russian transition: how did bureaucrats cope with the lack of appropriate formal rules for decision-making?

The answer is that in the early years, they continued to apply old rules to new situations. Some of these rules retained a degree of relevance (such as those specifying pharmacy size) while others were clearly obsolete (e.g. those assuming a single, centralized state distributor of drugs). As the retail and wholesale markets developed and became more competitive, officials relied more on informal ways of making decisions. They tended to favor the types of firms they knew (state pharmacies vs. private enterprises), helped out the people they knew, and prone to accept unofficial payments in exchange for the application of their discretion. These decision-making rules reflect informal rules carried over from the Soviet period. Table 1 in Chapter 1 highlighted four of the key informal mechanisms used by officials. Two of these four—the acceptability of gift-giving and the use of

connections—remain very relevant for bureaucrats in health departments. The other two, passivity and selective implementation, appear to have faded in importance.[88]

The narrative above highlights the way in which general informal rules become operationalized in practice. Criteria invented to limit the growth of untrusted private pharmacies were integrated into regional rules restricting entry into pharmaceutical markets. The ad hoc consulting fees imposed by impoverished regional offices to raise funds became official charges for additional services rendered. More problematically, a culture that promoted gifts of thanks to officials easily morphed into a culture of petty corruption. Valuing political connections fostered a market for trusted intermediaries, but it also resulted in skewed procurement practices. Informal rules played an important role in guiding behavior, particularly amidst uncertainty when formal rules lost their relevance. Long-standing habits of interaction between bureaucrats and their clients remained in place, along with the people who had relied on them for years. Informal rules are indeed sticky, in that they are hard to eliminate. But they also prove to be quite flexible, adapting to new circumstances and helping officials benefit from new opportunities.

In a transition, the changing environment creates opportunities for the evolution and expansion of informal rules into new areas. Officials are under pressure to adapt to new circumstances, and appropriate modifications to formal constraints generally lag behind events. Informal rules expand to fill the vacuum left by obsolete formal rules.

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[88] It is difficult to evaluate the extent to which passivity was used to resist reforms. Partially this is a selection problem: officials that agree to be interviewed are by definition less passive than those who would rather not be bothered. I found, however, that officials interviewed at all levels of health care-related agencies seemed to feel a genuine "moral obligation" to do their jobs as well as they can. Many said that they were not interested in working for a private firm, as this would make them focus on the narrow interests of the firm rather than the interests of society as a whole.

Over time, however, new reforms attempt to reassert the power of law and legislation. Successful institutional change requires not only new formal rules, but also their enforcement by political organizations and players (Eggertsson 1994:41). In areas where federal or regional state agencies are prepared to enforce new rules, formal reforms can gain some traction over informal rules—witness the whittling of administrative barriers imposed on the licensing process and the efforts to recentralize drug procurement in Samara. In the absence of effective enforcement, for instance in the Republic of Marii El under Kislitsin, attempts to counter the effect of informal institutions fail.

The following chapter considers reforms to the Russian state, health care, and pharmaceutical regulation that have been launched since President Putin's election in 2000. Under Putin, the Presidential Administration and the Russian Government have made a concentrated attempt to restore the coherence and strength of the federal government. As such, the approach of Putin's team to the post-communist transition is radically different from that pursued in the Yeltsin years. The momentum behind the decentralization of state authority has been arrested and replaced with an effort to recentralize political power in Moscow. This has been felt not only by the governors in the regions, but also in regional offices of federal agencies. Even the Ministry of Health has made a concerted effort to reassert its influence over regional health departments.

Applying the framework outlined in this dissertation, what we have witnessed in Russia over the past four years is an attempt by the federal government to reassert the power of formal rules over the more ad hoc and incoherent informal rules that

gained importance in the 1990's. Has this attempt succeeded? And if so, why? These are the questions addressed in Chapter 4.

CHAPTER 4: Realignment

2000-2004: Realignment of Formal Rules with the Informal.

Recentralization of the Federal State with New Formal Rules

The first decade of the Russian economic and political transition was one of radical change and dislocation. Government policies of shock therapy and privatization contributed to an atmosphere of uncertainty and turmoil. President Yeltsin, often ill during his two presidential terms, maintained a laissez-faire approach to democratization that fostered entrepreneurial behavior of all stripes. Russian society, long used to strict ideological and social controls, found itself cut loose from communist values. While this freedom gave some the courage to start new businesses, others the impetus to speak their minds in the press, and many the newfound right to privacy, it came at the expense of what is now wistfully referred to as "order" (*poriadok*). By the end of the 1990s, the shine had worn off of democracy and capitalism, and the Russian people were apparently craving "a safe, comfortable, and stable life" (Putin annual address 2004).

President Yeltsin unexpectedly resigned on the eve of the millenium, clearing the way for his Prime Minister of under five months, Vladimir Putin, to become Acting President. In March 2000, Vladimir Putin was elected Russia's second President, garnering just over half of votes cast. In frantic pre-electoral travels across Russia he projected an image of a modest and conservative official, an able learner ready to lead the country without the dramatic gestures and failings of his patron. In the four years of his first presidential term, Putin's promise to reestablish "law and

order" has been met through the growing power of the state and the federal government. The return to a more assertive central government has apparently found resonance among the Russian population. In 2004 Putin was reelected to a second term by over 70% of voters.[89]

This chapter picks up the narrative begun in the previous chapters but captures a dramatic shift in our plot. Whereas the Yeltsin years were characterized by decentralization of federal authority and health care policy, the penultimate installment in our story is one of recentralization. Under Putin, the balance of power between the federal government and gubernatorial administrations has shifted decidedly in favor of the former—to the extent that in September 2004 Putin announced that governors should be appointed in Moscow rather than elected in their regions. The federal government has been strengthened through the tightening of controls over regional leaders and the reassertion of ministerial authority over their regional counterparts. Putin, his Presidential Administration, the Russian Government and the Duma have steadily introduced formal laws and legislations to consolidate authority in the hands of the federal government.

But the lesson of the previous two empirical chapters is that adopting new formal rules does not in and of itself guarantee change. Putin's efforts to re-establish the power of the federal government have changed attitudes in Russia—one feels a palpable arrogance among Moscow-based bureaucrats and members of the party of power, United Russia, who are confident their ideas will command the respect they deserve. Governors who once personified the power of regional authority, including

[89] I am of course greatly simplifying the determinants of voting behavior. For a more profound analysis of voting in the Russian Federation, see Colton 2000.

Mayor Luzhkov of Moscow and President Shaimiev of Tatarstan, are now ostensibly supportive of plans to eliminate the regional elections on which their personal legitimacy was based. And of course Putin's overwhelming results in the March 2004 presidential elections would appear to suggest that there is substantial popular support for the ideas put forth in support of the new formal rules. But have these rules been implemented? Are they being enforced? If not, Putin's solutions to the problems inherited from the Yeltsin era should be interpreted as little more than a fig leaf over the immodest decay of a once powerful Soviet state.

Much of the literature on bureaucracies suggests that bureaucrats faced with dramatic reorganizations of their hierarchies, functions, and authority are likely to resist such measures (e.g. Crozier 1964; Blau and Meyer 1956; Kotchegura 1999). The empirical work cited in the previous two chapters further suggests that formal reforms launched in the past have failed because they have been poorly designed, or because they have failed to persuasively replace the use of informal rules at odds with the new reforms. In apparent support of these views, one of the main architects of Putin's much-touted "administrative reforms" of the bureaucracy, Mikhail Dmitriev, recently admitted that only some 15% of planned changes have actually been implemented (Korchagina 2004).

This chapter looks into the paradox of the first Putin Presidency. On the one hand, there appears to have been a critical shift in the nature of the Russian state, from one that is disorganized and decentralized, to one that managed "from above." On the other hand, in their dwindling candid moments, federal and regional officials rarely assert that the state is operating more effectively. Public dissent has been

quashed by restrictions on the televised media and political parties, but firms have begun to complain more and more loudly that the Russian economy is on the verge of "stagnation"—a loaded term traditionally reserved in the past for the final, sclerotic decade of Brezhnev's rule (Faulconbridge 2004).

The previous chapter concluded by noting that formal reforms are productive when they are not undermined by informal rules and when they are effectively enforced. The enforcers of complementary formal changes may be empowered state organizations or other 'winners' who stand to benefit from the new rules. Applying the framework developed in the previous chapters allows us to examine the contradictory results of Putin's first four years in terms of changes in the formal and informal rules governing the decision-making of public officials. This approach, which recognizes the importance of formal reforms while investigating their limitations, is well suited for the topic at hand: it obliges us to consider the subtleties of formal changes, the impact of informal understandings that reinforce or undermine these changes, and the resulting likelihood that intended reforms will be enforced.

This chapter again turns to health policy to delve into changes witnessed by the Russian state over the past four years. We begin with a brief overview of the main legislative changes that underlie the movement towards recentralization, with emphasis on the overall relations between the federal and regional governments. We then turn to health policy and to a perusal of how the Ministry of Health has tried to ride the wave of recentralization by increasing its control over regional health departments. The discussion initially considers formal changes to the Ministry of Health "*verticale*" of power over regional bureaucracies before moving onto a look at

how increasing Ministerial authority has altered licensing, pharmacy standards, and drug certification policies. As before, a "thick description" of pharmaceutical policy is used to ensure that we are judging reforms on the basis of changes in policy outputs rather than on intended results or policy outcomes. The sectoral focus permits us to get deep enough into reforms to appreciate the nuances in new rules as well as the subtleties of bureaucratic response. As before, the objective is to understand changes in the equilibrium between the formal and informal rules that guide bureaucratic behavior.

Increased Federal Control over Regional Government

In the first year of his reign President Putin grouped the 89 Russian regions into seven presidential districts (federal *okrugs*) managed by seven "fully authorized representatives of the president" or governor-generals (colloquially referred to as *polpredy*, short for *upolnomochennye predstavitelia*). This maneuver was widely interpreted as an attempt to reverse the decentralization process of the 1990s, and to bring the regions back under federal control. The governor-generals in charge of the regions are tasked with supervising the work of regions within their district. This new layer of government administration has been given power at the expense of the regions. Governor-generals have, for instance, been given the right to appoint regional security officials without the agreement of local officials. In addition, they have hired district inspectors to replace the presidential representatives in each region, and to supervise federal activities in each region. Regional financial autonomy has

been eroded by the 2000 tax code, which eliminated some of the taxes that had been directed to regional treasuries.[90]

Elimination of Contradictions in Legislation

From the beginning of his rule, President Putin attacked regional legislation that conflicted with federal laws. In 1997 the Justice Ministry had supposedly identified some 20,000 regional laws and executive orders that were unconstitutional (Dokuchaev 1997). In most cases, the regional authorities had illegally expanded their jurisdiction to pass laws changing the customs, tax, hard currency, credit regimes of their territories (Mitchneck et al 2001). In others, like the Tyva Republic, the regional constitution itself directly contradicted the Russian Constitution (Solnick 1995). In 2000-2001, regional prosecutors began to aggressively challenge illegal regional legislation. In Bashkortostan, for example, over 70 local licensing regulations (including some related to pharmaceutical firms) were annulled to bring local legislation in line with federal laws.[91]

Reconstruction of the Ministry of Health Verticale

Since 2000 the Ministry of Health has also tried to reconsolidate some of the authority it ceded to regional health departments in the 1990s. This effort has borne

[90] Regional offices of the federal treasury were tasked with collecting federal taxes as of 2001; until then the taxes had been collected at the regional level and then sent on to Moscow (Rabinovich 2000). The unified social tax (3.6% of which goes to the OMIFs) replaced the separate payments made by firms to the pension fund, social-insurance fund, and medical-insurance fund. These funds had often been controlled by allies of the regional governor. Firms' turnover tax rates, which had financed regional road and housing budgets, were reduced by 75%. VAT collections had been shared with the regions, but will now be collected entirely by the center. In the past, regions had offered to exempt potential investors from the regional component of the VAT (East European Constitutional Review 2000).

[91] Decision of the Cabinet of Ministers of the Republic of Bashkortostan No. 340 from 7 December 2000, "On Licensing of Different Types of Activities."

fruit, even though the Ministry has not gained tangible fiscal leverage over regional health administrations.

Table 1 in Chapter 1 listed the formal constraints that have traditional affected the degree to which the Ministry of Health has control over health care policy in Russia: the bureaucratic structure of the sector, the structure of financing, and responsibility for controlling markets. Taken together, these formal constraints have determined the balance of power between the Ministry of Health and the regional health departments. Since 2000, the Ministry has undergone some internal restructuring, but health care still formally subject to "joint coordination" between the federal and regional governments. The Ministry's contribution to this joint effort, however, has become more and more assertive, with Moscow now setting national standards for medical care and pharmaceutical controls. To better understand how the Ministry has gone about re-establishing its authority, each of these three areas of formal constraints merits additional discussion.

1) Reorganization of the Ministry of Health

Once Putin had created the new federal districts, ministries and agencies, including the Ministry of Health quickly established a presence in each of the new federal districts. The Ministry of Health representative to the Central Federal District, Vladimir Semenov explained for example that his job included implementing effective price controls on vital drugs, and verifying that rules and legislation adopted by the 18 regions in his jurisdiction were consistent with the "letter and spirit" of federal rules (2002). He flatly recommended that all important regional legislation be submitted to the Ministry of Health for approval before passage, noting that the

Tripartite Agreements gave the Ministry the right to approve the hiring and firing of health committee chairman—something that hadn't existed in the USSR. (In the same interview he regretted that the Ministry had no formal means of ensuring enforcement of its orders, which hadn't been a problem in Soviet days.)

Administrative reforms have gone beyond adding a federal district layer to the Ministry of Health hierarchy. In early 2000, while Putin was but Acting President, Minister of Health Shevchenko argued that only a "restoration of the management *verticale* will be the guarantee that the population will receive the maximum possible volume of medical assistance."[92] This wish was not unequivocally granted despite growing talk among health care professionals at all levels about the need for improved management in the sector.[93] In April 2000 and August 2001 departments were added, eliminated and merged, and subordination schemes within the Ministry were changed. The goal was to increase control over reform implementation, strengthening strategic forecasting and improving overall coordination and effectiveness of functions (Tragakes and Lessof 2003: 32), but one wonders how efficiency and morale could be sustained over such a long period of bureaucratic turmoil (Kotchegura 1999). In March 2004 the entire Ministry was merged with the Labor Ministry to become the Ministry for Health and Social Development, an organization that has been active in reforms (particularly of the

[92]This comment was made in a speech summarizing the health care lessons from the previous decade. Support for a stronger *verticale* was also apparently voiced by representatives from the health care sector in the regions (Panfilova 2000).

[93] The need for a stronger *verticale* was often voiced in the interviews conducted in the summer of 2002.

insurance system), but which remains extremely closed to outsiders interested in the inner workings of Russian health care.[94]

In 1998 the Ministry of Health had tried to develop a new approach to its relationships with the regions. Acknowledging that the bureaucratic constellation in effect at the time did not effectively subordinate regional health committees to federal authority, the Ministry began to enter into so-called Tripartite Agreements with regional health departments and local OMIFs. These agreements set a Guaranteed Package Program that stipulated the type and volume of care that was to be provided for free, and were intended to reconcile promises of free health care with available resources. The regions were to develop territorial programs that complied with MoH norms but were free to include additional services. The results of these agreements have been characterized as "tenuous as best." (Tragakes and Lessof 2003: 61).

2) Financing Health Care

The Ministry's limited financial support for regional committees has limited its political leverage since the early 1990s. In 2004 I sent a letter to all regional health departments asking them to report the total spent on health care in their region in 2002, and the total amount contributed by the federal budget. 20 of 89 regions responded to my request, reporting that the federal contribution to regional health care ranged from under 1% (Republic of Altai, Republic of Dagestan, Krasnoiarsk

[94] Despite my successes in scheduling and holding interviews in Moscow and in the regions, I was never able—in four years—to land a meaningful interview with an official in the Ministry of Health. Attempts to penetrate the organization through foreign and domestic academic contacts, World Bank connections, and at conferences never allowed me to get my foot in the door. Some consolation was provided by a Russian scholar who studies health benefits to the poor; she told me that the Ministry of Health has always been "more closed than the Ministry of Defense." Nevertheless, it would have been useful to get more information from inside the Ministry on the inner workings of the organization, and on the way in which officials have weathered the reforms wrought by the transition.

Krai) to 6-8% (Kaluga Oblast, Republic of Kabardino-Balkar). Ministry of Finance reports on budget implementation for the past decade reveals that the federal contribution to overall health care spending is somewhat higher, hovering around 9%. This does not necessarily contradict the reported figures from the regions; federal spending figures should include money spent on federal hospitals and that spent by ministries on their departmental facilities.

Under Putin the federal government has been trying to increase control over the federal funds spent by the federal obligatory medical insurance fund (FOMIF). One proposal under active consideration would bypass the regional TOMIFs and have companies and regional budgets send all their medical

insurance contributions directly to FOMIF. This federal entity would then

Table 6. Public Spending on Health Care, by Source

Year	92	93	94	95	96	97	98	99	00	01	02	03
Federal Budget	11.0	9.2	9.0	6.8	5.9	9.1	6.4	7.3	8.3	9.1	9.0	8.8
Regional Budgets	88.7	79.0	67.6	72.3	71.4	67.9	66.7	67.1	66.6	65.6	65.4	57.3
Federal OMIF	0.0	0.5	1.1	1.0	1.1	1.2	1.5	1.4	1.4	1.6	1.5	1.3
Regional OMIFS	0.0	11.3	22.3	19.9	21.6	21.8	25.4	24.1	23.7	23.7	24.1	32.6
Total public spending	100	100	100	100	100	100	100	100	100	100	100	100
Source: Institute of Economic Analysis calculations based on annual Ministry of Finance budgets.												

ensure that the regional share of health care spending is more evenly distributed across the country. Although there have been tensions in the past between regional

health departments and regional OMIFs[95], on this issue they find common ground: many officials from both organizations object to this proposal. Wealthier regions where the TOMIF works effectively (e.g. Samara) are naturally opposed to the scheme, which would require their regional companies to make contributions similar to what they make today, but would return smaller disbursements.

3) Control over Pharmaceutical Markets.

The Ministry has actively increased its role in the regulation of pharmaceutical markets. Arguing that the health sector is "no longer working in emergency conditions" and can therefore afford to standardize guidelines (Shevchenko 2003), the Ministry of Health has begun to lean heavily on the use of directives (*prikazy*) to tell the regions what to do. While it always issued sectoral rules and guidelines, since 2000 the sheer volume of instructions has increased dramatically, as has the range of activities governed by these instructions, and the attentiveness with which these instructions are followed by local officials. One entrepreneur in Samara compared the "wave of instructions" now issuing from the Ministry of Health with those that used to be generated by the Ministry of Finance in the Soviet days. Firms complain that they have trouble keeping track of all the rules being generated, and health committee officials allegedly show up with a deck-full of new rules when they want to harass a given company (Mr. Samoletov[96] 2004).

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[95] When the OMIFs were created many regional leaders objected strenuously to the creation of a new health care bureaucracy that would have control over funds the departments could not touch. The departments did have some control over the TOMIF (governors chose the TOMIF heads, and regional legislatures audit TOMIF budgets annually), and came to accept their existence, particularly when it became clear in the mid-1990s that the medical insurance scheme would be providing a needed infusion to regional health care budgets.

[96] Throughout this chapter, I have protected my sources where they made comments that could cause them trouble in their region. Pseudonyms are indicated by identifying sources as "Mr." or "Mrs."

Many of the directives cover familiar ground with added clarifications and a better understanding of markets. But in several critical areas of pharmaceutical activity the Ministry has begun asserting itself as never before, with mixed results. Part of the impetus for changing the regulatory regime for drugs and pharmaceutical firms has come from increasing fears that counterfeit drugs are widespread in Russia. It is difficult to assess the validity of the claim that some 12% of drugs sold in Russia are in fact "fakes."[97] Most regions claim to have limited experience with medicines that are not what they claim to be, while others report a constant inflow of counterfeit products.[98] Regardless of the actual incidence of counterfeiting, the federal government has used the fear of unsafe drugs to increase its role in drug dissemination and quality control.[99]

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rather than by last name only. The references at the end of this chapter also contain a list of cited interviews, with a rough indication of the qualifications of both anonymous and identified sources. Some of the anonymous sources are quoted by name elsewhere when their comments are innocuous.

[97] This statistic was repeatedly used by Robert Rosen, head of the Association of International Pharmaceutical Producers (AIPM) in Moscow. See for example the "Rosbalt" information agency article, "Every tenth drug sold in Russia is a fake," 25 March 2002. Note that this problem is far from unique to Russia. It is fairly common in developing countries, and even strikes developed countries. For a case in the US, see Petersen 2001.

[98] The Director of the Kuzbass Center for Drug Certification said that all incoming pharmaceuticals pass through her center, and the share of falsified or flawed drugs was "less than a hundredth of a percent" (Pharmatsevticheskyi Vestnik December 2002). The documented cases of falsified drugs are not encouraging. In Krasnoyarsk the police found a workshop producing veterinary products out of sunflower oil, wallpaper glue and expired novocaine. The people involved were also "re-dating" expired products for sale. The police were alerted to a problem after farmers and veterinarians complained that cows and sheep were dying after taking the "mysterious drugs." (Novosti Information Agency, 11 February 2004, www.pharmindex.ru/newsdetails.asp?id=4121). Altai krai also reported that $22,700 worth of a spray meant to kill encephalitic fleas in the region appeared to be fake (Novosti Information Agency, Siberia, 1 June 2004, www.pharmindex.ru/newsdetails.asp?id=4506).

[99] However given that allegations of falsified drugs continue despite the introduction of the greater controls, one has to wonder if the systems introduced are even theoretically effective, and whether or not they were really introduced to counter this problem.

The Ministry has also tried to increase its control not only over drugs, but also over the firms that sell them. The attitude in the Ministry of Health was clearly articulated by a department head in 2003:

> ...before, the regions were not ready for strict Ministry of Health standards for different types of pharmaceutical firms, so we had only recommendations. Now they are ready. The Licensing Commission and Pharmaceutical Inspectorate will begin strictly checking to make sure that pharmacy kiosks are not selling prescription drugs (which, when you think of it, is the same as selling without a license—they don't have a license for this type of activity). Right now it is still very difficult to take a license away (Podgorbunskikh 2003).[100]

The Ministry has increased its control over licensing of firms, an area that had previously been formally delegated to the regions. In addition to reclaiming the authority to license all wholesale operators, the MoH created a Pharmaceutical Inspectorate within its Moscow bureaucracy to "supervise" pharmaceutical activities.[101]

Appendix 2 summarizes the evolution of Ministry of Health powers over the past 15 years. It clearly demonstrates that during the Yeltsin transition years, the Ministry gradually lost control over key health care policy areas, but under Putin, this trend has been reversed. Has the Ministry of Health's ambitions had a real impact on the way in which pharmaceutical firms and markets are regulated? In other words,

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[100] Natal'ia Podgorbunskikh, Head of the Department (*upravlenie*) for the Organization of Pharmaceutical Activity and the Provision of Drugs and Medical Products, MoH RF. Speech at Apteka-2003 exhibition, 29 October 2003.

[101] The new Pharmaceutical Inspection Department of the MoH was planning to "begin its activities in the regions" as of 1 September 2002. In interviews conducted in the summer of 2002, officials and entrepreneurs in the regions remained in the dark about the purpose of this inspectorate. One regional health official said that she hadn't "felt" the inspectorate at all (Mrs. Smetannaia 2003). MoH website postings suggested that the inspectorate sporadically audited the licensing process of local committees, closing down pharmacies that had been inappropriately licensed. However given that a report on 2003 results of the Inspectorate noted that they had arrested 321 pharmaceutical licenses (in a country with thousands of wholesalers and tens of thousands of pharmacies), it isn't surprising that hardly anyone has noticed their activities (RIA Novosti newswire, 20 February 2004).

have the formal changes introduced by the Ministry of Health under Putin changed the way in which regional health departments regulate pharmacies and distributors? The following section addresses this question through an analysis of three areas in which Ministerial directives have been introduced to change regulatory policy.

The Balance of Power: Is the Ministry Stronger?

The Licensing of Pharmaceutical Firms[102]

In 2002, the Ministry of Health began working to unify the licensing system used in Russia. They did so not by issuing a firm set of standards by which potential pharmacies should be evaluated, but rather by first unilaterally assuming authority for licensing retail and wholesale firms, and then transferring the power over retail firms back to the regional health care authorities.[103] This procedure was as complicated as

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[102] It should be noted that while the Ministry of Health has been tightening the standards for pharmaceutical licenses, there is currently a wider debate over whether or not pharmaceutical firms need be licensed at all. The purchase and sale of drugs now primarily involves medicines that are already packaged long before they get to a pharmacy. The pharmacy's role is to sell the package, just as a grocery store will sell a box of cookies. Draft legislation prepared by the Ministry for Economy and Trade Development would eliminate the licensing requirement for certain kinds of businesses, including pharmacies, distributors, veterinarians and movie theaters. Naturally, nearly all of the firms and bureaucrats I spoke to were against such a change. The former have an interest in keeping some barriers to entry to the market, whereas the latter would like to protect their jobs. That being said, there are good reasons to carefully regulate the storage and sale of drugs. Unlike clothing or dry foods, medications should be handled by trained health professionals, and they pose a greater risk to the population if mishandled. Ensuring a safe drug supply will always require some restrictions on they way in which drugs are sold; rules that encourage careful storage, transport, and distribution of goods; and control over the quality of imported or domestically produced drugs. Unlike other consumer goods markets, drug markets have inherent and important asymmetries of information; "manufacturers, prescribers, and dispensers know more than consumers about the safety, efficacy and quality of drugs they manufacture prescribe and sell... [U]nlike other commodity markets, the drug market should not be allowed to and indeed cannot regulate itself" (Wondemagegnehu 1999).

[103] On July 1, 2002 Prime Minister Kasyanov signed a government Declaration (*postanovlenie* No.489) "On Confirming the Rule on Licensing Pharmaceutical Activities," in which licensing was to be carried out by the Ministry of Health and the executive organs of the regions. The Ministry would relieve the regions of their responsibility for licensing, and then re-empower them through agreements which authorized them to license distributors and pharmacies "on behalf of the Ministry." A new licensing department was created by the Ministry of Health. Regional licensing committees were taken aback by the suddenness of these changes and strongly recommended that in the future "it was extremely important [for the MoH] to conduct preventative consultations with regional licensing authorities" (Sedelkov 2002).

it sounds, and it brought the licensing process to a standstill in regions such as St. Petersburg and Tomsk, where the local authorities could not figure out if they were still authorized to issue licenses.[104] Licensing was to be carried out within the local regional health committee, not through external structures that had been used in a number of regions to eliminate conflicts of interest within committees that both managed state-owned pharmacies and regulated these entities. (Samara and St. Petersburg refused to comply with this aspect of the new rule and continue to license pharmacies through bureaucracies independent of the health committees.) The head of the Department for Pharmaceutical Activities and Drug Production in Perm Oblast concluded flatly that "the system of management and cooperation between the RF Ministry of Health and the authorities responsible for managing pharmaceutical activities in the regions has collapsed. The normative acts published by the government (MoH) don't stand up to any criticism" (Chernov 2002). The rule dictating a new administrative system for licensing had another failing besides its administrative extravagance. It neglected to mention that individuals, in addition to firms, had the right to receive licenses for pharmaceutical activities. The right of individuals to engage in the same activities as firms is guaranteed in the Russian Federation's Civil Code. And yet, for three months, until the MoH sent the regional licensing bodies a letter clarifying that individuals should have been mentioned in regulation No. 489[105], the regions were left in the dark about whether or not to accept

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[104] In Saint Petersburg the Licensing Chamber stopped giving out licenses as a result of this new rule because in the "resulting complicated and unclear situation," it was unclear if licenses given out locally would still be valid. (www.pharmindex.ru/newsdetails.asp?id=1784).

[105] Ministry of Health Letter No. 2510/10719-02-32 of 28 October 2002, signed by A. Katlinsky, Deputy Minister of Health.

the applications of individual entrepreneurs. In this period the regional licensing authorities decided for themselves whether or not they would issue licenses to individuals: some did and some didn't.

The result of these Ministry-initiated changes is that licensing of all wholesale firms is now done in Moscow. Taking away wholesale firm licensing from regional authorities was in part a response to the widespread opinion that Russia had too many drug distributors.[106] When the subject of counterfeit drugs began to attract attention, Boris Gryzlov, then Minister of Internal Affairs (MVD), stepped into the ring to declare that the number of firms had to be reduced.[107] The federal authorities were to be made responsible for culling firms, and the Ministry of Health accordingly raised the bar for drug distributors. The cost of getting a wholesale license is now set at $10,000 (compare to $2,000 previously charged in Ufa), presumably to discourage small fry from getting involved in this market. Other transaction-related expenses have also increased exponentially. A regional distributor told me in 2004 that the latest renewal of his wholesale license involved delivering 124 notarized documents to Moscow, hosting a commission of 4 people at his facility, filling out an extensive survey, and then sending the General Director to the Ministry of Health to pick up the

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[106] Whereas developed countries may have 3-6 large national distributors, Russia supposedly had as many as 7,000 licensed distributors in 2003.

[107] RIA Novosti news agency. 26 February 2003. "The Head of the Russian MVD B. Gryzlov proposes to reduce the number of companies that have licenses to trade drugs." Available at www.pharmindex.ru/newsdetails.asp?id=2615.

license. ("Of course, the rules don't stipulate that the GD need personally pick up the license, but who wants to risk displeasing Moscow?")[108]

Two years into Putin's presidency, the Ministry of Health was trying more emphatically to influence the regulatory environment for firms in the health care sector. Its impact was necessarily limited by flaws in official directives, the autonomous habits of regional health care departments, and the behavior of bureaucrats accustomed to having discretion over firms.

Putin's election, and the Ministry of Health's early efforts to restore the *verticale* did not automatically change conditions inside the bureaucracies responsible for licensing pharmacies and distributors. In the course of doing interviews in four regions, I found a few officials who appeared to be candid about their working conditions and motivations. When I suspected someone of honesty, I asked local entrepreneurs about the official's reputation for efficiency and integrity. One of the most vocal and as it turned out, most well-respected licensing officials had had decades of experience in health care administration before assuming charge of a regional licensing committee. She acquired a reputation amongst firms as being objective and incorruptible, and among officials as being too outspoken and difficult to work with. In 2004, when her region complied with new federal regulation absorbing licensing functions into health departments, this official lost her mandate. Former officials are often more candid than serving officials, and in this case, she provided invaluable insights into how licensing bureaucracies really work. On the

[108] Mr. Samoletov also mentioned that many of his documents had to be resubmitted because there was some confusion over the punctuation used in his firm's name. The local Tax Inspectorate had never questioned these documents, but the licensing department at the Ministry was pickier.

basis of my meetings with other officials, I strongly suspect that her observations also hold true for many other regional bureaucracies, though in an ideal world one would of course want to conduct many interviews with many officials to prove this point.

In a public speech my contact described the problems she found in the licensing commission when she arrived there. Contradictions between the insurance and drug laws and between federal and regional laws, combined with a lack of clear federally-set rules on licensing meant that

> regions independently worked out mechanisms for licensing medical and pharmaceutical activities in their own way with many lawless (*vneprotsedurnye*) actions not anticipated by legislation in force, which subsequently gave rise to various violations and abuse. The emergence [of this] and subsequent developments in licensing did not guarantee observation of the constitutional rights of citizens, [and] facilitated the appearance of corruption and arbitrary rule by officials.

More precisely, employees were hired arbitrarily, paid low wages (on average no more than $33 per month), and assigned to inappropriately structured departments. License applicants were asked to submit documents in accordance with a list that was "extensive, veiled, and unwarranted by existing legislation." They had no access to information about the licensing procedure, about the conditions they would be required to observe, or about the status of their application while it was being processed. There were no formal criteria for granting, refusing, suspending and canceling licenses.

The remedies adopted by this official also say much about the problems confronting street-level officials. She created a single list of documents for applicants to submit, regardless of whether they were state-owned or private. This list was less than half the length of the previous list, as she eliminated all of the additional

approvals (*soglasovanie*) that licensees were supposed to get from local health care authorities, health care specialists, professional medical associations, and labor protection offices. Visitors to the licensing commission were greeted with a large bulletin board of relevant information, and were given the means to track the progress of their application through the commission. By introducing a "control sheet" (*kontrol'nyi list*) for all reviewers of the application to sign in turn, it was impossible for individual members of the commission to use delays in reviewing an application as a means to elicit bribes. Quarterly reviews of applications were held, and when it was discovered that a commission employee had turned a blind eye to shortcomings in an application, the employee and the licensee were called on the carpet to explain themselves.

The medical and pharmaceutical markets responded by trying to guess exactly how much they would have to pay for a license—assuming that all these changes merely disguised an increase in the bribe price. Offers by firms to "sponsor" the commission were not unusual. In time the situation stabilized. Employees unwilling or unable to work in the new circumstances left and those remaining were rewarded on the basis of their abilities. The average salary was increased by a factor of ten, and real bonuses were instituted. Planned inspections of licensed firms became regularized and were held by a commission of three, rather than by a single inspector. Penalties were imposed openly and not subject to negotiation. Firms no longer used the commission to attack each other, realizing that they were all equally subject to the requirements of the law. Receiving a license to engage in pharmaceutical trade

became a purely "technical" matter.[109] Or at least it was prior to the reorganization of licensing bodies.

What does this anecdotal account tell us about Ministry of Health attempts to reassert its influence over licensing? First, it reinforces a point made in earlier chapters: regional bureaucrats do not make decisions on the basis of formal rules alone. Informal "ways of doing business" can be far more important in explaining decision-making than formal legislation. Second, it provides yet additional confirmation that Yeltsin transition years were a time when informal rules, both legal and illegal, were codified into regional regulation, often creating discretionary and corrupt regulatory regimes. Third, and more encouragingly, it reveals that local changes—specifically those that directly affect the incentives presented to officials—can have a direct positive effect on how local bureaucracies are run. Introducing new, local formal rules based on an understanding of key informal rules greatly increases reform's chances of success. The reforms described above succeeded in cleaning up the licensing commission because the new chief understood that officials were underpaid and therefore susceptible to bribe-taking, weak when confronted with political connections, and able to selectively implement requirements because they were poorly supervised. Increasing salaries and instituting bonuses, reducing the list of documentation required from firms and giving them the means to track their application, and introducing strict consequences for violators of the new rules restricted the operation of informal rules. The fourth conclusion one can draw from

[109] I cross-checked this moving account of reforms with entrepreneurs in the capital of this region. The directors of both a large pharmacy chain and a smaller chain confirmed that while getting a license was still complicated, it was not a matter that required connections or bribes.

this example is that leadership play's a critical role in improving or worsening the functioning of an organization.

The Introduction of Federal Standards for Pharmacies

In 2003 the Ministry tackled the question of standards for pharmacies. Until 2003, as noted in earlier chapters, regional officials had themselves determined the standards to which entrepreneurs would be held when opening pharmacies. On 4 March 2003 the MoH issued Directive #80, which set minimum space requirements for pharmacies.[110] A pharmacy now had to have 70 m^2 of space in cities and 60 m^2 in rural areas —a rather dramatic increase over the 10 or 12 m^2 most often stipulated in local rules (when noted at all).[111] Entrepreneurs complained that this numbers were arbitrarily large (Pharmindex.ru 2003), but they were based on the 1961 rule that had also specified that pharmacies could not be closer than 500 meters apart (Mr. Orekhov 2004).

The clumsy and unexpected attempt by the Ministry of Health to assert control over the licensing of pharmacies caught both licensing organs and firms by surprise. From the text of the directive, it was unclear if existing firms should be required to increase their retail space to come into compliance with the new rule. Queries from regional licensing commissions to the Ministry of Health eventually prompted clarifying instructions. The Ministry of Health letter, dated 15 July 2003, noted that

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[110] "On Confirming the Industry (*otraslevyi*) standard 'Rules for the release (sale) of drugs in pharmacy organizations'. Basic Rules."

[111] In Bashkortostan, pharmacy kiosks had to have at least 12 m^2 of space, and pharmacy "points" only 10 m^2. Kiosks sell over-the-counter items and are not allowed to sell prescription drugs. Points are either located within a hospital (and can sell prescription or non-prescription drugs) or in rural feld'sher-midwife offices. The different forms of pharmacies were defined in USSR Ministry of Health Order No. 705 from 27.07.1978, "On standards of development and principles for locating pharmacies."

these new rules were to be applied only as entrepreneurs applied for new licenses; pharmacies with licenses still in force were not to be subjected to the new standards until their licenses came up for renewal.[112] On 23 September 2003, apparently in response to a challenge by the federal Anti-Monopoly Committee in the Supreme Court, the new standard was cancelled and replaced with a 40 m^2 minimum in Directive #460. On 17 December 2003, this revised standard was cancelled and the March requirement reinstated by Directive #598 ("On the expiration of MoH Directive #460 from 23 September 2003), apparently because the Anti-Monopoly Commission had lost its case.[113]

How did local officials deal with this vacillating regulation? In some cases, they stuck as closely to the letter of the law as possible. Entrepreneurs realized that there was no room for negotiation, and they set about trying to bring their pharmacies into compliance with the new rules (Maknunov 2004). A more typical approach seems to have been for regional officials to consider real estate requirements more flexibly. In one region, the head of the agency responsible for ensuring compliance with Directive #80 told me that he had support from the Republican government to turn a blind eye to non-compliance in rural regions. The new rule required that village feld'sher-midwives have at least 22 m^2 to serve as a pharmacy.[114] It was

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[112] Letter No. 2510/9224-03-32 "On implementation of the standard (*OCT*) 'Rules for release (sale) of drugs in pharmacy organizations. Basic Rules."

[113] The Supreme Court ruled that the Ministry of Health could introduce this standard because it was only temporary. A new law on technical standards came into effect on 1 June 2004, and contained "permanent" standards for pharmacies (Mr. Orekhov 2004).

[114] A feld'sher is defined by Webster's Dictionary as "a medical or surgical practitioner without full professional qualifications or status in some east European countries and especially Russia." A feld'sher is roughly equivalent to a physician's assistant in the US, or a "barefoot doctor" in China.

totally unrealistic, he asserted, to expect that an impoverished rural village would expand its sparse medical offices; yet he could hardly close down the only source of medication for an entire village. The official would thus pay his obligatory visit the feld'sher, "wag his finger at her," tell her she is in violation of the law," (*ukazat' narushenie*) and then leave her be (Mrs. Smetannaia 2003).

Firms were even more taken aback by the new rules. One pharmacy director called such legislative fluctuations "discredit[ing] to the whole system of pharmaceutical supply, including the Ministry of Health itself... here they issue directives, and before you can read to the end, they've already made changes or cancelled them altogether" (Gurtsevich 2003). While many of the larger, established pharmacies and chains were pleased to see barriers erected against the smaller kiosks flooding the drug market, not all could afford to buy additional space to enlarge their existing pharmacies. Mr. Samoletov (2004) noted that his free-standing pharmacy, surrounded on all sides by underground public infrastructure, could only be expanded upwards. When we met he was preparing to build a "big white tooth" as a monument to Directive #80 as he applied to renew his license.

Most pharmacies are in the first floor of apartment buildings. When the new regulation appeared, these pharmacy owners launched desperate attempts to buy the apartments abutting their pharmacies. In Ufa, one entrepreneur explained to me that when Directive #80 came out, he started to buy apartments adjacent to his pharmacies. In one case, he bought the three flats on all sides of a pharmacy. He began to convert them into retail space. Then the revision to Directive #80 came out in September, and he put one of the flats back on the market. Fortunately, it never

sold, as in December, he was required to add it back onto the now expanded pharmacy. Unfortunately, the pharmacy had to again close for renovations, as the unification of the two new flats with the original space had already been completed (Mr. Skorobogat'ko 2004). In light of this example, one sympathizes with businesspeople that complain of an unstable business environment. The director of a Moscow pharmacy summarized the attitude of many pharmacy managers:

> It's unclear who is developing all these standards and directives. [We get the impression] that 'above' [*sverkhu*] people are sitting around developing different legislative theories. It's possible that they are writing doctoral dissertations on these subjects. We get all this passed to us for implementation, but in my opinion, no one is really interested in how it is implemented (Puchkova 2003).[115]

The example of Directive #80 is illustrative of the changing relationship between the Ministry of Health and regional authorities. The Ministry's attempt to standardize guidelines for retail trade in drugs across Russia was not spurious—many local health departments themselves object to small pharmacy kiosks in which drugs freeze during the winter and bake during the summer. Gusarova 2004).[116] The new standards do not limit the quantity of pharmacies *per se*, but rather their quality, although the effect of the stricter space requirements has been a decrease in the number of small pharmacies.[117] However the way in which the Ministry of Health produces its directives, which often require subsequent clarification, correction or

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[115] Puchkova continues "Pharmacy managers have a clarification signed by Deputy Health Minister A.V. Katlinskyi in which he writes that regardless of the new standard (OST), organizations engaged in retail trade of drugs under an old license are allowed to continue their work. It's unclear why the new standard was introduced if, after all, in principle everything remains as before."

[116] Regions that had tried to introduce such size restrictions themselves were warned by local Anti-Monopoly Committees that these restrictions constitute an illegal barrier to entry (Antimonov 2004).

[117] Samara expected to see the number of pharmacies fall by about 30% as a result of new standards adopted in 2003 (Mr. Vinogradov 2004).

cancellation, is terribly inefficient. Many rules are drafted without consultations with regional authorities, let alone the business community. One pair of entrepreneurs joined the League of Pharmaceutical Workers and went to Moscow (at the invitation of the Ministry but at their own expense) to discuss the regulatory environment with the head of the department responsible for drafting regulations relating to pharmacies. In the course of the meeting they asked about upcoming new standards and changes. Mrs. Podgorbunskikh calmly replied only that when the new rules were ready, they would be placed on the MoH website (Mr. Skorobogat'ko 2004). Until then, firms should not concern themselves with the drafting of regulation.[118]

Finally, the example of Directive #80 reveals that implementation of federal rules is far from automatic. Regional officials are called upon to fill in the blanks in poorly-prepared legislation, and must often improvise to apply regulations that appear to be drafted without knowledge of what is happening at street level.[119] While the Ministry may be correctly striving to bring the Russian regulatory environment more in line with international standards, the gap between intent and implementation remains large. Moreover, the degree to which legislation is loosely interpreted varies from region to region. One entrepreneur told me that in Samara, the rules are liberal, and if you open a pharmacy that doesn't *exactly* satisfy the rules, you won't get into

[118] The MoH website was indeed a decent source of information about legislation related to pharmaceutical activities. Since the announced merger of the Ministry of Health with the Ministry of Labor, however, the website has been out of order.

[119] Another controversial Directive was #89, which forbade firms from selling anything but whole packages of drugs. While this appears highly reasonable from the perspective of a developed country, in Russia many pensioners cannot afford to buy an entire box of drugs when they only need a few tablets. Moreover, many drugs are sold in packages of 20 to 100 tablets, when the average patient needs only a few doses (Mikhailenko 2003). Until this directive, pharmacies would break open packages and sell the number of pills required by each customer (without copies of the accompanying literature). The new rule was perceived by officials and pharmacies to have been drafted by someone who "hadn't been in a pharmacy in a long time" (Mr. Nezhdanov 2003).

trouble. In Ul'ianovsk, however, everything must be done strictly according to the letter of the law (Mr. Sinegubko 2004). Thus while the federal Ministry has been increasing its formal influence over health care policy in the regions, its ability to guarantee implementation of federally-drafted legislation remains questionable.

Drug Certification

In Soviet times, each region had a "Pharmatsiia" organization that was integrated into the pharmacy department (*aptechnoe upravlenie*). The regional Pharmatsiia owned a large drug warehouse, received all centrally distributed drug shipments to the region, and then distributed these to pharmacies and hospitals. With the dissolution of the Soviet Union, these warehouses lost their monopoly position in the distribution chain and either languished unused, were privatized, or were used in some capacity by the regional government to handle government purchases. Each Pharmatsiia had a "control-analytical laboratory" that tested drugs that were suspect for any reason. In most regions, these laboratories became independent government offices in the first half of the 1990s. The chief of the laboratory generally stayed on as head of the new quality control center.[120]

In the second half of the 1990s, in an effort to reassert control over fast and loose drug markets, the Ministry of Health issued a directive requiring that regions maintain quality control laboratories, but did not provide any funding. Regions thus began to introduce a system of "incoming controls" (*vkhodnoi kontrol'*) on drugs entering their territories as a means of financing the quality control center (Mr. Bezotechestvo 2002). The firm or individual bringing drugs into a region were

[120] In both Bashkortostan and Samara, for example, the heads of the quality control centers had not been changed in at least a decade.

required to drop off samples of their product at the center. The control in question usually entailed checking the paperwork accompanying the drugs; rarely were the chemical contents analyzed to make sure they corresponded to the paperwork.[121] In practice, this meant that distributors had to pay each regional quality control center to issue local certificates testifying to the integrity of the drug to be sold. The cost of regional certificates varied widely, from 9 to 95 rubles per "stamp."[122] This toll for entering the region created a convenient rent-collecting mechanism for the centers themselves, as well as for the officials issuing the certificates, who could often be encouraged to work faster with a bit of "speed money" (Mr. Belousov 2002).

In the Fall of 2002 the Ministry of Health and Gosstandart issued new certification rules. These altered the regime for imported drugs and created 8 federal certification centers through which all drugs intended for sale in Russia were to be verified and approved. American FDA and EC approved certificates would no longer to be automatically accepted as proof that the drugs being imported were above board. Firms were instead expected to pay a significant fee (about $250) for a national certificate and required analyses.[123] However most regions maintained their requirement that regional quality control centers also check all incoming drugs and issue regional certificates, despite a Ministry of Health directive confirming that firms

[121] One entrepreneur said that the local centers do not have the kind of equipment required to do a truly accurate analysis of any drug. (Mr. Samoletov 2004).

[122] Sources in one of Russia's largest national distributors told me in 2002 that the monthly payment for certifications in a cheap region like Samara would be around $500, while in an expensive region it could run to $5,000-8,000 (Mr. Belousov 2002).

[123] In the Kuzbass Center for Drug Certification, for example, the cost of a certificate had been 134 rubles in December 2002 (Pharmatsevticheskyi Vestnik December 2002). The ITAR-TASS news agency reported in February 2003 that whereas a certificate had cost 250 rubles before, the total cost now of obtaining a certificate from a national center and paying for the required analyses was 7,500 rubles (ITAR-TASS 5 February 2003).

were not obligated to certify their drugs locally. (Firms feared that ignoring a regional requirement, even with a Ministry of Health directive in their pocket, would create problems in regional markets.) In most cases, the regional center verification involves taking drug samples for up to two weeks and copying details from vials and national certificates into a journal, at a cost of 7 to 70 rubles per sample, depending on the region (Mr. Samoletov 2004).

After the new system was adopted, the reports of counterfeit drugs fell dramatically. The new head of the Federal Agency for Supervision of Health and Social Development, cynically explained this result.

> [The new certification system], in my view, is a clear example of that which should not be done. It was argued that the main goal of certification was concern over the quality of drugs. In fact, the quantity of rejected production in 2003 was half what it was the previous year. Do you think that there was a sharp improvement in the quality of medicines or the conditions under which they were produced? No. Because [people] simply started paying money to buy permission to supply drugs. Acquiring "sham" papers turned out to be cheaper than working on quality.[124] (Mardanov 2004)

The regions apparently agreed the introduction of national certification centers was no reason to relax their vigilance (such as it is) over drugs entering their regions. To the contrary, many have increased the requirements for incoming drug shipments

[124] Ramil Khabriev had worked in the Ministry of Health for years, most recently running the division in charge of issuing the much-coveted Good Manufacturing Practice (GMP) certificates to pharmaceutical producers. These certificates will soon be required of all Russian producers, but Soviet-era factories require millions of dollars in upgrades before they can meet the sanitary, packaging, and quality control requirements. Khabriev left the Ministry several years ago to work for a consulting company that allegedly helped companies prepare for GMP testing. He returned to public service and the agency in charge of supervising the Ministry of Health with a reputation for exploiting conflicts of interest, but also with an understanding of how the Ministry is run. His reading of the new certification system is consistent with what I heard from businesspeople who were adamant about staying off the record.

(as in Orenburg Oblast) or by creating new structures to monitor drug quality (as in Ivanovo Oblast and Kemerovo Oblast).[125]

Why would heightened federal supervision provoke redundant regional controls? One explanation is that increasing awareness of a problem obliges regional leaders to demonstrate that they are fighting the problem. A second explanation is the one mentioned by Khabriev: everyone understands that the Ministerial solution will not work. Some counterfeits are imported but most seem to be locally produced and therefore not subject to the national quality control centers. A third and less charitable reading of the situation is that the national certification centers were created to satisfy personal interests rather than solve genuine problems (Mr. Sinegubko 2004).[126]

An analysis of changes introduced by the Ministry of Health to the drug certification system reinforces the observation that reforms of formal rules under Putin have produced ambivalent results. In a departure from the Yeltsin years, the federal government has made an attempt to address issues that have been crying out for attention for years. Regional variation in the licensing regimes for firms, where the variation often takes the form of discretionary corruption, is a problem worth fighting. Cracking down on pharmacies that cannot possibly store drugs properly, or

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[125] Information on Orenburg from Pharmindex, 28 November 2003 (www.pharmindex.ru/newsdetails.asp?id=3828). On Ivanova from Pharmindex, 29 April 2004 (www.pharmindex.ru/newsdetails.asp?id=4409), and for Kemerovo from Pharmindex, 14 January 2004, www.pharmindex.ru/newsdetails.asp?id=3994).

[126] A certain someone at the Ministry of Health was suspected by many of having calculated the size of the imported drug market and establishing a system for skimming a percentage of that-- the national centers, after all, are private. The name of this person came up repeatedly in interviews, but since I have no proof of corruption, I will not provide it here. Incidentally, he was removed from his post in March 2004 when the Ministry of Health was restructured.

on producers of counterfeit drugs, are also worthy objectives. Unfortunately, the imposition of federal rules alone does not ensure change.

In an improvement over Yeltsin's reforms, policy changes made under Putin recognize that reform takes place when formal rules are enforced. The federal government has been reasserting itself through a combination of the legislative measures described at the outset of this chapter and a resurrected fear of reprisals from Moscow. However a closer analysis of specific policies introduced by one federal ministry, the Ministry of Health, suggest that there remains a serious gap between policy design and implementation.

Consistent implementation can be ensured by shifting responsibility from the regional to federal level, as was done for the licensing of wholesale firms. Eliminating regional variation in policy implementation can also be achieved by shifting the responsibility for enforcement away from regional authorities to a third party, as in the case of the new certification centers for quality control. Alternatively, enforcement can be left at the regional level, if one is relatively confident that the new formal rules take into account or reinforce informal rules used by lower level officials to implement policy. In the case of federal standards for pharmacies, federal rules correspond to the demands of regional authorities: they restrict the market to larger firms. Regional health departments are thus more likely to enforce the new standards.

To close this section, we should return to the question posed in its heading. Is the Ministry of Health stronger now than it was four years ago? The answer is yes. The Ministry has been able to assert its authority through the passing of legislation covering issues once previously the preserve of regional authorities. Appendix 2, a

comprehensive listing of the areas in which the Ministry has reintroduced itself, makes this clear. Regional health care departments have taken Putin-era reforms more seriously than attempted reforms under Yeltsin because they are more certain that the federal government means to enforce its rules and regulations. In addition, some of the formal rules adopted correspond closely to regional norms established in the second half of the 1990's. These regional rules were always better enforced than federal laws because they reflected the interests and informal rules of regional health officials charged with their implementation.

A nagging doubt lingers. Putin's reforms are taking place in an environment populated by bureaucrats and firms who have by now accepted the virtues and vices of democracy and capitalism. So one can assume that the cognitive dissonance between informal rules and proposed formal rule changes is less noisy than it was in the early 1990s. And yet given the power accumulated and wielded by regional authorities in the first decade of the transition, one has to wonder why they have agreed to the reimposition of centralized control. One is reluctant to claim that submission to the federal government is explained by an atavistic fear of the Russian tsar.

The Consolidation of Regional Power

The framework of interacting formal and informal constraints can provide a more compelling explanation for regional willingness to submit to federal authority. The federal government, here embodied primarily by the Ministry of Health, has reclaimed authority over policy areas deemed most critical to the federal

government—the setting of national health care standards and policy and the licensing and regulation of pharmaceutical firms. Reforms to formal rules may have been poorly designed, but they do not fundamentally contradict many of the formal rules that the regions had introduced in the late 1990s, nor do they markedly clash with informal rules used by bureaucrats on a daily basis. The regional governors and department heads have felt the wind in their backs and have conceded much of the power they had over issue areas coveted by Moscow. They have done so as part of an exchange.

After the disastrous September 2004 hostage-taking incident at a Beslan school President Putin announced that he would introduce new policies to improve federal control over terrorism and disarray in Russia. One measure announced soon afterwards was the cancellation of elections for regional governors. Regional chiefs would, from 2005, be nominated by the Presidential Administration and "approved" by the regional legislature. While initially taken aback by this reversal of democratization, most governors soon hopped on the bandwagon to voice their support for Putin's initiative. Many believed that demonstrating loyalty to Putin would improve their bargaining position when it was their turn to be reappointed, and a long line of eager politicians formed outside the United Russia headquarters to join the party.

The governors' reaction may reflect old habits honed under years of single-party rule. But it is also indicative of a simple calculation. In the words of the governor of Leningrad Oblast, Valeriia Serdiukov, "the power *verticale* [running from] the federal center [to the] regions...should be extended further—to the level of

local government." Edward Rossel, the once defiantly independent governor of Yeltsin's native Ekaterinberg Oblast, could hardly contain his enthusiasm for Putin's plan. At a press briefing he announced that certain additional conditions were required for political centralization to work effectively. First, elections should be eliminated not only for governors, but also for mayors. This would further improve control over the regions. Second, the governor-generals could be sacked—if the governors were appointed by the President, then this extra layer of bureaucracy would become redundant. And third, the oblast should once again be given the right to control some of the functions of federal agencies on their territories, and to approve the nominations of regional directors of federal agencies (Klimovich 2004). The President of the Republic of Mordovia voiced the opinion of many governors when he confessed that he was looking forward to having more direct control over the local law enforcement and security agencies operating on his territory (Mereu 2004a). As of the end of 2004, the regional leaders had not been told which additional powers they would receive as payment for submitting to presidential appointment. Their collective expectations nonetheless reveal a consensus view among political actors about how the Russian state works under Putin.

The introduction of stronger federal government has restricted the scope of authority of regional officials, while paradoxically increasing their right to use the power they have left. This observation seems to hold true not only for the Russian state as a whole, but within policy areas, if the case of health care is indicative. Even before Putin's announcement, a former head of a regional health committee and life-long health care official, put it succinctly, "As Putin does in the center, so they do in

the regions" (2004). In Putin's Russia, consolidation of authority is valued more than pluralism. For regional leaders, submission to a vertically-imposed hierarchy is the price one must pay for having freedom of movement within one's narrowed sphere of influence. For federal authorities, giving compliant regional leaders the freedom to use the power they have kept is a relatively efficient means of rebuilding a consolidated state.

This exchange of power is a significant milestone in Russia's transition, and it will no doubt be closely studied by scholars interested in federalism, pluralism, and state-building. The framework of institutional change developed in this thesis can also be applied to understand what the consolidation of federal and regional power will mean for Russia.

This dissertation looked at how changes in formal rules affect policy, given the existence of informal rules that are both sticky and flexible. Chapter 2 found that in periods of great uncertainty, the absence of relevant formal rules increases the importance of informal decision-making mechanisms that linger from the past. Chapter 3 noted that attempts to introduce formal rules amid uncertainty are greatly complicated by the ability of informal rules to adapt to new circumstances and compromise attempts at reform. Informal rules are often integrated into new formal legislation, especially if officials in charge of implementation are able to design regulation themselves. The codification of informal rules into formal legislation opens the door to corruption. This very phenomenon is the likely outcome of Putin's willingness to give regional leaders more freedom over certain key issue areas.

A Window Into the Future? Recentralization of Drug Procurement

The federal government has been allowed to consolidate power in those areas that Putin feels most strongly about— strengthening the law enforcement and tax *verticale*, for instance. The regions have reoriented themselves to seize those areas of influence that the federal authorities have left behind. The executive branch of the federal government has been empowered and strengthened at the expense of the judiciary[127], legislature[128] and the regions. At the regional level, governors have concluded that as long as they support the federal government, they are entitled to strengthen their own *verticale* as they please. In the four regions I studied, regional health committees have used the last four years to augment their control over policy and public health care funds. They have been particularly active in recentralizing drug procurement procedures.

Public procurement of drugs has been a painful topic since the demise of the Soviet Union. As noted in earlier chapters, in the 1990s medical facilities were given the right to procure the drugs they needed for hospitalized patients, and municipalities purchased the drugs required to service Entitled ambulatory patients. In many cases, this led to ineffective and improper procurement practices, with hospitals using small and expensive distributors, head doctors choosing suppliers on the basis of kickbacks,

[127] In October 2004 the Federation Council approved a bill giving the Presidential Administration more control over the Supreme Qualification Collegium. This body appoints judges to the Supreme Court and Supreme Arbitration Court, and is the only entity that can fire judges (Mereu 2004b).

[128] President Putin led the charge to replace the governors in the upper house of the legislature, the Federation Council, with full-time delegates. This took away from the governors the right to sign off on all legislation passed by the lower house, the Duma. The political party created to support the Putin presidency, United Russia, swept the Duma elections of December 2003. As a result, this party now controls just over 300 of the 450 seats in the legislature, which guarantees that the presidential administration can pass any law it initiates.

and medical personnel selling medicines purchased with public funds out the back door (Mr. Pokhmel'kin 2002). Apart from the irregularities provoked by the unmonitored use of budget funds, full-scale decentralization of drug purchasing made it impossible for regions to take advantages of bulk discounts for large purchases. The World Health Organization argues strongly that

> public procurement for an entire public health service should as far as possible be centralized nationally; decentralization of government administration may be a laudable aim, but if it means that drug purchasing will henceforth be handled by twenty or more inexperienced and small provincial bodies, the quality of procurement can hardly be expected to improve. (Everard 2003: 145)

Pooling resources at the highest possible level is considered to be the key to reducing drug expenditures. Have attempts to centralize drug purchases in the regions produced positive results? A survey of procurement regimes in the four regions I studied produced mixed results.

Samara Oblast

In the first half of the 1990s, decentralized drug purchasing by hospitals and Entitled patients led to a near collapse of the distribution network for free and discounted drugs. State budgets at all levels accrued significant arrears to state pharmacies that had given out discounted drugs, and found themselves without the resources to cover uncontrolled costs. In Samara alone pharmacies were owed over $1 mln for drugs that had already been consumed (Mr. Nechaev 2004). To deal with the crisis, as early as 1995 in more organized regions, municipal health committees began to reconsolidate drug purchases made with government money. In the city of

Samara an efficient regime of open tenders was launched to buy large batches of drugs for municipal hospitals.[129]

What happened next in Samara is striking, and deserves careful study. Not only because it represented a major development in local drug procurement policy, but also because the new procurement model has been lauded as an example to other regions. In 2000, Rudolf Galkin retired as Chairman of the Oblast Health Committee after having kept the region at the forefront of health care reforms since 1987. Galina Gusarova, who had an excellent reputation as a health care administrator (Bondarenko 2002), took his place and commissioned a study of public drug procurement across the oblast. She found that the prices paid by for identical drugs varied widely across the oblast, from town to town and hospital to hospital. Some medical facilities used up to 70 vendors to buy their products, and often these distributors did not have appropriate warehouse facilities. Moreover, hospital head doctors were often redirecting money earmarked for pharmaceuticals to pay salaries, thereby leaving both inpatients and outpatients to purchase drugs on their own (Liubimova 2002).

Gusarova's concerns were well-founded. But the manner in which she chose to tackle the problem exposed her to considerable controversy. Gusarova proposed that the region hold a tender to select an "empowered pharmaceutical company" (*upolnomochnaya farmatsevticheckaya predpriatia* or UFP) to serve as the exclusive purchaser of drugs for hospitals and the Entitled population.[130] Whereas medical

[129] This system was lauded as fair by local entrepreneurs and remained in place until 2001.

[130] The system was described in Decision (*rasporiazhenie*) No. 325-r of the Governor of Samara Oblast, dated 30 July 2001, "On development of a system to provide drugs and medical supplies to

facilities had previously purchased drugs independently, or within bulked municipal tenders, they would now place orders with the UFP, which would then source combined orders at lower prices from reliable distributors. The UFP would be selected in a competitive process, and would remain in place until the oblast government or territorial obligatory medical insurance fund gave notice that they were unsatisfied.

In December 2001 Pharmbox, an unremarkable private distributor that had inherited a large Soviet-era drug warehouse in Samara, won the tender for UFP. Critics argued that the conditions written into the tender were such that only Pharmbox was a serious contender.[131] Until it won this competition, Pharmbox had an annual turnover of under $2 mln; after winning the right to source all drugs for oblast hospitals, guaranteed revenues from the oblast budget reached $15- 30 mln per annum (Shtanov 2001; Mr. Samoletov 2004), or 16-20% of the Samara pharmaceutical market (Samarskoe Obozrenie 2002: No. 5). Pharmbox did not have infrastructure in place to start tracking orders of all the medical facilities in the region, but it began to build a computerized database of all hospitals, doctors, Entitled patients, diagnoses, and entitlements. This database now exists and is impressive—it allows the oblast to ensure that doctors are following standard treatment protocols; that hospitals, doctors and patients are not abusing access to subsidized drugs; and

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Entitled categories of the population and medical organizations within the system of obligatory medical insurance."

[131] Tender conditions required that the firms striving to be selected as UFP would have a license to work with narcotic and psychotropic drugs, and have a warehouse of no less than 3,000 m^2. One of the larger Samara-based firms, Voskhod appealed to the anti-monopoly committee with the complaint that conditions comprised barriers to participation by other firms. The anti-monopoly committee did not perceive any problems with the terms of the tender (Samarskoe Obozrenie 2002). My attempts to get the views of the anti-monopoly committee in Samara were unsuccessful.

that doctors and hospitals can be held accountable for ordering drugs that are not used. The ability to monitor the use of state funds in detail represents a great progress in the responsible spending of budget funds. However there are disadvantages to this system.

Behind closed doors, doctors grumble that Pharmbox does not deliver drugs in a timely manner.[132] Opponents to the scheme argue that the prices paid by the oblast budget are not as low as they should be,[133] and find it scandalous that public funds

[132] A round table held by the Samara oblast Duma in December 2003 was convened to review the Pharmbox system. Although the discussion was allegedly open to outsiders and the press, there was virtually no coverage of the event, apart from a write-up of the main recommendations of the Duma health committee. By reading between the lines, however, it appears that the four hour session consisted of doctors complaining at length about poor service (Recommendations 2003). 17 head doctors had complained to Governor Titov in an open later dated November 2002 that Pharmbox prices were too high. The TOMIF coincidentally (?) began auditing 15 hospitals for misuse of funds directed towards supplying the Entitled (Samarskoe Obozrenie 2002: No. 6).

[133] The General Director of Pharmbox, Vladimir Ezhkov, explained in a 2002 interview that their prices are 9% cheaper than retail prices but 14% more expensive than average wholesale prices. He believes that the appropriate comparison is with retail prices, given that Pharmbox is now the last contact with the consumer (Shtanov 2002). It may well be that Pharmbox prices are lower than average retail prices. But given that the point of this system was to cut out distributors from the supply chain, opponents argue that prices should be equal or better than average wholesale prices (Mr. Samoletov 2004). In fact, it would be nearly impossible for Pharmbox prices to be lower than those of their regional competitors as they are using local companies (e.g. Vita) as well as national distributors (e.g. Protek) to source the drugs they sell. An internet check of July 2004 retail prices for one domestically produced drug (Analgin, 2 doses) and four imported drugs [Akva-Maris nasal spray (Jadran, Croatia), Viagra (Pfizer, 3 doses), Iodomarin (Berlin-Chemi, Germany, 3 doses), and Movalis (Boehringer Ingelheim, 3 doses)] found that in only one case (Viagra, 50 mg No.4) was the Pharmbox retail price unequivocally lower than that offered by Vita and Implozia, the two largest regional retail chains. (Note that the prices charged to hospitals may be lower than those in Pharmbox pharmacies—this I could not check.)

Remedium (October 2002), a leading national medical and pharmaceutical journal, stated in October 2002 that prices in Samara rose by over 60% after the Pharmbox system was introduced. Officials familiar with the pharmaceutical markets and unhappy about the Pharmbox system also confirmed that prices rose as a result of the adoption of the Pharmbox regime. They say, however, that they don't bother to fight the system since 'resistance to Gusarova is futile' (Mr. Krivopal'tsev, Kirillov 2002). The city of Samara, which considered that it had a decent system for sourcing drugs to hospitals and for the Entitled, resisted the Pharmbox system for months after it was introduced. Political and appointed officials complained of higher prices and objected to paying for Pharmbox to build a database which the city had already produced for its Entitled population (Samarskoe Obozrenie 2002: No. 5).

should be used to build up a private company.[134] Most disturbing, Gusarova's son has served as a Pharmbox Deputy General Director (apparently responsible for I.T.) since a year before the UFP tender (Shtanov 2002, Samarskoe Obozrenie 2002). While this alone does not mean that the procurement system has been rigged, it speaks to a very serious conflict of interest for Gusarova.

The Pharmbox system has been hailed as a model for other regions, not least of all by Gusarova, eager to justify her scheme (Shkatov 2002). It is attractive to other regional health committees not only because it gives regional health committee officials more control over the use of budgetary funds, but also, one strongly suspects, because it facilitates the institutionalization of schemes that smell a lot like grand corruption.[135] Samara's case is particularly provocative because the UFP is private. Other regions that have centralized their government drug purchases have not chosen the same neat model as Samara. Often there is no official UFP to control government orders, although one can nearly always discover a leading regional firm with good contacts receiving a large share of public funds.

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[134] In 2000 Ezhkov bought 29% of Pharmbox shares, though this was diluted down to 3% in a subsequent share issue. All Pharmbox shares belong to unnamed individuals, apart from a block purchased in voucher auctions by an American company (Shtanov 2002). Competitors outraged (and/or jealous) of Pharmbox's monopoly on state drug purchases (Belousov and Chernogusev 2002, Cherepakhin 2002,) as well as reputable public servants (Mr. Krivopal'tsev 2002), and leading professional periodicals (Remidium April 2002) argue that the government should not be directly assisting non-competitive private firms with uncontested government orders.

[135] "Grand corruption" occurs when a high-ranking official abuses his authority over major programs to reap significant monetary benefits. (Moody-Stuart 1997; Rose-Ackerman 1999, 27-30). A typical example of grand corruption is the allocation of a government purchase order to a company that gives a kickback to the official in charge of selecting the vendor. The most serious instances of grand corruption often involve "capture" of the rules for awarding government contracts.

The Republic of Bashkortostan

In Bashkortostan, the state-owned Bashpharmatsiia (BF) flirts with monopoly status by controlling 30-34% of the distribution market,[136] though its market share is falling under the pressure of competition from consolidating retail pharmacy chains (Mr. Tysiachnyi 2002, Mr. Orekhov 2004). The company acts as the regional Ministry of Health's partner for providing drugs for hospitals. "Open" tenders are held for procurement, but they allegedly have a "closed or semi-closed character" as the result is known ahead of time-- Bashpharmatsiia wins (Mr. Muzikantyi 2002). Besides using BF for the purchase of Entitled drugs, the oblast Health Ministry purportedly puts pressure on hospitals that attempt to source their drugs from other sources (Mr. Skorobogat'ko 2004). However wholesale competitors are no longer prevented selling to BF's pharmacies; the Anti-Monopoly Committee forced BF to reverse an internal order requiring its many pharmacies to source drugs exclusively from the mother company.[137] The AMC has been less successful in forcing BF to offer competitive pricing: the prices paid by regional and municipal budgets for Entitled drugs from Bashpharmatsiia are higher than those of other private companies (Mr. Orekhov 2004), despite formal restrictions on BF margins.[138]

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[136] Anti-Monopoly Committee methodology defines a monopoly as a firm that controls 35% or more of its market over a period of 2 years. In Ufa, the AMC has apparently been at odds with the Ministry of Health for years over BF's market position (Mr. Tysiachnyi 2002).

[137] This is not a small market: BF has 216 pharmacies with 255 pharmacy "points", plus 14 kiosks (Zagidullin 2004).

[138] I was not able to confirm the convincing assertion of one public servant that the reason that BF remains in a privileged position (even as Ministers of Health in Bashkortostan come and go) is that BF's management realizes that they need to spread their gain around to a number of officials at the regional Ministry of Health.

Volgograd Oblast

In Volgograd, the state-held Volgopharm once dominated the pharmaceutical distribution market, but has now shifted primarily into retail, where it now owns some 50 pharmacies in the region. Volgopharm was the state-owned drug monopolist for the Volgograd region in the Soviet Union, and in 1993-4 rode its good contacts to grab the last imports from COMECON countries before ties to Eastern Europe irrevocably collapsed. From 1997, the company began building a large retail network by selling drugs in its pharmacies at wholesale prices. Competing pharmacies went under or sold themselves to Volgopharm, and wholesale prices dropped dramatically (Mr. Medvedev 2002). The head of Volgopharm, Natal'ia Bozhko, happens to be the wife of Armen Gukasian, the Head of the Oblast Department for Drug Supply (*upravleniia lekarstvennogo obesnecheniia*).

There is, however, internal competition for government money with Volgograd oblast since the Volgograd municipal government has close ties to another firm, Kominfarm. This private company remains afloat strictly due to the administrative resources expended on its behalf (Mrs. Nenashaia 2002). It was created to supply hospitals with cheaper drugs, but poor financial management has resulted in large debts, which in turn mean that it must sell medications at higher prices than alternative suppliers.[139] Nonetheless, the city health administration lobbies hospitals to use its preferred vendor, and transfers funds more quickly to facilities that make their pharmaceutical purchases with Kominfarm (Mr.

[139] Kominfarm is required to take longer credits from suppliers, which raises the prices at which drugs are offered to it.

Krivoshapko 2002).[140] A review by the city legislature's Accounting Chamber found that in 2003, the city chose Kominfarm to supply it with insulin even though Volgopharm had proposed prices that were 30% lower.[141]

The Republic of Marii El

The situation in Marii El is better. Marii El Pharmacia (MEP) was created by President Kislitsin, who intended to use it as a vehicle for his partners (owners of 49% of the company) to tap budget funds. At that time, the company "didn't behave so well" (Mrs. Smetannaia 2004). Its main competitor for state business was the old-fashioned successor to the Soviet Pharmatsiia, GUP[142] Pharmatsiia, which was slowly drowning in debts, barter and bad management, especially after the 1998 financial crisis. In 2002, MEP was reincarnated as a 100% state-owned open joint-stock company (OAO) Marii El Pharmatsiia, with all the same assets but none of the debts (Mit'shev 2002). Since then, it has become the "right hand" of the regional Ministry of Health, and is the main supplier of drugs purchased with government money. The government holds tenders for public contracts and MEP and GUP Pharmatsiia are the

[140] An official of the Volgograd TFOMS said that she reimburses hospitals on the basis of what they have spent on a given patient. Incredibly, however, she said that this bill is not broken down into components (pharmaceuticals, food, etc.) (2002). Overspending on pharmaceuticals is thus a matter to be handled by the oblast or municipal state owners of the spendthrift facility. In the case of overspending on Kominfarm drugs, the city appears willing to turn a blind eye. The ultimate result of this strategy is that the city budget runs out of money for health care expenditures before the end of the year. In 2002, they had problems buying insulin by the summer (Mrs. Nekhoroshaia 2002).

[141] The circumstances under which Kominfarm were selected can only be described as suspicious. Three tenders (*konkursy*) were held for the insulin contract. All three results were invalidated. Then the chairman of the municipal tender committee, in accordance with a city administration decision (*postanovlenie*) of 19 June 2002 (No. 685), agreed that in the case of a 4th tender, the city would only buy insulin from a single source: OAO Kominfarm. This they did, even though Volgopharm proposed to provide the insulin for 30% less (Fedotov and Chistiakova 2004).

[142] GUP= Gosudarstvennaia Unitarnaia Predpriiatiia (State Unified Enterprise). This legal status is common among state-owned wholesalers across Russia.

two primary contenders. MEP seems to win most of the lucrative contracts (apart from those for narcotics or medical spirits). The open tenders (*konkursy*) won by GUP Pharmatsiia are often cancelled and replaced with closed bid solicitations, which they do not always win again (Mr. Tsaregorodtsev 2002). In conversations with local entrepreneurs, GUP is hardly mentioned as a force on the pharmaceutical market. Nonetheless, the fact that Marii El has two large entities competing for government contracts distinguishes it from Samara and Bashkortostan. The absence of family ties between health care officials and the leading firm distinguishes it from Volgograd and Samara. Complaints about procurement prices in Marii El are much more muted than in other regions.[143]

The Disadvantages to Centralized Markets

Consolidation of procurement and wholesale markets is not, in and of itself, a bad thing—as noted earlier, it is typical in developed western economies, where there may be a handful of distributors supplying all pharmacies in the country. What is disturbing in the cases described above is that local Russian pharmaceutical markets are being narrowed not through a Darwinian selection of the fittest, but through administrative fiat. In addition, while consolidation of a market into a few competitive players can produce lower prices, reducing a market to a single supplier is likely to have the opposite effect. The procurement regimes in the four regions I examined are all artificially biased in favor of companies favored by municipal or

[143] One entrepreneur mentioned that for 11 rubles a dose, he could provide the oblast with 500,000 doses of a drug that they purchase for 16 rubles from MEP (Mr. Krivosheev 2003). However I was unable to find any other evidence of excessive prices at MEP, and cannot rule out that this was empty boasting.

regional administrations. In three regions these companies provide drugs at higher prices than those offered by their competitors on the open market.

My perusal of the Russian pharmaceutical press, and the result of my faxed query to regional health departments suggest that most of Russia's remaining 85 regions are gradually introducing drug purchasing systems that resemble the four systems described here.[144]

Recentralization of the Russian State: Possible but Problematic

What does the administrative consolidation of four regional pharmaceutical markets tell us about political centralization in Russia? It illustrates the risks inherent in giving regional officials unchecked control over even narrow policy areas and budgets in their regions.

In four years President Putin has managed to arrest the decentralization of the Russian state permitted by President Yeltsin. Reforms that strengthen the role of federal bureaucracies in the regions have indeed curbed regional autonomy. Regional legislation in conflict with the Constitution or federal law has been cancelled, presidentially-appointed governor-generals supervise regional executives more closely than before and will soon manage leaders hand-picked by the Kremlin rather than election, ministries with strong vertical hierarchies have reasserted their control

[144] Without traveling to the regions, it is virtually impossible to identify the particular scheme used to abuse procurement systems. Occasionally one can see reports of the more outrageous cases of grand corruption. Ul'ianovsk provides one example. While still Deputy Governor of the oblast, V. Kurochka, set up a firm that was "government in form but commercial in substance." Budget funds were sent to this government entity, which then determined not only the suppliers for all oblast hospitals, but also which drugs would be purchased (head doctors were no longer able to specify what they needed). A local newspaper wrote "Whether or not [Kurochka] personally gets something, is unknown, but it is known that he is always abreast of the affairs of this company," even though he now lives in Moscow (Polenov 2004).

over regional offices, and less integrated federal agencies have used growing respect for federal rule-making to increase their influence.[145] Compliance with new formal rules is much higher now than it was under Yeltsin, though it still leaves much to be desired.

This chapter has relied on an investigation of reforms in the sphere of pharmaceutical regulation to discover why formal rule change now has produced greater results than formal rule changes under Yeltsin. Whereas most of the reforms introduced by Yeltsin's team in the early 1990's were extremely radical from the perspective of Russian bureaucrats (Bird and Wallich 1994), the Ministry of Health's recent efforts to increase control over pharmaceutical firms and health committees relies on regulations that have much in common with regional rules developed in the second half of the 1990's. Health departments had tried to squeeze small pharmacy kiosks and distributors out of local markets throughout the 1990s, for instance, but were thwarted by the courts and anti-monopoly committees; new federal standards for pharmacies and wholesale licensing rules essentially eliminate smaller businesses from regional markets. In cases like this, new formal rules meet the needs of regional officials, and are willingly enforced.

Putin's reforms have also been more successful because they speak to the informal rules that have governed bureaucratic behavior for the past dozen years.

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[145] Casual references to the "*verticale*" often ignore important differences between the 50 or so federal institutions with regional offices (for example, the Tax Ministry, the Ministry for Extreme Situations, or SES) and federal ministries without their own regional subdivisions (such as the Ministry of Health or the Federal Obligatory Medical Insurance Fund). The latter have inherently less control over corresponding regional bureaucracies charged with implementing policy. Re-establishing a "*verticale*" in the former implies internal reforms to make the hierarchy more efficient and improve reporting mechanisms within an organization. Creating a "*verticale*" in the latter requires serious shifts in the balance of power between organizations that are not entirely subordinate to one another.

Informal rules inherited from Soviet times evolved during the transition years as the economic environment changed. The Soviet practice of giving "thank you gifts" to helpful officials has been monetized under capitalism; now many services are provided in exchange for an official and an "unofficial" fee (INDEM 2001). The development of markets has meant that networks are less important for sourcing scarce goods and services, but more important for obtaining access to new markets and lucrative contracts. The old concept of *blat* has found new life in the use of intermediaries to facilitate licensing and other bureaucratic procedures. Respect for political connections has also promoted an environment in which conflicts of interest are not taboo. Among regional health departments, it is now normal for leaders to have close relationships with the drug distributors receiving the bulk of procurement contracts.

We thus can see proof that administrative enforcement of formal rules becomes much easier when reforms represent modifications rather than wholesale changes in existing formal rules. Introducing formal changes that accommodate rather than fight informal rules also facilitates enforcement. But better enforcement of legislation may not be the answer to all that ails Russia. Early analysts of Russia's transition assumed that reforms were thwarted because it was impossible to ensure compliance at the regional level.[146] The benefits of federalism and decentralization seemed to be out of reach because local governments were unable to ensure compliance with reasonable reforms (Oates 1999). In the early 2000's, a new school of thought advocated coupling economic decentralization with political centralization

[146] This was the underlying logic of the privatization voucher auction system which removed all discretion from the hands of local privatization officials.

to reduce the risk of regionalist policies (Blanchard and Shleifer 2001). As if in response to this advice, we now observe in Russia an increasingly centralized political system with pockets of decentralized policy-making. The goals of both federal authorities and accommodating regional officials have been brought in line with each other, as have many of the formal and informal rules driving bureaucratic behavior. Ironically, the twelve years of transition away from a single-party, command economy Communist system have pushed political, bureaucratic and institutional incentives to converge on the benefits of reducing political and economic competition.

CONCLUSIONS

This dissertation immodestly set sail with the aim of discovering uncharted territory in the field of institutional change. A great deal of constructive research has illuminated the way in which formal institutions evolve and frame the expectations of political actors. Informal institutions have proven to be more illusive. They are resilient and flexible in the face of dramatic change, understood but unwritten, and we know from observation and personal experience that that they are essential in explaining why people behave the way they do. Studying informal rules in Russian bureaucracies is like learning to drive in a developing country. It helps to know the official rules of the road, and how they differ from those in the West. But what is really important is communicated through word of mouth and practice—the rules one uses to navigate around terrible infrastructure, unpredictable changes in traffic patterns, egotistical and distracted drivers, and corrupt policemen are the ones that really matter. After a dozen years of skirmishing with Moscow traffic, I set out to investigate informal institutions.

Studying the role of informal rules in determining bureaucratic behavior required that I peer into the dark and dank recesses of the state. This was often frustrating and time-consuming, requiring that one penetrate deep enough into an organization to understand its formal constraints and operating principles. Ultimately, it proved to be well worth the investment in effort and language skills. Interviews rigorous enough to reveal specifics but casual enough to encourage candor yielded a great deal of information about how regional officials perceived the changes

in the early 1990s, how they adapted to the uncertainty of the post-communist period, how their formal environment changed over the course of the decade following 1991, and what they have come to expect from the Putin years. The narrative presented in chapters 2, 3 and 4 describe why and how the regulation of pharmaceutical firms evolved between 1991 and 2004. This chapter highlights the salient aspects of the case study within the framework of five conclusions.

Conclusion 1. Unanticipated Radical Change in Formal Rules Increases the Importance of Informal Rules.

While it is rarely referred to as a revolution, the Russian transformation from centralized communist control to democracy and capitalism has been no less dramatic than what was witnessed in Eastern Europe. Born less out of popular discontent than irrevocable economic and moral obsolescence, the Russian transition has seemed incremental only from the outside. From the inside, the "loss of the motherland" provoked by the independence of the surrounding Soviet republics, the trauma of hyperinflation and concurrent loss of savings, the sudden irrelevance of many social conventions and coping mechanisms—even the flooding of empty shops with food and Chinese clothing—was a shock to a population used to the rather grim certainty of Soviet life. The disintegration of the Soviet Union inaugurated a period of great personal and professional uncertainty for all Russians.

In the face of uncertainty, people consciously and unconsciously search for ways in which to understand what is happening and what to do. When the old formal constraints on behavior vanished with the Communist Party, people groped for rules to live by. Some, particularly the elderly, continued to live according to the old rules,

paying their respects to Soviet heroes and ideals, and staving off the frustration of their irrelevance by dreaming of a return to a glorious past. Others threw themselves into the waters, shaking off the initial cold by vigorously swimming in the direction of least resistance. Many stood at the banks of the transformation, perhaps pleased to see that it brought more freedoms and information about the world, but wary about getting carried away by the current.

Life in bureaucracies was much the same, although the illusion of continuity was perhaps sustainable for a little bit longer. Since its establishment in Tsarist times, Soviet bureaucracy had been known for its conservative adherence to planning and reporting. Officials were chosen for their loyalty and deference to the regime, and in exchange enjoyed a life with more perks. Life as a public servant was one of stability and relative privilege.

When President Yeltsin's crew of "young reformers" began liberalizing the economy, many bureaucrats looked on in abject horror. The ones surrounding me in 1992 in the committee charged with the design and implementation of the privatization program were those who just happened to sit in the building assigned to the State Property Committee (GKI). They had been part of the Ministry of Finance, and had been passed along to GKI along with a building not far from Red Square. The overwhelming majority not only objected to the idea of privatization, but openly hoped for a swift return to life as Soviet citizens. Few were interested in participating in the transformation—or dissolution—of their country's achievements, and they assumed an attitude of passive resistance. Dismay and denial appear to have been nearly universal in the earliest years of Yeltsin's rule.

In Soviet days, officials in regional health bureaucracies were supposed to implement plans and programs passed down from the Ministry of Health. They were not expected to creatively address problems they observed; reports were sent up the strict hierarchy to a level where they would be processed, and quotas were sent down. Of course, bureaucracies did not function as ideal types and there was as much shirking of responsibilities and ineffective quota filling in state organizations as in industrial factories. When the number of hospital beds in a region was to be increased, facilities were converted or constructed to increase quantity with little regard for quality. Officials took advantage of their position to access good doctors, hospitals, and drugs for themselves and their contacts. Statistical and anecdotal evidence suggests that the health care system was already deteriorating by the mid-1980s. But officials in regional bureaucracies were, with very few exceptions, not able, empowered, or interested in solving fundamental problems inherent in the structure of Soviet health care.

However the leaders of regional bureaucracies as well as the civil servants below them were asked to take on enormous responsibilities as the centralized Soviet state was dismantled. Growing regional sovereignty, including over health care, by 1993 had left regional officials in charge of financing and running their local health care systems. Unsure or unable to do this, many tried for several years to continue applying Soviet era rules to the new environment. All pharmacies had been state-owned and subordinate to regional health committees, so many officials continued to favor state pharmacies and discriminate against the nascent private sector, even as it became clear that private entrepreneurial activity could provide the solution to

widespread drug deficits. Soviet pharmacy standards, drafted when real estate was administratively assigned and universal health provision was a top priority, promoted the even dispersal of large pharmacies across cities and rural areas. In the early 1990's, many health officials continued to resist the idea that pharmacies could be opened wherever there was enough demand, and many clung to the old requirement that they be no closer than half a kilometer apart. Although old rules had lost much (though not all) of their relevance, bureaucrats unsure of what to do continued to apply them.

By 1993 and 1994, new legislation in the area of medical insurance sent an important signal that the Soviet health care system would never again exist as it had before. The state would not finance all expenditures, and a new bureaucracy, the Obligatory Medical Insurance Fund (OMIF) would begin collecting payments from firms and government budgets to assist in financing medical facilities and personnel. The idea that markets would play a key role in health care, while arguably overstated in the early years of the transition, began to sink into the mentality of regional health care officials. They understood this not only from the federal laws being sent from Moscow, but also from their observation of the burgeoning and largely uncontrolled drug distribution markets around them. Something had to be done to ensure drug safety, and applying old rules was proving to be ineffective.

A lack of experience with private economic activity contributed to doubts felt in regional health care bureaucracies. How could one distinguish between "good" firms and "bad" firms? What role should health departments play in drug procurement made with public funds? Would the market sell drugs at prices that

people could afford? Not knowing the answers to these questions, both high-level and lower-level officials relied on informal rules to guide their behavior. Personalized problem-solving habits honed amid Soviet conditions of scarcity provided some guidance in addressing these issues. Good firms were those that were run by managers known to the officials. Bureaucrats could overlook problems with companies in exchange for a gift. Bad firms were those that were less interested in "helping out" the health department by servicing poor pensioners than in profits; officials used their discretion to keep these firms from expanding their market share. In the absence of effective formal institutions, informal rules assumed a greater role in guiding the actions of bureaucrats.

Conclusion 2. Increasing the Relative Importance of Informal Rules Compromises Radical Reforms.

Because they were unprepared for the transition to a market economy and democratic government, officials did not fully understand the goals of reformers, nor did they accept the means proposed to achieve them. Part of the problem was that reforms propagated in Moscow were unsurprisingly flawed, their drafters not having had much more experience with capitalism and democracy than their counterparts in the regions. Many reforms represented attempts to transplant institutions developed over centuries in the west onto the inhospitable ground of the post-Soviet state. Many reforms were poorly explained, and Moscow's often condescending attitude towards the former industrial and bureaucratic elite did not go unnoticed in the provinces.

While Yeltsin fought with Gorbachev over control of Russia, savvy regional leaders had begun seizing authority for the executive branch of regional governments.

Bilateral agreements between Yeltsin and certain regions (most commonly the ethnic republics) had created an inconsistent federal system based on exceptional agreements and continuous negotiation between the center and the periphery. The 1993 Constitution gave regional government joint jurisdiction over many policy areas, including health care. Regional health care departments had never borne real responsibility for health care before, but they found themselves charged with raising and spending funds, managing health care facilities and personnel, sourcing drugs and equipment, and overseeing plunging health care statistics. The tasks they confronted were overwhelming, and having risen to positions of power via Soviet bureaucratic careers, they were ill-prepared to lead their organizations though difficult straits.

The informal rules used on the ground to license and regulate pharmaceutical firms in many regions contradicted the objectives of market reforms. Rather than foster small and medium enterprises, local officials threw up barriers to entry for new firms. Instead of forcing state-owned companies to adjust to the dictates of market forces, health departments continued to allow municipal and regional pharmacies to operate with soft budget constraints. Property rights and contracts were not enforced by the police or the courts; instead, corrupt street-level officials competed with protection rackets to extort bribes from entrepreneurs. In the first half of the 1990's, formal rules introduced by new reforms competed with existing, Soviet-era informal rules—and lost.

The result was an environment in which regional officials used their discretion to assist or hinder businesses. Rent-seeking by individuals with power and organizations starved for funding inhibited the development of normal markets, and

partially explain why Russia suffered such a sharp recession in the first decade of transition. Yet despite the administrative obstacles in their path, determined entrepreneurs did establish themselves in lucrative markets and build businesses. Across Russia, in the first half of the 1990's retail and wholesale pharmaceutical markets developed from scratch. Reforms alien to implementing bureaucrats failed to produce an immediate change in the biases and behavior of Russian officials, but they opened the door for an expansion of informal activities. Informal rules led bureaucrats to pursue decisions inconsistent with the stated goals of reforms. Meanwhile, the application of informal rules by businesspeople generated mechanisms for circumventing officials and fostered underground economic activity.

Conclusion 3. Informal Rules Adapt to Changing Circumstances to Provide Ongoing Guidance to Bureaucrats.

Yeltsin's victory over the Communist Party in the 1996 Presidential election, while apparently master-minded by a narrow group of wealthy businessmen and self-interested politicians, was interpreted as a sign that there was no going back to the USSR. Even those not confident that Russia could or should follow the western path to pluralism largely recognized that they would have to come to terms with post-soviet economic and political conditions.

The development of retail and wholesale pharmaceutical markets, sometimes despite the best efforts of officials to limit them, meant that the circumstances facing regional health department officials were changing. The Ministry of Health, out of touch with local conditions and no longer meaningfully involved in financing regional health care, issued instructions and directives that were poorly prepared and

easy to ignore. Officials in charge of licensing pharmacies and drug distributors, operating with only skeletal formal legislation, filled in the gaps by adapting informal rules.

Soviet-era respect for connections and the frequent use of friends or contacts to solve problems evolved into respect for the role of intermediaries. Firms turned to experienced "fixers" to run interference between them and the bureaucracy assigned to regulate their activities. An entrepreneur keen to reduce the time and hassle involved in opening a firm could buy a pre-registered firm or use an expert to run paperwork through the licensing commission. The added cost of the intermediary's services and the bribes paid to officials along the way were taken into account as part of the cost of doing business.

In hospitals, the disintegration of centralized provision of drugs forced head doctors to source drugs themselves. The Soviet-era habit of relying on *blat* and personal networks to find scarce goods and services helped these administrators choose vendors. Drug distributors run by former doctors or friends were favored, as were those willing to provide the doctor with a kickback in exchange for contracts. More used to petitioning for additional funds than allocating scarce resources doctors, like regional health care officials, would turn to the next bureaucracy up the line for more money when their accounts ran dry.[147] Informal rules developed in conditions

[147] Decentralization without training was a problem in many bureaucracies and in many Central and European countries as well. One account of how government financing had changed noted in 1994 that "at present in most of the transition economies, those local officials who are not simply waiting, more or less passively, for orders to come down from above—as they have for decades—have understandably been using their energies primarily to attempt to wheedle more money out of the central government" (Bird and Wallich: 99).

of communism proved flexible enough to continue guiding the behavior of officials and entrepreneurs in times of capitalism.

Connections had been used to get jobs, housing, and food, to obtain favourable positions on waiting lists for allocated goods and services (such as telephones), and to get access to good hospitals, doctors and drugs. The use of connections was perceived more as a form of cooperation than corruption, of "mutual support with a long-term perspective." Bureaucrats, people with problems, and those with an entrepreneurial nature had all relied on connections to address situations that were not resolvable through normal official channels. In the early days of the transition, when official channels became even more ineffective, it was normal for people to turn to the same sort of coping mechanisms they had used before to solve problems they hadn't encountered before.

Conclusion 4. Informal Rules Can be Codified Into Formal Rules.

Regional health care departments assumed responsibility for health care in their jurisdictions. There was wide variation in the degree to which they succeeded in meeting the simultaneous challenges of autonomy, under-funding, and failing infrastructure. Leaders and lower-level officials coped by gradually introducing new formal rules to guide decision-making within the organization. Codified into regional legislation as decisions of the regional government, local laws, or departmental instructions, these rules supplemented the Ministry of Health directives that sporadically arrived by special government post or blurry fax.[148] In many cases

[148] I made a monumental and ultimately unsuccessful effort to get a list of all the Ministry of Health directives produced between 1992 and 2004 in order to identify trends in formal rules. In the end I concluded that such a list does not exist. The official Central Government Library to which the

regional legislation openly defied federal rules, but in the Yeltsin years the federal government chose ignored these contradictions.

The codification of informal rules into legislation meant that the bureaucratic discretion fostered in soviet days was incorporated into the formal rules used in post-soviet regulation. Bureaucrats were obviously interested in formalizing their control over the access of firms to markets, and in institutionalizing many of the rent-seeking mechanisms they had put into place. Potential opponents of such measures, the entrepreneurs themselves, were not in a position to protest. They had not yet formed associations that could productively amplify potential objections into a collective voice, and they were used to solving problems and circumventing formal rules on an ad hoc basis.

The lack of opposition to formal rules that incorporate rent-seeking measures is explained in Joel Hellman's seminal article "Winners Take All" (1988): winners are organized, but losers are diffuse. In the early stages of transition, well-placed entrepreneurs profit from distortions created when highly regulated markets are partially opened. (In the classic Russian example, enterprise directors with access to valuable natural resources sell subsidized oil or metals on expensive world markets.) Hellman was concerned primarily with the activities of the nascent private sector, but his approach can be applied to the study of high-level regional bureaucrats as well. Officials who use their positions to extract revenues have a strong incentive to

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Ministry is supposed to send copies of all directives receives 10-20 of the hundreds of *prikazy* produced each year. The Ministerial website, when it existed, had links to many decrees, but not all. Medical journals and publications only print those directives that are of particular interest. Heroic efforts by my contacts to obtain a list from the Ministry itself suggests that there is no procedure for keeping track of every single directive. One has to wonder, if no one keeps a reliable list of all the Ministerial directives, how can threats of enforcement be credible?

formalize these arrangements and block subsequent changes that might eliminate sweet partial equilibriums. (Lower level officials who may also want to formalize their rent-seeking generally do not have the political influence required to lobby for executive or legislative decisions in their favor.) The losers in the transition—those who pay higher prices as a result of this rent-seeking—are not organized and do not have enough access to the levers of power to object.

Once the winners have formalized the mechanisms that ensure their flow of revenues and keep them in power, they are free to develop their "business" as they wish. This phenomenon has been loosely referred to as the capture of regulatory agencies by regulated firms, but the findings of this study suggest an important modification to the capture literature. In its most recent incarnation, capture is defined as "the capacity to influence the formation of the basic rules of the game (i.e. laws, rules, decrees and regulation) through private payments to public officials."[149] The implication is that powerful firms aggressively try to sway the judgment of important politicians or officials. My research indicated that at least in smaller markets like those related to drug distribution and sale, highly-placed health care officials first establish themselves in a bureaucracy, solidify their control mechanisms over markets, and then look for ways to profit from their position. It is not that an outside firm seizes control over a regulator and then begins to manipulate its activities; instead, a well-positioned insider uses his or her influence to give special access to a firm. While the resulting relationship may produce results identical to

[149] Hellman, Jones and Kaufmann 2000. An earlier wave of research on capture in the 1970's focused on the relationships between monopolies and regulatory agencies (e.g. Stigler 1971; Peltzman 1976).

those described by those who see firms as the aggressor,[150] emphasizing the role of bureaucrats in compromising the state's objectivity and finances should be of interest to scholars interested in how the Russian state has evolved in the post-communist transition. Weak state officials are not passively accepting bribes in exchange for procurement contracts. In many cases they are consciously building networks and firms that can exploit their conflict of interest for maximum personal gains. In other words, highly-placed officials in regional bureaucracies understand how to formalize their informal relationships in preferential procurement contracts. Monitoring entities that should be interested in quashing these relationships, be it the gubernatorial administration or accounting office of the regional legislature, are unable or unwilling to fight this form of grand corruption.

Conclusion 5. Formal Reforms that Modify, Rather than Replace Existing Formal Rules are More Likely to Succeed, as are Reforms that Complement Informal Rules.

Hellman argued that the winners in the early stages of transition, those who benefit from partial reforms, have a strong incentive to resist the completion of reforms that will eliminate their opportunities for arbitrage. Once markets are open to all, competition increases and profit margins go down. Similarly, highly-placed bureaucrats that have benefited from the obstacles they create for businesses are

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[150] Note that there are studies that just look at the incidence of capture without trying to trace its origins (e.g. Slinko, Yakovlev and Zhuravskaya 2004).

unlikely to willingly give up their discretionary power. They will resist radical change, and are more likely to support partial reforms.

Since he took office, President Putin has been intent on recentralizing state authority and reaffirming federal control over key policy areas. After insisting that regions abandon legislation that contradicted federal rules, he empowered federal ministries to reassert their influence by strengthening the vertical subordination of regional bureaucracies to their federal superiors. Not all agencies have been able to do so, and those without clear hierarchical and financial control over regional entities have struggled to get their directives enforced. Nonetheless, regional leaders who have come to like independent decision-making have slowly come around to the inevitability of greater federal control. The antagonism of governors has been quieted as it has become clear that Putin will remove the defiant from office, and as regional officials realize that they can also benefit from Putin's attempts to centralize control. Even the plan to replace gubernatorial elections with Kremlin appointments has been met with understanding as regional governors assume that they will be given the right to recreate their own power "*verticale*" within their regions in policy areas of little direct interest to the Kremlin.

Giving up broader freedoms for greater control within one's abbreviated jurisdiction also appeals to regional health care departments. Managers of health departments may need to be more responsive to Ministry of Health guidelines on the standards of medical care to be provided, and on the way in which pharmaceutical firms will be licensed. But in exchange for their obedience they will apparently retain the right to procure drugs as they see fit. If anything, the regional tendency to

consolidate procurement and pharmaceutical markets has been sympathetically interpreted as a parallel effort to reduce "disorder" via re-centralization of state functions.

Bureaucrats operating under governors and managers of health care departments have also been subjected to reforms under Putin. Broader administrative reforms of registration, licensing and certification procedures that have tried to reduce the role of bureaucratic discretion and improve the business environment have produced mixed results.[151] Reforms introduced in this area target the behavior of lower-level officials who have resisted attempts to reduce their discretion since 1991. In contrast, modifications in licensing rules introduced by the Ministry of Health have been easier to swallow and implement. In many cases new restrictions on the size of firms mirrors the inclinations of regulatory officials. The propensity to favor large firms over small ones, and established companies over new competitors echoes earlier preferences for "the firms you know." In the appreciative words of one employee of an oblast pharmaceutical department, "the time of muddy waters has passed." Formal reforms that complement informal rules are met with understanding rather than resistance. Those who benefit from new formal rules because it allows them to continue applying existing ideological beliefs or their discretion will step forward themselves to enforce these reforms.

[151] Attempts to reduce the time and expense required to license a firm and the burden of inspections for small and medium-sized firms produced short-term improvements in 2002, but progress has slowed in subsequent years. (CEFIR 2003).

Bringing the State Back In

What do these conclusions tell us about how the Russian state has changed over the past dozen years? They suggest that breaking down the state into its bureaucracies, the bureaucracies into hierarchies, and the hierarchies into managers and lower-level officials can yield valuable insights into how policy decisions are made and implemented in periods of transition. Understanding the formal and informal constraints that guide bureaucratic behavior, as well as the changing balance of power between these sets of rules, helps us understand why certain centrally-planned reforms succeed while others fail.

By tracing the changing social, economic, and professional environment of Russian health care bureaucrats, one can find important examples of both persistent informal institutions, as well as new informal rules that emerge in response to changes in the political and economic environment. What determines the way in which formal and informal rules interact with each other? The findings of this thesis can be summarized in a modified version of the Helmke and Levitsky typology presented in Chapter 1.

The empirical narrative recounted in the middle chapters of this thesis cover three of the possible four scenarios represented by the quadrants above. In the early reform years, old, relatively stable, informal rules are used by officials to deal with the uncertainty generated by rapidly changing formal institutions. Formal rules are incomprehensible to officials or fundamentally contradict their beliefs, and are disregarded in favor of familiar informal institutions (Quadrant 2). Over time, informal institutions adapt to new circumstances. New markets force officials to

Figure 3. Typology of Formal and Informal Institutional Change

OUTCOMES	Stable Formal Institutions	Changing Formal Institutions
Stable Informal Institutions	1 *Equilibrium* (pre-Gorbachev USSR)	2 *Increased reliance on informal rules* (Yeltsin 1st term)
Changing Informal Institutions	3 *Adaptation of informal rules to new circumstances* (Yeltsin 2nd term)	4 *Realignment of formal rules with informal norms* (Yeltsin 2nd term)

regulate firms they were able to ignore before, and informal rules retain their importance even as they are applied to situations that were irrelevant before. Selective enforcement of formal rules makes them slightly more relevant in the decision-making calculus of officials, but only in so far as they are consistent with informal institutions (Quadrant 3). As bureaucrats adapt to the transition period, they begin to understand the role to be played by their organization and themselves, and they begin to lobby for new formal rules that reflect their interests. The codification of informal constraints was particularly strongly felt in Russia's regional legislation, which was allowed to contradict the Russian Constitution and federal law under Yeltsin (Quadrant 4).

President Putin's actions in his first term have been described as a shocking departure from the spirit of the Yeltsin years. And yet if we look more closely at the allegedly new trend towards centralized power, we can see that the formal rules adopted in the past four years represent less of a departure from operational formal and informal institutions than one might initially imagine. Regional leaders have steadily consolidated their control over their jurisdiction for years; indeed, the fact

that many ran their oblasts and republics like personal fiefdoms was one of the points used to justify appointing governors in Moscow. While they may resent the reduction in authority they have over their region as a whole, regional leaders appreciate the value of centralized control and seem to be looking forward to making the most of the power remaining in their hands.

In four years, Putin has restored the image of a strong federal state, although this study of the effectiveness of one federal ministry suggests that state operations still leave much room for improvement. Nevertheless, many of Putin's efforts to recentralize state functions in Moscow have been more successful than one would have expected. This is partially a reflection of the fact that his reforms are taking place ten years after Yeltsin's, when the Russian population has already come to terms with the idea that the Soviet Union has ceased to exist. Implementation of Putin's reforms does not require an impossible leap of faith from bureaucrats; many changes adapt formal rules already put in place over the past dozen years.

One strongly suspects that Putin's veering off the road to a free economy and society may ultimately turn out to be less dramatic a change in direction than it currently appears. More research is required into the way in which the current reconsolidation of political and economic power is being supported by informal institutions established during the Soviet period of Russia's history. The case study presented here suggests that informal rules of behavior are flexible and persistent, and confirms that informal institutional change is a matter of incremental change rather than replacement. The ease with which Russians have accepted the resurgence of state power, reduced political competition, and a narrowing of free speech suggests

that on some level these reforms resonate with their informal understanding of how the state and their world should operate. The ease with which Putin's administration has reintroduced Soviet symbols and institutions, from the adoption of a reworded Soviet national anthem to the reestablishment of a single, dominant political party, leads one to suspect that Yeltsin may have been the driver swerving off Russia's evolutionary road, not Putin. Assessing reforms through a carefully built framework of formal and informal institutional change would allow one to understand Putin's reformation of the state in light of the Soviet experience without have to blindly attribute success to the mysterious influence of Russian culture.

This dissertation suggests some additional productive avenues for future research. It would be helpful to have more studies on the evolution of other Russian state bureaucracies since 1991. While my impression is that the experience of the Ministry of Health is reasonably typical for federal agencies without strictly subordinated regional offices, research in other issue areas jointly coordinated by the federal and regional governments (for example, in education or environmental policy) are necessary to confirm this assumption. Studies of federal agencies with stronger hierarchical structures, such as the tax administration or Goskomstat, the State Statistical Bureau (Herrera 2004), will be invaluable to improving our understanding of how the Russian state has evolved in the post-communist tradition. Comparing the decentralization and partial recentralization of health care in Russia with the experience of other post-soviet countries would permit us to better understand why the Ministry of Health proved unable to provide meaningful leadership in the first decade of transition, and also facilitate the identification of factors that make certain

regional bureaucracies more able to cope successfully with change than others. The role of leadership in transition is another topic shouting for additional attention.

Finally, while it ultimately did not focus exclusively on corruption, this thesis makes it clear that state transformations can aggravate the abuse of public office for private gain. The rapid and disorganized decentralization of state power in the initial post-communist years removed the control mechanisms that once limited opportunities for officials to enrich themselves on the job. Ironically, the re-centralization of state power over the past four years has not necessarily curtailed these opportunities, and may have made it easier for highly placed officials to exploit their authority to further their self-interests rather than those of the state. Alexander Kotchegura, a longtime observer of the Russian civil service and attempts to reform it, recently summarized the direction in which administrative reforms should move.

> Managers of public management reform in CEE and CIS countries should focus on identification of 'bad practices,' and 'vulnerable' arrangements that create administrative barriers and artificial deficits of services by the state and facilitate 'administrative blackmail' and other corruptive behavior. The powers of officials to exercise control and impose possible sanctions should be reviewed to assess their vulnerability. Measures to reduce interference by the state in business affairs also should be considered. Particular attention should be paid to handling of public procurement and elimination of excessive administrative burdens, e.g. unnecessary licenses, permits, fees. (2004)

In the past four years, health care reforms have moved in exactly the opposite direction. Regional officials have used the logic of the *verticale* to consolidate and recentralize markets, often into the hands of affiliated or "friendly" companies. Measures designed to reduce economic and political competition, all adopted in the name of increasing order and accountability, have produced an environment that facilitates the abuse of public trust and public funds. It would be melodramatic to

conclude that Putin's reforms are destined to produce a corrupt and autocratic state. It is reasonable, however, to point out the very real dangers inherent in adopting formal rules that centralize power without taking into account informal institutions that encourage its abuse.

APPENDIX 1: The Selection of Regions

The rapid decentralization of Russia's health care system in the early 1990s demanded that my investigation into pharmaceutical policy and implementation be conducted primarily at the regional level. In selecting my regions, I wanted to pick cases that were as different from one another as possible in terms of economic and political conditions. Given that health care is a policy area handled primarily by the regions, to comfortably extrapolate my findings from four regions to the rest of the country, I had to be sure that I wasn't just looking at health care in large, well-developed areas, or conversely, in struggling, poor regions. I wanted to choose four cases that would capture some of the diversity of the Russian regions.

The four regions analyzed in this dissertation are almost never compared. Three are in the Volga region (Samara, Bashkortostan, Marii El), and one (Volgograd) is in the South. Two are republics, and two (Samara and Volgograd) are oblasts. Three regions have populations of well over 2 million people, while one (Marii El) has but 728,000 inhabitants. So how did they end up in the same thesis?

What makes Russian regions different from one another? In such a large country, geography is a factor. The location of a region affects not only its natural endowments and economic structure, but often its relationship to Moscow. From my experience, however, what really determines whether or not a region has successfully survived and prospered in the transition period is (a) their wealth and (b) their propensity to effect transition-induced reforms. I use the term "wealth" to refer not to the existence of plentiful natural endowments, but rather to the well-being of the local population. A successful transition should produce a higher standard of living, as

well as profitable companies. The second criterion, the propensity to implement reforms, reflects the ability of regional leadership to design and implement reforms in a supportive political and social environment. The quality of regional leadership, and the ideological prejudices of the governor or republican president, seems to make a huge difference in whether or not real reforms are seen through to the end. To select my regions, I boiled down these factors into two parameters: wealth and propensity for reform. I therefore wanted to identify one region in each of the four quadrants of the square below.

Figure 4. Typology of Regions, by Wealth and Propensity for Reform.

		Propensity for Reform	
		Low	High
Wealth	Rich	Rich low reformer	Rich high reformer
	Poor	Poor low reformer	Poor high reformer

Operationalizing these criteria turned out to be more challenging than I expected. The proxy generally used to measure wealth is income, per capita income, or per capita Gross Regional Product (GRP). Wealth is the result of natural endowments and the ability to make the most of them. I wanted to be sure I was capturing personal wealth rather than regional endowments. My interest has always been in the decision-making process of officials and entrepreneurs. It thus made sense to look at average monthly per capita incomes, adjusted for differences in the

price of living by region.[152] In 2000, the last year for which the data was available when I was selecting my regions, this number was between 489 and 3,559 rubles, or 437 and 2,734 once adjusted for cost of living differences. (Moscow city and the Tiumen region were outliers: in Moscow, monthly per capita income was 9,291 rubles, or 7,391 once adjusted for the cost of living; the respective figures for the oil-rich Tiumen region were 4,905 and 3,859 rubles.)

Measuring the extent to which regions have implemented reforms was more difficult. I was unable to find any robust rankings of regions based on reforms. Some indices exist (e.g. *Expert* magazine's regional rankings), but they rarely correlate with other listings. Rankings by "politologists" tend to be ad hoc summaries of Moscow-based elites or press freedom watchdogs. I concluded that I had to design a new way to determine whether or not regions had implemented serious reforms since 1991. Reforms adopted by legislatures are hard to assess as the adoption of reform legislation does not reveal whether or not it has been implemented. The election of progressive deputies or executive branch candidates is also an unreliable measure. While it may reveal that the population of a given region is more liberal in spirit, whether or not the governor will actually effect change once in office is not

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[152] I have used "average per capital monetary income (monthly), in rubles, 2000" [*srednedushevye denezhnye dokhody (v mesiats), rub. 2000*]. Russian Statistical Yearbook [*Rossiiskii statisticheskii ezhegodnik*] 2001. Moscow: Goskomstat. I adjusted the income for each region by multiplying the monthly income figure by a coefficient equal to (Russia's overall basket cost/cost of basket in the region). The consumer basket is in "The cost of the minimal basket of food products in December 2000" [*Stoimost' minimal'nogo nabora produktov pitaniia v dekabre 2000 goda*]. The Socio-Economic Condition of Russia [*Sotsial'no-ekonomicheskoe polozhenie Rossii*]. 2000. Moscow: Goskomstat.

Adjusted per capita average monthly income (my measure) is correlated with adjusted per capita GRP (correlation coefficient is 0.87 for all regions without autonomous okrugs). It is also correlated with adjusted monthly average salaries (correlation coefficient = 0.83). I have used monthly income rather than salaries because the former takes into account the non-working population that receives pensions and transfers, as well as people earning money in markets. Adjusted monthly income is reassuringly correlated with the number of cars per 1,000 residents (0.33).

measurable by his victory alone. Measures of judicial reforms were similarly elusive.[153] An attempt to measure "symptoms of change," such as increases in the number of auditors, was also rejected when the association of auditors warned me that many registered auditors are in fact doing sham audits on behalf of their clients. In the end, I decided to rely on indicators that would show whether or not economic reforms had been implemented.

The goal was to find a variable that would capture reforms in the regulatory or business environment without requiring me to check if (a) each region had adopted a particular law and (b) assess the extent to which the law was being enforced. Instead I asked "what would one expect to see in a region that has implemented successful economic and regulatory reforms?" Among other changes, one would expect to find more small and medium sized businesses, a more robust private sector, more foreign investment, and less ineffective state intervention in local markets.[154]

The economic indicators of reform were grouped into three categories: the strength of the private sector, changes in industrial structure, and the extent to which the region has price controls. For each category, I created an index that would pull together the information from two different sources. In all cases I used the latest available data.

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[153] Lawyers no longer need to be licensed, which makes it impossible to reliably count them across regions. In email consultations, Katarina Pistor and Kathryn Hendley discouraged me from using (or creating) an indicator of legal reform. They argued that changes in the number of court cases is (a) not reflective of legal reform because the laws have changed and many more people are submitting tax cases; and (b) is not an unambiguous indicator. The number of court cases may have increased because more people use the courts, or because the rules are unclear and require clarification in court. Moreover, this data is not readily available on a regional basis. Neither specialist in legal reforms had seen a satisfactory measure of legal reform that could be used to rank the regions.

[154] In simple rankings of economic success, GRP growth is often used as a proxy for reforms. However growth in regions rich in oil, timber and metals is closely linked to changes in international prices for these commodities.

The **strength of the private sector** was measured in two ways. First I calculated the proportion of the labor force employed in the private sector. My assumption is that in more reform-oriented regions, more people will be employed by private firms and non-governmental structures. Goskomstat data on employment in the "government" and "municipal government" are more reliable indicators than those of employment in the private sector, which exclude people working in non-governmental organizations, "mixed Russian" or "mixed foreign" firms, or the shadow economy. I thus added the employment figures for the two listed forms of state employment and ranked the regions according to the percentage of the population employed by the state.[155] The greater the share of state employees, the lower the region's "reform score" on this measure. Tula oblast ended up having the largest proportion of non-state workers (69%) while the Republic of Tyva had the fewest (only 34.8% of the labor population works outside of the public sector). Tula was assigned a score of "5" and Tyva was given a "0." All other regions received rankings within this range that corresponded to the position of their state-employment-percentage relative to these two extremes.

In each region, I also looked at the percentage of privatizable homes that had been privatized by the beginning of 2002.[156] This measure is a more questionable measure of the strength of the private sector, but it should give some information

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[155] "The distribution of employment in the economy according to ownership firm, annual averages, 2000" [*Raspredelenie srednegodovoi chislennosti zaniatykh v ekonomike po formam sobstvennosti v 2000 gody*]. Goskomstat. This measure includes teachers and doctors, as well as civil servants.

[156] "The proportion of privatizable housing space as a percentage of housing space that can be privatized, % as of beginning 2002" [*Udel'nyi ves privatizirovannykh zhilykh pomeshchenii v chisel zhilykh pomeshchenii podlezhashchikh privatizatsii, % (na nachalo 2002g)*], Regions of Russia [*Regiony Rossii*], 2003, Moscow: Goskomstat, Table 12.22..

about the extent to which the local population recognizes the value of private ownership. There was significant variation across Russia in 2002. In Arkhangelsk, 34% of apartments had been privatized (earning a score of 0), whereas in the Republic of Altai the corresponding figure was 82% (earning a score of 5).

The "strength of the private sector" index was created by adding the scores on private employment and privatized apartments. Given that the first measure appears to be a much better indicator of the strength of the private sector, however, its weight in the index was 3 times that of the apartment indicator.

The second index was to estimate **changes in the industrial structure** of the regional economy. Here I was less interested in changes across economic sectors (e.g. downgrading of the defense industry or increases in the service sector), and more interested in looking at whether resources were migrating to new, private businesses and to certain regions but not others. To measure the growth in new businesses I looked at the percentage of the labor force employed in small firms in 2000.[157] Moscow and St. Petersburg reported much higher numbers (26% and 26.5%, respectively). I excluded them from the rankings, which meant that Leningrad oblast became the leader (with 16.6% of its population working in small businesses) and the Republic of Ingushetiia retained its position at the bottom (with only 2.5% of the population reportedly working in small enterprises).[158]

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[157] "The proportion of the average number of people working in small enterprises as a proportion of the average number of people in the labor force in the economy" [*Udel'nyi ves srednespisochnoi chislennosti rabotaiushchikh na malykh predpriiatiiakh v srednegodovoi chislennosti zaniatykh v ekonomike, %*]. One could instead measure the number of SMEs per 1,000 population but this figure is less accurate. Many small firms are created for single transactions, and many unused firms are not liquidated because of the cost of this procedure.

[158] For most Goskomstat data tables, information on the neighboring Republic of Chechnia is lacking.

The second component of the industrial structure index captured foreign direct investment in the regions. To smooth over the annual fluctuations in investment that can be brought on by a single large investment project, I calculated cumulative FDI between 1999-2001. This time period, beginning immediately after the 1998 crisis, was generally positive for the Russian economy. Devaluation of the ruble improved the competitiveness of many Russian industries, and a reforming gubernatorial administration would have attracted the attention of the investors who came to Russia after the crisis.[159] I therefore divided this figure by the regional population to measure per capita FDI for this period. Certain regions fly off the charts with their high levels of foreign investment. These include Sakhalin, the beneficiary of offshore oil projects ($2,725 in FDI/person), Krasnodar krai in the south ($428), Leningrad oblast around St. Petersburg ($408), Moscow city ($400 per person) and Kaluga oblast just south of Moscow ($183). Omitting these outliers to ensure a broader distribution along the 5-point scale still leaves us with 15 regions (including 10 republics) reporting no or virtually no FDI over the three period (earning scores of 0 - 0.02). The highest scorer becomes Magadan oblast, with cumulative per capita FDI of $147.[160]

The third index looks at **distortions** in the economy. The first component of this index measures the gap between the prices paid by households and industrial

[159] Some of these foreign investors, particularly the ones registered in Cyprus (Russia's biggest foreign investor), are in fact Russian businesspeople who have moved their assets offshore.

[160] Magadan saw a lot of FDI in 1998 (nearly $200 per person) but this then dropped every year, reaching $18 in 2001. It is worth noting that Sakhalin's rates are also uneven, with $1,680 per capita having reached the region in 1999, compared to an average for the 3 other years of $312. This is not unusual in natural resource-rich regions, where one foreign company may make a particularly large investment in a single year.

companies for electricity. In nearly all countries, individuals pay more for electricity than firms, as it is more expensive to lead the necessary wires and pipes to individual households than to large industrial users. Factories and firms also consume more electricity and get the equivalent of bulk discounts on power. In Russia, a legacy of the communist period is that industrial tariffs cross-subsidize residential users. One of the key elements in the reform of local economies has been the reversal—or at least reduction—of this cross-subsidization. The extent to which political leaders will narrow the gap between industrial and residential tariffs is a good proxy for their willingness to make the difficult political decisions required for transition-triggered reforms. I was able to find the average electricity tariffs paid by residential consumers and industrial consumers, by region, for the end of 2001.[161] The most expensive electricity prices are paid in cold and distant Kamchatka (1037 rubles/thousand kilowatt hours for residential customers; 3,860 for industrial users). The cheapest tariffs are in Irkutsk (69 rubles for residentials, 175 rubles for industrials) and the Republic of Khakasiia (156 rubles for companies), both of which have large hydroelectric dams. The smallest gap between residential and industrial users is in Krasnoiarsk, which also has a large hydropower plant (232 rubles for households; 237 rubles for industrials). This region scored a 5 on this component of the index. The largest gap was in Orenburg, where residential users pay 152 rubles/thousand kilowatt hours while industrial users pay 626 rubles.

[161] I used the "Average producer tariffs for electricity released to the population" [*Srednie tarify proizvoditelei na elektroenergiiu otpushchennuiu naseleniiu*] and the "Average producer tariffs for electricity released to industrial users" [*Srednie tarify proizvoditelei na elektroenergiiu otpushchennuiu promyshlennym potrebiteliam*]. Data were not available for the Republics of Kabardino-Balkarskiia, Karachaevo-Cherkesskaia, Chechnia, Ingushetiia, Altai and Tyva. These regions are thus not included in the distortion index.

The second, equally weighted element in the distortion index was a measure of regional price controls on food products. To calculate this measure I took the food component of Goskomstat's standard basket of goods for 2001.[162] This basket is used to compare the cost of living in different regions. I re-weighted the contents of these products to create a new food-heavy consumption basket.[163] I then took information on the percentage of each of the food components that were sold subject to some form of price controls.[164] One can see from this data that, for example, 5% of the meat and poultry sold in Russia in 2001 was sold subject to some price controls, as were 3% of the bakery products. The price controls on food vary widely across regions. In Belgorod oblast, for instance, 14% of the meat and poultry products were subject to price controls. Returning to my basket, for each region each element of the basket was multiplied by the corresponding level of price controls, producing a list of price controls, adjusted for the importance of the particular food product in the total basket. By adding up all the adjusted price controls for each region, I produced a "price control sum" that reflected the extent to which the food-heavy basket in each region is subject to price controls, with higher scores indicating greater regulation. These

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[162] "The weight of expenditures on the purchase of different food products in the consumer expenditures of households, 2001" [*Udel'nyi ves raskhodov na pokupku otdel'nykh produktov pitaniia v potrebitel'skikh raskhodakh domokhoziaisv, 2001*].

[163] The basket includes basic food categories (e.g. meat, oil, eggs, flour, sugar, bread, flour, potatoes, vegetables) plus soaps and cleaning products and drugs. The largest component in the food-heavy basket is meat and poultry (22% of total basket), followed by bakery products (14%), sausages (12%), sugar (7%) and vegetables (5%). Drugs make up 3% of the food/drug basket.

[164] "The share of different food products upon which prices were controlled, as a share of retail trade turnover (in these products), by region of the RF, 2001" [*Dolia v oborote roznichnoi torgovli otdel'nykh tovarov, po kotorym osushchestvlialos' tsenovoe regulirovanie, v sub"ektakh RF, 2001*].

scores were then rescaled to the standard 0-5 scale to rank the regions.[165] By this measure it was possible to discover that the least distorted food market was in Kaliningrad oblast, and the market most subject to price controls was in Vladimir oblast.

The rankings of regions according to the components of the indices and the three indices themselves are provided in Table 7. The three indices were created by adding each region's scores for the two component measures, to produce a sum score between 0 to 10. Correlations between the components and the indices are provided in Table 8.

[165] Here (as in the case of the electricity tariff gap), a higher score indicates greater regulation. To make the index consistent with the others, where a high score indicates more reform, I subtracted all scores from 5. This ensured that regions with more distortions would be assigned lower scores.

Table 7. Components and Indices Used for Regional Selection.
(Regions selected marked in bold, as is the Russian Federation figure)

		Per capita monthly monetary income (2000 rubles)		Strength of private sector			Degree of distortions			Industrial Structure		
		Average Income	Adjusted Income	Owner-ship score	private apts score	sum (0-10)	tariff gap score	food price controls score	sum (0-10)	SME score	per capita FDI score	sum (0-10)
Russian Federation	**RF**	**2193**	**2193**	**3.95**	**1.67**	**6.75**	**3.83**	**3.84**	**7.67**	**2.77**	**2.96**	**5.73**
Belgorod oblast	Bel	1382	1591	4.73	1.46	7.82	2.15	1.01	3.16	0.96	0.51	1.46
Briansk oblast	Bri	1150	1332	4.19	1.56	7.07	2.50	1.55	4.05	1.03	0.24	1.27
Vladimir oblast	Vlad	1127	1276	4.47	2.08	7.74	4.56	0.00	4.56	1.70	1.06	2.76
Voronezh oblast	Vor	1239	1418	4.47	2.29	7.84	1.98	2.97	4.95	3.12	0.63	3.75
Ivanovsk oblast	Ivan	912	1011	3.99	0.94	6.45	3.36	2.31	5.67	2.45	0.11	2.56
Kaluga oblast	Kalu	1212	1280	4.19	1.46	7.02	4.46	2.89	7.35	3.05	6.22	9.27
Kostroma oblast	Kost	1241	1448	3.18	1.56	5.55	3.73	2.71	6.44	1.49	0.29	1.78
Kursk oblast	Kur	1259	1474	4.77	1.25	7.78	2.23	2.22	4.45	0.71	0.58	1.29
Lipetsk oblast	Lip	1693	1915	4.74	1.88	8.05	3.78	3.33	7.11	1.17	0.45	1.62

Moscow oblast	MO	1908	1896	3.34	0.52	5.27	3.30	1.83	5.13	2.77	4.77	7.54
Orel oblast	Orl	1325	1529	4.64	1.15	7.53	3.22	2.99	6.21	1.03	2.85	3.88
Riazan oblast	Riz	1200	1315	4.26	1.67	7.23	3.99	2.92	6.91	3.19	0.11	3.30
Smolensk oblast	Smo	1626	1727	3.60	1.67	6.23	2.82	4.19	7.01	1.24	0.00	1.24
Tambov oblast	Tam	1433	1683	4.05	1.46	6.80	1.39	3.69	5.08	0.89	0.79	1.68
Tver oblast	Tve	1198	1265	3.89	1.98	6.82	2.70	3.42	6.12	2.09	0.54	2.63
Tula oblast	Tul	1428	1474	5.00	1.46	8.23	2.46	2.02	4.48	1.56	0.86	2.42
Iaroslavl oblast	Yar	1683	1762	4.47	1.46	7.43	4.25	2.90	7.15	2.38	0.30	2.67
Republic of Karelia	Kar	2168	2000	2.72	0.31	4.23	1.81	2.19	4.00	2.06	2.04	4.09
Republic of Komi	Komi	2788	2734	2.99	1.04	5.01	2.99	4.73	7.72	1.17	2.94	4.11
Arkhangelsk oblast	Arkh	1870	1859	2.07	0.00	3.10	3.50	3.55	7.05	0.96	0.07	1.03
Vologod oblast	Volo	1826	1847	4.60	0.31	7.05	1.84	3.18	5.02	2.80	0.39	3.19
Kaliningrad oblast	Kali	1655	1627	3.74	1.77	6.50	3.37	5.00	8.37	3.55	0.50	4.05
Leningrad oblast	LO	1357	1348	4.28	0.73	6.78	2.58	2.65	5.24	5.00	13.88	18.88
Murmansk oblast	Mur	3334	2701	2.34	1.77	4.40	4.37	2.62	6.99	1.17	1.35	2.52
Novgorod oblast	Novg	1689	1808	3.48	1.46	5.95	3.85	3.87	7.72	2.34	3.56	5.90
Pskov oblast	Psk	1293	1405	3.64	1.88	6.40	3.76	2.73	6.49	1.70	0.30	2.00
Republic of Adygeia	Ad	1113	1184	3.77	1.77	6.54	3.09	3.40	6.49	1.81	0.26	2.07

Republic of Dagestan	Dag	851	929	3.50	1.67	6.08	3.12	1.56	4.68	0.74	0.00	0.74
Republic of Ingushetiia	Ing	489	437	1.81	4.17	4.79	n/a	n/a	n/a	0.00	0.00	0.00
Republic of Kabardino-Balkaria	KabBal	1136	1287	4.06	2.29	7.24	3.28	3.48	6.76	0.74	0.01	0.76
Republic of Kalmykiia	Kal	956	1106	2.27	3.13	4.97	3.09	1.90	4.99	0.85	0.00	0.85
Republic of Karachaevo-Cherkesiia	KarCher	1021	1125	3.68	4.48	7.77	n/a	4.08	n/a	1.77	0.01	1.78
Republic of North Ossetia – Alaniia	SevOs	1613	1769	1.89	3.23	4.45	n/a	3.32	n/a	0.96	0.00	0.96
Krasnodar krai	Kdar	1576	1797	4.64	2.08	8.00	2.87	2.64	5.51	2.20	14.55	16.75
Stavropol' krai	Stav	1363	1510	4.94	3.33	9.08	3.55	3.90	7.45	2.09	0.56	2.65
Astrakhan oblast	Ast	1603	1711	3.29	2.29	6.09	2.51	3.01	5.52	2.13	0.45	2.58
Volgograd oblast	**Volg**	**1204**	**1273**	**4.41**	**2.29**	**7.76**	**4.05**	**3.68**	**7.73**	**2.02**	**2.06**	**4.08**
Rostov oblast	Ros	1617	1907	4.93	3.02	8.90	4.17	3.04	7.21	2.62	0.58	3.20
Republic of Bashkortostan	**Bash**	**1732**	**1837**	**3.38**	**1.88**	**6.01**	**3.44**	**0.06**	**3.50**	**0.60**	**0.27**	**0.88**
Republic of Marii El	**ME**	**864**	**968**	**3.34**	**1.04**	**5.53**	**3.03**	**2.08**	**5.11**	**1.10**	**0.00**	**1.10**
Republic of Mordoviia	Mor	1090	1244	3.15	0.83	5.14	0.15	3.67	3.82	1.10	0.46	1.56
Republic of Tatarstan	Tat	1779	2076	3.32	2.60	6.29	3.06	2.93	5.99	0.89	0.60	1.48
Udmurtiia Republic	Udm	1405	1454	3.66	1.56	6.27	3.64	2.84	6.48	2.09	0.06	2.15
Chuvashia oblast	Chu	1016	1138	4.38	0.42	6.78	4.44	3.87	8.31	1.45	0.53	1.99
Kirov oblast	Kir	1155	1277	3.87	0.21	5.91	3.95	2.35	6.30	0.82	0.18	1.00

Nizhnegorodskii oblast	NN	1562	1678	4.42	1.25	7.26	1.00	3.06	4.06	2.48	0.57	3.05
Orenburg oblast	Oren	1404	1471	4.58	1.77	7.76	0.00	1.95	1.95	3.26	2.14	5.40
Penza oblast	Pen	1137	1277	3.79	2.08	6.72	3.15	2.87	6.02	3.16	0.01	3.17
Perm oblast	Perm	2166	2203	4.02	1.67	6.86	3.65	2.72	6.37	0.82	1.39	2.20
Samara oblast	**Sam**	**2561**	**2383**	**4.70**	**1.88**	**7.98**	**3.16**	**4.07**	**7.23**	**3.23**	**2.62**	**5.85**
Saratov oblast	Sar	1378	1396	3.67	1.46	6.23	2.92	4.22	7.14	1.35	0.11	1.45
Ul'ianovsk oblast	Uli	1212	1507	3.84	1.15	6.34	2.21	3.34	5.55	1.10	0.01	1.11
Kurgan oblast	Kurg	1198	1298	4.21	1.77	7.19	3.34	3.41	6.75	0.74	0.02	0.76
Sverdlov oblast	Sve	1771	1666	3.48	2.19	6.32	3.79	2.13	5.92	1.70	1.88	3.58
Cheliabinsk oblast	Chel	1883	1828	3.99	1.77	6.87	1.70	2.20	3.90	2.09	1.24	3.33
Republic of Altai	Alt R	1147	1129	2.47	5.00	6.21	n/a	2.63	n/a	3.48	0.02	3.49
Republic of Buriatiia	Bur	1381	1360	3.02	1.35	5.21	3.24	1.28	4.52	1.10	0.01	1.11
Republic of Tyva	Tyva	1095	978	0.00	2.19	1.09	n/a	0.27	n/a	0.32	0.00	0.32
Republic of Khakasiia	Khak	1552	1389	3.97	3.02	7.47	4.77	4.62	9.39	3.76	0.01	3.76
Altai krai	Alt K	1160	1289	4.08	3.75	7.99	4.07	2.37	6.44	1.84	0.21	2.05
Krasnoiarsk krai	Kyar	2583	2324	3.66	1.77	6.37	5.00	3.61	8.61	2.48	0.23	2.72
Irkutsk oblast	Irk	2190	1925	3.50	1.35	5.92	2.55	3.72	6.27	1.28	0.58	1.86
Kemerova oblast	Kem	2203	2279	3.83	2.81	7.15	4.17	2.25	6.42	1.81	0.09	1.90

Novosibirsk oblast	Novo	1478	1505	3.22	1.98	5.82	4.28	3.19	7.47	3.05	4.61	7.66
Omsk oblast	Omsk	1307	1425	4.21	3.65	8.13	2.96	2.80	5.76	2.87	0.13	3.01
Tomsk oblast	Tom	2002	2142	3.16	1.56	5.53	3.40	4.49	7.89	1.95	0.48	2.43
Chita oblast	Chit	1018	933	1.94	1.15	3.48	3.04	3.78	6.82	1.91	0.01	1.93
Republic of Sakha (Iakutiia)	Sakha	3559	2398	1.89	1.15	3.41	3.22	1.47	4.69	0.82	0.18	0.99
Primorskii krai	Pri	1694	1337	3.79	1.88	6.62	3.73	3.27	7.00	3.09	1.82	4.91
Khabarovsk krai	Khab	2240	1846	2.44	1.25	4.29	4.20	2.38	6.58	2.91	1.16	4.07
Amur oblast	Amur	1466	1411	3.02	1.88	5.47	3.71	2.19	5.90	1.28	0.24	1.51
Kamchatka oblast	Kam	3041	1972	2.44	0.94	4.13	0.64	3.09	3.73	2.38	0.08	2.46
Magadan oblast	Mag	2979	1729	2.93	1.46	5.13	4.02	2.76	6.78	4.29	5.00	9.29
Sakhalin oblast	Saklin	2564	1623	3.53	1.15	5.86	4.41	3.42	7.83	2.94	92.69	95.63
Moscow (city)	Moscow	9291	7391	4.47	1.98	7.69	2.84	3.31	6.15	8.33	13.60	21.93
Tiumen oblast	Tiu	4905	3859	4.77	1.77	8.04	3.94	1.66	5.60	1.67	3.83	5.50
St. Petersburg (city)	SP	2590	2367	4.31	0.94	6.93	2.09	4.36	6.45	8.51	3.88	12.39

Shaded cells represent the scores of outliers. The scores in non-shaded cells were calculated by omitting the shaded outliers to avoid compressing all remaining regions towards zero scores. I then recalculated what the scores for the outliers would be. The first row, with data for the Russian Federation as a whole, was also not included when the 0-5 scales was calculated.

Regions are listed in the order in which they appear in official Goskomstat data tables, by federal okrug, roughly moving from West to East.

Table 8. Correlation Coefficients for Indices Components and Indices.

	Adjusted Monthly Income	Ownership	Private Apartment	**PRIVATE SECTOR**	Tariff Gap	Price Controls	**DISTORTION**	SME	FDI	**INDUSTRIAL STRUCTURE**
Adjusted Monthly Income	1.00	0.15	-0.11	0.11	0.01	0.10	0.07	0.47	0.37	0.34
Ownership	0.15	1.00	-0.06	0.94	-0.05	0.15	-0.02	0.27	0.15	0.20
Private Apartments	-0.11	-0.06	1.00	0.27	0.26	0.01	0.17	-0.02	-0.22	-0.09
PRIVATE SECTOR	0.11	0.94	0.27	1.00	0.03	0.14	0.03	0.26	0.07	0.17
Tariff Gap	0.01	-0.05	0.26	0.03	1.00	0.01	0.73	-0.02	0.14	0.13
Price Controls	0.01	0.15	0.01	0.14	0.01	1.00	0.70	0.29	0.06	0.17
DISTORTION	0.07	-0.02	0.17	0.03	0.73	0.70	1.00	0.18	0.14	0.20
SME	0.47	0.27	-0.02	0.26	-0.02	0.29	0.18	1.00	0.44	0.77
FDI	0.37	0.15	-0.22	0.07	0.14	0.06	0.14	0.44	1.00	0.87
INDUSTRIAL STRUCTURE	0.34	0.20	-0.09	0.17	0.13	0.17	0.20	0.77	0.87	1.00

Not surprisingly, the components of the indices are correlated with the indices themselves. Adjusted monthly income is correlated with the number of SMEs and FDI, which is also to be expected. SMEs are also linked to the private sector index through the link between SMEs and the proportion of the labor force employed in the private sector. Surprisingly, there is a strong correlation between price controls and SMEs, perhaps reflecting ideological fears that more active private markets need to be more actively controlled.

Once I had regional scores for each of the three indices, I used them to draw 3 scatter plot graphs. Each graph plotted adjusted monthly income against one of the three reform indices. I did not combine the three indices into a single mega-index as I felt this would allow regions to compensate for a lack of progress in one area by exceptional performance in another. I wanted to find regions that were firmly grounded in a particular quadrant across the three measures. These scatter plot graphs are reproduced below as Figures 5, 6 and 7.

Figure 5. Scatter Plot of Private Sector Score vs. Adjusted Income.[166]

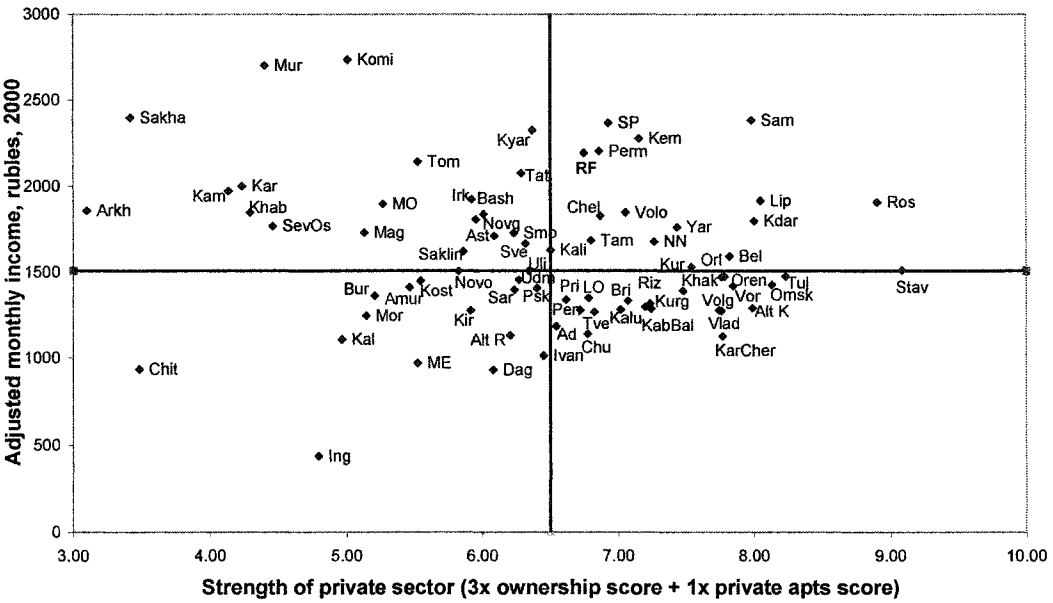
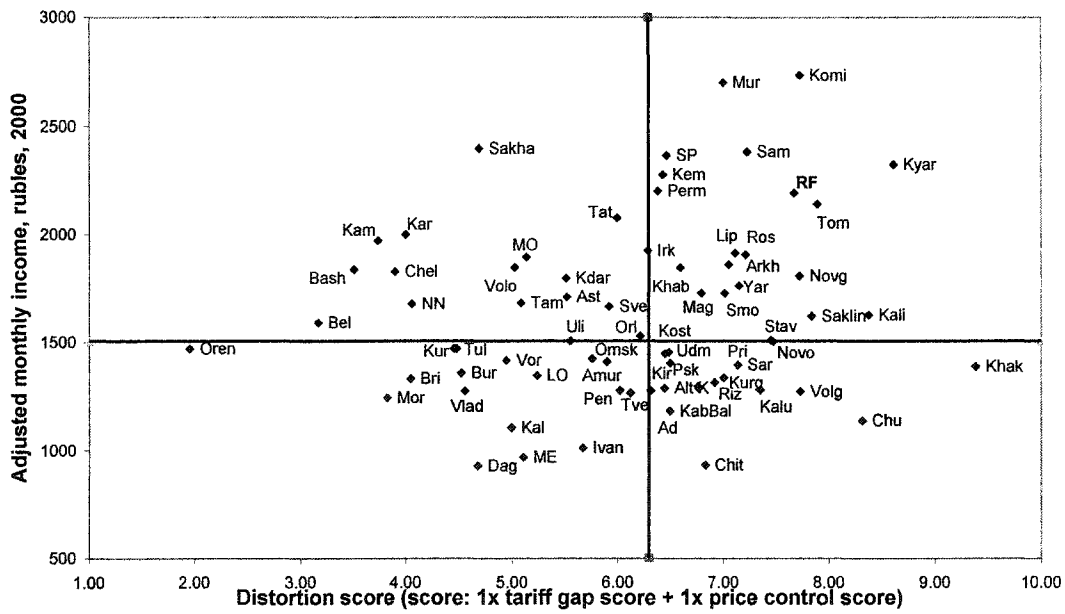
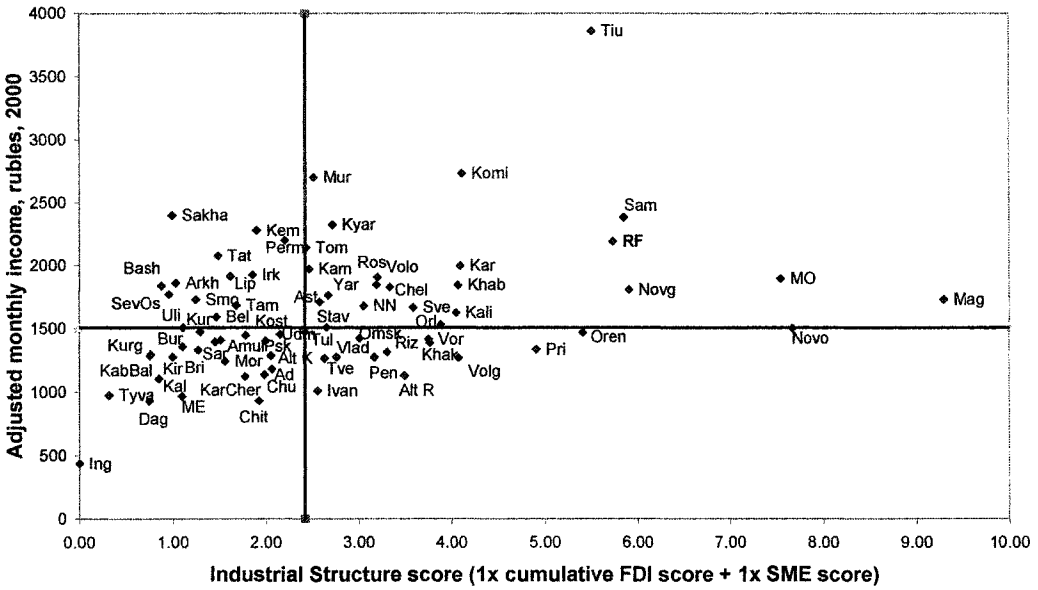


Figure 6. Scatter Plot of Distortion Score vs. Adjusted Income.



[166] The median of the x-axis variable was used to divide the graphs into right and left halves. For the income variable, I used 1500 rubles (rather than the median of 1433) for the sake of graphic elegance.

Figure 7. Scatter Plot of Industrial Structure Score vs. Adjusted Income.



From these 3 graphs, I was able to identify the residents of each of the four quadrants for each index. I then looked at regions that were always in the same quadrant for each of the graphs. This narrowed my choices down to the following regions:

Figure 8. Potential Regions by Quadrant.

		Propensity for Reform	
		Low	High
Wealth	Rich	**Rep. Bashkortostan** Rep. Tatarstan	**Samara obl.** Rostov obl.
	Poor	**Rep. Marii El** Rep. Buriatiia Rep. Kalmykia	**Volgograd obl.** Rep. Khakassia Primorkii krai

I considered the location of these regions. I wanted my regions to be reasonably close to each other to control for potential geographical differences related to economic structure (natural resources) and distance from Moscow. The rich

regions were primarily in the Volga region (with the exception of Rostov), which made it a logical anchor for the analysis. The Republics of Buriatiia, Khakassia, and Primorskii krai were in Siberia and the Far East, so I ruled them out, leaving Volgograd as the poor high-reformer. I chose Samara over Rostov because more has been written about the region, and I hoped to be able to supplement my research with that of other scholars. And when choosing between Marii El and Kalmykia, I ruled out the latter because it did not seem like a safe place to question the scruples of its leaders. A liberal journalist highly critical of the republican President was killed there in 1998, apparently because of her reports on corruption.[167] The choice between Tatarstan and Bashkortostan was more difficult. The regions are quite similar politically and economically. In the end I decided against Tatarstan because regional presidential administration is so strong there that I feared it would be difficult to get people to talk to me.

As one can see in Table 9, as planned, the regions ultimately selected differ from one another in many respects. The interviews conducted with over fifty officials involved in health care and pharmaceutical regulation in these regions suggested, however, that more unites these officials than divides them. As I traveled across Russia, the dominant feeling that emerged was not that each region and each bureaucracy was distinctive, with its own problems, its own solutions, and its own formal and informal institutions. I was instead struck by the similarities of responses of officials across regions and across organizations. For many of these civil servants,

[167] Larissa Yudina was Editor-in-Chief of *Soviet Kalmykia Today* and a member of the Yabloko party. A former presidential aide and the presidential representative in one of the Republic's districts were charged with the murder (RFE/RL 16 June 1998).

the major changes in their professional and personal circumstances during the transition were triggered by the sea-changes experienced by Russia as a whole, and the health care sector in particular. This is quite fortunate. For it suggests that it is possible to make generalizations about health care reform (and corruption) across these four regions, and that these generalizations may be more widely applicable across Russia, and across governmental bureaucracies.

Table 9. Characteristics of the Regions Selected.

	Russia	Samara	Bashkortostan	Volgograd	Marii El
General characteristics					
Territorial status		oblast	republic	oblast	republic
Federal okrug		Volga	Volga	South	Volga
Current Governor/President		Konstantin Titov	Murtaza Rakhimov	Nikolai Maksyuta	Leonid Markelov
Years as Governor/President		13	11	8	3
Population, 2002 (mln) [a]	145.16	3.24	4.10	2.70	0.728
Urban : Rural population, 2002 [a]	73.3 : 26.7	80.6 : 19.4	64.1 : 35.9	75.2 : 24.8	63.2 : 36.8
Gross Regional Product (GRP), 2000 (mln rubles)[b]	6,277,782.2	155,732.2	160,751.2	73,877.7	11,862.7
Per capita GRP, 1999 (thousand rubles)	28,547	17,888	27,723	18,603	13,772
per capita regional (consolidated) budget expenditures, 2002 (rubles)		9,312	9,282	6,060	6,728
Rank among regions by investment potential, 2002-2003 (1= top potential, 89= bottom)[c]		6	15	25	71
Investment climate rating, 2002-2003 [c]		medium potential, moderate risk	medium potential, moderate risk	medium potential, moderate risk	marginal potential, moderate risk
Migration/Immigration, 2002 (people per 10,000 residents)[d]	+5	+3	+5	-9	-3
Price of standard food basket, 2000 (rubles) [e]	749.9	806	707	709.2	668.6
Distortions					
% difference between industrial and residential electricity tariffs, 2001	74.5	116.20	98.57	60.96	124.36
Price controls in food-heavy basket, 2001 (by weight, higher = more controls)	211	195	222	471	332

Table 9. Characteristics of the Regions Selected (continued)

	Russia	Samara	Bashkortostan	Volgograd	Marii El
Private sector					
% of labor force employed by the state & municipal governments, 2000	37.9	32.7	41.8	34.7	42.1
% of privatizable apts. privatized, 2002	50	52	52	56	44
Industrial Structure					
Cumulative FDI per capita, 1999-2001 ($)	87	77.1	8.1	60.4	0
% of labor force employed by SMEs, 2000	10.3	11.6	4.2	8.2	5.6
Health					
Mortality rate, 2002 [f]	16.3	16.3	16.1	16.4	14.1
Infant mortality, 2002[f]	13.3	8.4	12.6	13.4	12.7
Life expectancy, 2002 (years, men & women) [f]	72.04	72.58	72.99	73.12	71.40
Illness rates, 2001 (# of cases, per 1,000 people of illnesses registered for the first time[g]	725.6	801.8	844.3	716.7	793.8
Health care					
Per capita public health spending, 2002[h]	$ 93.40	$ 74.80	$ 41.90	$ 45.70	$ 46.40
# hospital beds per 10,000 residents, 2001 (thousands at year end) [i]	115.4	87.8	117.0	125.4	114.8
# of doctors per 10,000 residents, 2001 (people at year end)[i]	47.3	47.1	45	47.2	40.7
Corruption measures[j]					
Amount of corruption (0= lowest)		0.200	0.114		
Amount of business corruption		0.031	0.021		

Sources for Table 9. Characteristics of the regions selected.

(a) Report of Goskomstat of Russia 'On the results of the All-Russian Census of 2002' at the Government meeting of 12 February 2004 [*Doklad Goskomstata Rossii 'Ob itogakh Vserossiiskoi perepisi 2002 goda' na zasedanii Pravitel'stva Rossiiskoi Federatsii*], Table 1. Available at http://www.gks.ru/PEREPIS/osn_itog.htm. **(b)** Gross Regional Product [*Valovoi regional'nyi product*]. 2001. Russian Statistical Yearbook [*Rossiiskii statiticheskii ezhegodnik*], Table 12.23. **(c)** Marchenko and Machulskaya 2004. **(d)** Coefficients of Migration growth [*Koeffitsienty migratsionnogo prirosta*], Russia's Regions [*Regiony Rossii*], 2003. Moscow: Goskomstat, Table 2.16. **(e)** Cost of the minimal basket of goods in December 2000 [*Stoimost' minimal'nogo nabora produktov pitaniia v dekabre 2000 goda*]. 2000. Russia's Socio-Economic Condition [*Sotsial'no-ekonomicheskoe polozhenie Rossii*], 2000. Moscow: Goskomstat, pp. 356-7. **(f)** Overall Death Coefficient [*Obshchie koeffitsienty smertnosti*], Infant Mortality Coefficient [*Koeffitsienty mladenchiskoi smertnosti*], Life Expectancy at Birth [*Ozhidaemaia prodolzhitel'nost' zhizni pri rozhdenii*], Russia's Regions [*Regiony Rossii*], 2003. Moscow: Goskomstat, Tables 2.9, 2.10, and 2.12 (respectively). **(g)** Illness per 1,000 people in the population [*Zabolevaemost' na 1000 chelovek naseleniia*], Russia's Regions [*Regiony Rossii*], 2002. Moscow: Goskomstat, Table 6.13. **(h)** My calculations based on Ministry of Finance reports on consolidated regional and municipal spending on health care in 2002, plus Goskomstat-published data on TOMIF budgets (Execution of Territorial Obligatory Medical Insurance Fund Budgets [*Ispolnenie biudzhetov territorial'nykh fondov obiazatel'nogo meditsinskogo strakhovaniia*], Russia's Regions [*Regiony Rossii*], 2003. Moscow: Goskomstat, Table 20.7. However these numbers do not match up with figures that the regions sent me. 20 regions sent me their version of these figures, and virtually none of them match the official numbers. This is in part because some regions include federal spending on health care in their region as regional spending. But this adjustment does not explain the full discrepancy between my numbers and those of the regions. **(i)** Number of hospital beds for 10,000 people [*Chislo bol'nichnykh koek na 10 000 chelovek naseleniia*], Number of doctors for 10,000 people [*Chislennost' vrachei na 10 000 chelovek naseleniia]*, Russia's Regions [*Regiony Rossii*], 2002. Moscow: Goskomstat, Tables 6.2, 6.7 (respectively). **(j)** Transparency-International-Russia. 2002. Regional Corruption Indices. Available on www.transparency.org.ru. Unfortunately this index only covers 40 of Russia's regions. Of the ones in my study, only Samara and Bashkortostan are included.

APPENDIX 2: The Shifting Responsibilities of the Ministry of Health of the Russian Federation

To capture the ways in which the Ministry of Health lost authority in the 1990s, and then regained jurisdiction over regional health departments under Putin, I created a table indicating when control was lost and regained (Table 10). Note that the rows in this table do not provide an exhaustive list of ministerial functions; they list priority responsibilities in the top part of the column, and those specific to regulation of pharmaceutical firms in the lower portion.

Table 10. The Shifting Responsibilities of the Ministry of Health of the Russian Federation

CODE: x = Ministry of Health responsibility; -- = Ministry of Health lost this authority in the year indicated; ++ = control over this area was strengthened or remains very strong; + indicates that an attempt was made to increase MoH influence, with marginal effects; ? = currently a subject of policy debates.															
	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Approve regional budgets	x	x	-- [i]	-- [ii]											? [iii]
Approve hiring/firing of regional HC leaders	x [iv]							x [v]	x	x	x	x	x	x	x
Set minimal standards for regional health care	x	x	x	-- [vi]					x [vii]	x	x	x	x	x	x
Formulate national health care policy	x	x	x	x	x	x	x	x	x	x	++ viii	x	x	x	x
Fund federal medical programs	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Oversee medical education and training	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Oversee training and research	x	x	-- [ix]												
Oversee Sanitary-Epidemiological Service (SES)	x	-- [x]					x[xi]	+[xii]	+	+	+	+	+	+	+ xiii
Licensing of medical activities and pharmaceutical firms				-- xiv									++ xv	++	++
Certification of medical goods and services				x[xvi]	x	x	x	x	++ xvii	x	++ xviii	++ xix	++ xx	++	++
Price controls										x[xxi]		x[xxii]			
Pharmacy standards	x	x	--										+ xxiii	++ xxiv	++

Notes to Table 10

[i] As stipulated in Law No. 2449 of 5 March 1992 "On krai and oblast councils and krai and oblast administrative bodies."

[ii] 1993 Constitution of the Russian Federation reaffirms regions' right to manage their own finances and medical services, appoint their own heads of health authorities and medical facilities, and develop their own programs for health care, health promotion and disease prevention (Tragakes and Lessof 2003: 60) A later law of 31 July 1998 (No. 145) "On the budget code of the Russian Federation" further confirms the independence of local budget formulations and allocations.

[iii] Draft legislation currently under consideration contemplates setting fixed tariffs according to which regional governments would have to make contributions to their TOMIF for the non-working population. (Currently they set their rates independently.) (Natarov 2004) Another proposal under discussion would have the federal government pay the contributions for the entire non-working population. A third would change the balance of required employer contributions to the obligatory insurance funds: firms would only need to pay 2.8% of their payroll to OMIFs (down from 3.6%); of this, 1.8% would go to the regional OMIF and 1% would go to the federal OMIF (reduced from 3.4% and 0.2% respectively). The goal would be to increase the funds available to the federal OMIF for equalization of health care expenditures across Russia (Grozovsky 2004).

[iv] This was not the responsibility of regional Communist Party Hierarchies, not the Ministry of Health.

[v] From 1997, Tripartite Agreements signed between regional health care committees, regional obligatory medical health insurance funds, and the Ministry of Health give the latter the right to approve hiring and firing of regional health committee leaders.

[vi] Obligatory Medical Insurance law gives regions right to set content of TOMIF program, which in turn determines the division of responsibilities and power between the health committees and TOMIFs (Shishkin 1995: 29)

[vii] Government Decision "On the program of state guarantees ensuring free health services provision to the citizens of the RF" of 9 November 1998 (No.1096) set minimal standards for each region, specifying the per capita number of hospital beds and doctors to be provided by speciality. Each region was to bring the number of beds it had into line with the Guaranteed Government Program (GGP) standards, which

were adjusted every year from this point on. This led to the changes in beds that one can see in 1999.

[viii] Decision of the Government of the RF "On confirmation of a regulation on the state sanitary-epidemiological service of the Russian Federation and state sanitary-epidemiological norms" of 24 July 2000 (No. 554) replaces Decisions of 6 May 1994 and 30 June 1998 with stricter standards and greater responsibility for their observance (Tragakes and Lessof 2003: 185).

[ix] Decree of the President of the RF "On transformation of the Academy of Medical Sciences" of 4 January 1992 establishes the Russian Academy of Sciences as a separate legal entity. The Academy of Medical Sciences is funded by the Ministry of Finance in agreement with the Ministry of Science, and receives funding for clinical activity from the Ministry of Health.. The separation of research from the education of doctors reflects a perception that doctors are merely technicians who need to fix broken bodies (Tragakes and Lessof 2003: 37).

[x]The Sanitary-Epidemiological Surveillance Service was pulled out of the Ministry of Health and given institutional and financial independence as a result of the Law of the RSFSR "On separation of the state committee for sanitary and epidemiological surveillance from the Ministry of Health" of 19 April 1991 (No. 1034).

[xi] In August 1996 SES was reintegrated into the federal Ministry of health as a department.

[xii] From 1997, SES became a federal structure and the federal government (through the SES department of the Ministry of Health) assumed near complete responsibility for financing regional offices. Until then, regional administrations had paid for the operation of SES subdivisions.

[xiii] On 9 March 2004 Putin signed a decree assigning all the functions of SES to the newly formed Federal Agency for Surveillance in the Area of Defense of Consumer Rights and Well-Being of Man."

[xiv] Decision of RSFSR Government "On powers of bodies of the executive authority of krais, oblasts, independent (autonomous) territories, cities of federal importance on licensing different kinds of activity" from 27 May 1993 (No. 492). Regions begin to take responsibility for licensing, though it would be inaccurate to say that the Ministry of Health was responsible until this time. Licensing was not formalized until 1993, and even then on an ad hoc basis by individual regions.

[xv] Starting in 2002, the Ministry of Health claimed the right to license all pharmaceutical firms through the Rule on Licensing Pharmaceutical Activities (confirmed by Decision No. 489 of the RF Government, 1 July 2002). The responsibility for licensing retail entities was transferred back to the region in

bilateral agreements between the MoH and regional committee. The Ministry retained the right to license wholesale firms operating on the territory of these regions for itself (Pharmvestnik 2002).

[xvi] Law of the RF "On certification of production and services" of 10 June 1993 (No. 5151-1) establishes rules for obligatory certification of various medical goods and services, including ??? pharmaceutical products.

[xvii] Federal Law of the RF "On Drugs" of 22 June 1998 (No.86) provides a framework for the development, manufacture, pre-clinical and clinical testing of medicines; quality control, controls over efficacy and safety; controls on pharmaceutical markets.

[xviii] Letter/instruction of Ministry of Health of the RF "On certification of medical equipment and medical engineering" of 13 January 2000 (No.2510/280-32) establishes 35 bodies in 33 regions responsible for certification of medical equipment. Note that regional quality control centers for drugs had been in place since the Soviet period.

[xix] Gosstandart of Russia passes a decision "On confirmation and introduction in action of rules of certification of medications" on 3 January 2001 (No.2) setting basic principles and requirements for certification of domestic and imported drugs. This marks the beginning of stricter regulation (at least in terms of paperwork) of drugs.

[xx] Ministry of Health creates a new certification system based on 8 federal centers that have the exclusive right to issue certificates for imported drugs. Regional quality control centers remain open, however, and keep busy by checking the certificates of all incoming drugs.

[xxi] Decision of the Government of the RF "On measures concerning state controls on prices on pharmaceuticals" from 29 March 1999 (No.347) limits the permissible wholesale and retail markups on drugs and directs the MoH to monitor regional prices of chosen drugs on a monthly basis. Note that many regions had already adopted similar rules in the 1990s. Samara oblast was exempted from this decision.

[xxii] Decision of the RF Government "On government regulation of prices of pharmaceuticals" of 9 November 2001 (No.782) stipulates that the MoH is to register the "maximum output price" of drug producers for medications on the essential drug list. This price is to be used as the basis for margin limits.

[xxiii] On 6 December 2001 the Ministry of Health created the Pharmaceutical Inspectorate (Directive 428), a department meant to "bring order to the pharmaceutical market" according to its Head, S. Zaitsev (Denisova 2002). One of the main missions of this group was to fight counterfeit drugs, though its ultimate effect was marginal.

[xxiv] Directive (*prikaz*) 80 of the Ministry of Health, "On confirming the Sectoral standard 'Rules for the release (sale) of drugs in pharmacies. Main Regulations'." originally issued on 4 March 2003, sets the minimum footage for a pharmacy at 70 m2. This is much greater than what is used by nearly all pharmacy kiosks and "points," and is greater than nearly all regional requirements. Many regions had eliminated such requirements (along with its Soviet-era counterpart, that pharmacies must be no closer than 500 meters apart) under pressure from local Anti-Monopoly Committees. Although the order was disputed, modified (in Directive #460 from 23 September 2003 "On the introduction of changes to MoH Directive #80"), and annulled, by the end of the year the standards first set in #80 were re-established in Directive #598 ("On the expiration of MoH Directive #460 from 23 September 2003).

BIBLIOGRAPHY

Albats, Evgeniia. 2003. *Bureaucrats and the Russian Transition: The Politics of Accommodation (1991-2003)*. Ph.D. diss., Harvard University.

Andvig, Jens Chr., Odd-Helge Fjeldstad, Inge Amundsen, Tone Sissener and Tina Søreide. 2000. Research on Corruption: A Policy Oriented Survey. Bergen/Oslo: Chr. Michelsen Institute and Norwegian Institute of International Affairs.

Betlugin, I. 1987. At the Turning Point. [*Na Perelome.*] *Meditsinskaya Gazeta*, 25 March.

Bird, Richard M. and Christine I. Wallich. 1994. Local Government Finance in Transition Economies: Policy and Institutional Issues. In *Institutional Change and the Public Sector in Transition Economies*, ed. Salvatore Schiavo-Campo. Washington, D.C.: World Bank Discussion Papers (#241).

Blanchard, Olivier and Andrei Shleifer. 2001. Federalism With and Without Political Centralization. China versus Russia. *IMF Staff Papers*, volume 48.

Blau, Peter M. and Marshall W. Meyer. 1956. *Bureaucracy in Modern Society*. New York: McGraw-Hill, Inc.

Blundo, Giorgio and Jean Pierre Olivier de Sardan. 2000. La corruption comme terrain. Pour une approche socio-anthropologique. In *Monnayer les pouvoirs. Espaces, méchanismes et représentations de la corruption*, ed. Giorgio Blundo. Paris: Presses Universitaires de France. Quoted in Jens Chr. Andvig, Odd-Helge Fjeldstad, Inge Amundsen, Tone Sissener and Tina Soreide. 2000. Research on Corruption: A Policy Oriented Survey. Bergen/Oslo: Chr. Michelsen Institute and Norwegian Institute of International Affairs

Bogdan, S. 1981. Not a Temporary Position [*Ne vremennaya dolzhnost*]. *Pravda*, 3 November.

Bondarenko, Andrei. 2002. The Mayor Promised a Fistfight: the 'Drug' Scandal in Samara Could Turn into Loud Firings [*Mer poobeshchal mordoboi: 'lekarstvennyi' skandal v Samare mozhet obernyt'sia gromkimi otstavkami*]. *Nezavisimaia Gazeta*, 8 February.

Boycko, Maxim, Andrei Shleifer and Robert Vishny. 1995. *Privatizing Russia*. Cambridge: MIT Press.

Breslauer, George W. 2002. *Gorbachev and Yeltsin as Leaders*. Cambridge: Cambridge University Press.

Buev, V.V. 2003. Adaptation Problems of Small and Medium-Sized Firms and Organs of Control (Supervision) to the Reforming Legislative System of Government Regulation of Entrepreneurial Activity: the Results of Two Years of Debureaucratization [*Problemy adaptatsii malykh i srednikh predpriiatii i organov kontrolia (nadzora) k reformiruemoi zakonodatel'noi sisteme gosudarstvennogo regulirovaniia predpreinimatel'skoi deiatel'nosti: itogi dvukh let debiurokratizatsii*]. Moscow: *Natsional'nyi institut sistemnykh issledovanii problem predpreinimatel'stva.*

Bunce, Valerie. 1999. *Subversive Institutions: The Design and the Destruction of Socialism and the State.* Cambridge: Cambridge University Press.

Business News Agency. 2002. In Murmansk Oblast Wholesale and Retail Markups on Drugs Are Limited. [*V Murmanskoi oblasti utverzhdeny predel'nye optovaia i roznichnaia nadbavki na lekarstvennye sredstva*]. Reported by Pharmindex, 23 April. www.pharmindex.ru/newsdetails.asp?id=1549.

Center for Economic and Financial Research (CEFIR). 2002. Monitoring of Administrative Barriers to Small Business Development in Russia, Round 1 [online slide presentation]. Moscow: CEFIR, accessed 7 October 2003. Available on http://www.cefir.org/p_dereg.html.

CEFIR. 2002. Monitoring of Administrative Barriers to Small Business Development in Russia, Round 2[online slide presentation] Available at www.cefir.ru.

CEFIR. 2004. Monitoring of Administrative Barriers to Small Business Development in Russia, Round 3 [online slide presentation]. Moscow: CEFIR, accessed 1 December 2004. Available on http://www.cefir.org/Papers/admin_eng/Round3_eng_Nov2003.pdf.

Chazov, Evgenii I. 1987. Our Dialog: The Science of Health [*Nash dialog: Nauka zdorov'iia*]. *Sovietskaia Rossiia*, 5 July.

Chazov, Evgenii. 1991. Health and Power [*Zdorov'e i Vlast*]. Moscow: Novosti.

Chazov, Evgenii I. 2000. Fate [*Rok*]. Moscow: Geotar-Med.

Chen, Lincoln C., Friederike Wittgenstein, and Elizabeth McKeon. 1996. The Upsurge of Mortality in Russia: Causes and Policy Implications. *Population and Development Review* 22: no. 3 (September): 517-530.

Chernichovsky, D., H. Barnum and E. Potapchik. 1996. Health System Reform in Russia: the Finance and Organization Perspectives. *Economics of Transition* 4, no.1: 113-134.

Chernichovsky, Dov and Elena Potapchik. 1999. Genuine Federalism in the Russian Health Care System: Changing Roles of Government. *Journal of Health Politics, Policy and Law* 24, no. 1 (February): 115-44.

Chernov, Anton (Head of the Perm Oblast Department for Pharmaceutical Activities and Drug Production). 2002. Cited in: From the Podium: Russia's Pharmaceutical Market is 10 Years Old. Results and Prospects [*Tribuna: Farmrynku Rossii – 10 let. Itogi i perspektivy*]. *Pharmvestnik* no. 25(264), 27 August.

Chertukhina, O.B. 2003a. Practical Experience [with] Reform of Municipal Health Care: the Experience of Samara City [*Prakticheskii opyt reform munitsipal'nogo zdravookhraneniia na primere g. Samary*]. Moscow: "Geotar-Med" Publishing House.

Chertukhina, O.B. 2003b. Fundamentals and Development of the Basis for Reform of the System of Health Care of Large Municipal Entites [*Obosnovanie i razrabotka osnov reform sistemy zdravookhraneniia krupnykh munitsipal'nykh obrazovanii*]. Summary of doctoral dissertation prepared for Samara State Medical University.

Chubais, Anatolii. 2000. Privatization, Russian-style [*Privatizatsiia po-russkii*]. Moscow: Vagrius.

Colton, Timothy J. 2000. *Transitional Citizens: Voters and What Influences Them in the New Russia*. Cambridge, Massachusetts: Harvard University Press.

Colton, Timothy J. 2004. Introduction. (ms.)

Constitutional Watch. 2000. *East European Constitutional Review*. 9, no. 4 (Fall). Available at www.law.nyu.edu/eecr/vol9num4/constitutionwatch/Russia.html.

Crozier, Michel. 1964. *The Bureaucratic Phenomenon*. Chicago: University of Chicago Press.

Das-Gupta, Aridam and Dilip Mookherjee. 1998. *Incentives and Institutional Reform in Tax Enforcement: An Analysis of Developing Country Experience*. Delhi: Oxford University Press.

Davis, Christopher. 1983. Economic Problems of the Soviet Health Service: 1917-1930. *Soviet Studies* 35: no. 3 (July): 343-61.

Denisova, T. 2002. Report: Pharmaceutical Help--the Most Important Directions of Activities for the RF Ministry of Health [*Khronika: Pharmatsevticheskaia pomoshch'—vazhneishee napravlenie deiatel'nosti Minzdrava Rossii*]. *Pharmvestnik* no 12 (52), 2 April.

De Soto, Hernando. 1989. *The Other Path: The Invisible Revolution in the Third World.* New York: Harper & Row Publishers.

Dokuchaev, Dmitrii. 1997. The Center Declared War on the Economic Separatism of the Regions. [*Tsentr ob"iavil voinu ekonomicheskomu separatismu regionov*] *Izvestiia.* No. 210. 4 November.

Downs, Anthony. 1967. *Inside Bureaucracy.* Prospect Heights, Illinois: Waveland Press, Inc.

Eggertsson, Thrainn. 1994. The Economics of Institutions in Transition Economies. In *Institutional Change and the Public Sector in Transition Economies*, ed. Salvatore Schiavo-Campo. Washington, D.C.: World Bank Discussion Papers (#241).

European Bank for Reconstruction and Development. 1999. *Transition Report 1999: Ten Years of Transition.* London: EBRD.

Evans, Peter, Dietrich Rueschemeyer, and Theda Skocpol. 1985. *Bringing the State Back In.* Cambridge: Cambridge University Press.

Evans, Peter. 1995. *Embedded Autonomy: States and Industrial Transformation.* Princeton: Princeton University Press.

Everard, M. 2003. Access to Medicines in Low-Income Countries. In *Drugs and Money: Prices, Affordability and Cost Containment.*, ed. M.N.G. Dukes, F.M. Haaijer-Ruskamp, C.P. de Joncheere and A.H. Rietveld. Amsterdam: IOS Press, on behalf of the World Health Organization Regional Office for Europe.

Fainsod, Merle. 1958. *Smolensk Under Soviet Rule.* Reprinted in Winchester, MA: Unwin Hyman, 1989. (Originally published by RAND corporation in 1958.)

Faulconbridge, Guy. 2004. Putin Soothes Business Concerns. *The Moscow Times*, 17 November.

Fedotov, S. and N. Chistiakova. 2004. Conclusions of the Accounting Chamber on the Execution of the Volgograd (city) Budget for 2003 [*Zakliuchenie kontrol'no-schetnoi palaty na otchet ob ispolnenii biudzheta Volgograda za 2003 god*]. Volgograd city: Accounting Chamber, Volgograd City Council of Peoples' Deputies.

Field, Mark G. 1999. Reflections on a Painful Transition: From Socialized to Insurance Medicine in Russia. *Croatian Medical Journal* 40: no. 2 (March).

Frye, Timothy and Ekaterina Zhuravskaya. 2000. Rackets, Regulation, and the Rule of Law. *The Journal of Law, Economics and Organization* 16: 478-502.

Galaeva, A. 1987. Interview: A Doctor on the Threshold of the Third Century [*Interv'iu: Vrach na poroge III tysiacheletiia*]. *Literaturnaia Gazeta*, 29 April: 11.

Galligan, D.J. 1998. Informal Rulemaking: Maternity Benefits, Police Checks of Cars and Public Drunkenness. In *Administrative Justice in the New European Democracies: Case Studies of Administrative Law and Process in Bulgaria, Estonia, Hungary, Poland and Ukraine*, ed. Denis J. Galligan, Richard H. Langan II and Constance S. Nicandrou. Budapest: Constitutional and Legislative Policy Institute.

Geddes, Barbara. 1994. *Politician's Dilemma: Building State Capacity in Latin America,* Berkeley: University of California Press.

Goskomstat. 2000. The Socio-Economic Condition of Russia [*Sotsial'no-ekonomicheskoe polozhenie Rossii*]. Moscow: Goskomstat.

Goskomstat. 2001. Russian Statistical Yearbook [*Rossiiskii statisticheskii ezhegodnik*]. Moscow: Goskomstat.

Goskomstat. 2002. Russia's Regions [*Regiony Rossii*]. Moscow: Goskomstat.

Goskomstat. 2003. Russia's Regions [*Regiony Rossii*]. Moscow: Goskomstat.

Goskomstat. 2004. Report of Goskomstat of Russia "On the Results of the All-Russian Census of 2002" at the Government Meeting of 12 February 2004 [*Doklad Goskomstata Rossii 'Ob itogakh Vserossiiskoi perepisi 2002 goda' na zasedanii Pravitel'stva Rossiiskoi Federatsii*]. http://www.gks.ru/PEREPIS/osn_itog.htm

Goskomstat and *Ekonomika Zdravookhraneniia* (no.7). 2001. Reprinted by Tragakes, Ellie and Suszy Lessof. 2003. In *Health Care Systems in Transition: Russian Federation.* 5: no. 3. Copenhagen: European Observatory on Health Systems and Policies.

Grozovsky, Boris. 2004. There's Not Enough for Insurance: FOMIF Revenue May Have a Five Fold Increase [*Ne khvataet na strakhovku: Dokhody FOMS mogut vyrasti v 5 raz*]. *Vedomosti*, 28 May.

Guboglo, M.N., editor. 1997. Federalism of Power and the Power of Federalism [*Federalism Vlasti i Vlast' Federalisma*]. Moscow: IntelTekh.

Gurtsevich, Rimma, Director of GUP No. 348 "Podol'e" pharmacy, Moscow. 2003. Interviewed in article entitled: A topic for a Doctoral Dissertation? [*Tema dlia doktorskoi dissertatsii?*]. *Pharmindex* no. 34(313), 28 October.

Health Care Crisis in Russia: a Public Health Issue. 1999. *Nursing Standard* 13, no. 22 (February 17).

Hellman, Joel S. 1993. *Breaking the Bank: Bureaucrats and the Creation of Markets in a Transitional Economy.* Ph.D. diss., Columbia University.

Hellman, Joel S. 1998. Winners Take All: The Politics of Partial Reform in Postcommunist Transitions. *World Politics* 50, vol. 2: 203-234.

Hellman, Joel S., Geraint Jones, and Daniel Kaufmann. 2000. Seize the State, Seize the Day: State Capture, Corruption and Influence in Transition. *World Bank Policy Research Working Paper* 2444 (September). Washington, D.C.: European Bank for Reconstruction and Development and the World Bank.

Hellman, Joel, Geraint Jones, Daniel Kaufmann and Mark Schankerman. 2000. Measuring Governance, Corruption and State Capture: How Firms and Bureaucrats Shape the Business Environment in Transition Economies. *World Bank Policy Research Working Paper* 2312. April.

Helmke, Gretchen and Steven Levitsky. 2004. "Informal Institutions and Comparative Politics: A Research Agenda." *Perspectives on Politics* (forthcoming).

Hendley, Kathryn. 1998. "Struggling to Survive: A Case Study of Adjustment at a Russian Enterprise." *Europe-Asia Studies* 50: no. 1 (January): 91-119.

Hendley, Kathryn. 2001. 'Demand' for Law in Russia—A Mixed Picture. *East European Constitutional Review* 10: no. 4 (Fall).

Hendley, Kathryn. 2004. Business Litigation in the Transition: a Portrait of Debt Collection in Russia. *Law and Society Review* 38: no. 2.

Hough, Jerry. 1969. *The Soviet Prefects: The Local Party Organs in Industrial Decision Making.* Cambridge: Harvard University Press.

Herrera, Yoshiko. 2004. The Transformation of Goskomstat in the 1990s (manuscript of 4 April).

INDEM. 2001. *Diagnostika Rossiiskoi korruptsii: Sotsiologicheskii analiz* (Diagnostics of Russian Corruption: A Sociological Analysis). Moscow: Fond INDEM, accessed 17 September 2003. Available from www.anti-corr.ru/awbreport/index1.htm. Pages cited refer to English version.

Kamalov, M. Kh. and M.E. Petrov. 1986. Improving the Development of Health Care in Bashkirii [*Sovershenstvovanie razvitiia zdravookhraneniia Bashkirii]. Ufa: Bashkirskoe knizhnoe izdatel'stvo.*

Kareva, N. 2001.[Speaking at the podium]: The Verticale of Power in Pharmaceuticals. Historical Parallels. Reality. Perspectives. [*Tribuna: Vertikal' vlasti v pharmatsii. Istoricheskie paralleli. Real'nost'. Perspektivy.*] *Pharmvestnik* no. 8 (207), 6 March.

Kaser, Michael. 1976. *Health Care in the Soviet Union and Eastern Europe*. London: Croom Helm.

Kaufmann, Daniel and Paul Siegelbaum. 1996. Privatization and Corruption in Transition Economies. *Journal of International Affairs* 50, no.2 (winter): 419-58.

Khal'fin, R. A., L.V. Putilova, S. L. Leont'ev, T. N. Grigor'eva, V. A. Tarasov. 1998. The System of Licensing and Accreditation of Medical and Pharmaceutical Activities in Sverdlovsk Oblast. [Sistema litsenzirovanii i akkreditatsii meditsinskikh i pharmatsevticheskikh deistvii v Sverdlovskoi oblasti]. Ekaterinburg: "Ekaterinburg" Publishing House.

Khlebnikov, Paul. 2000. Godfather of the Kremlin: *Boris Berezovsky and the Looting of the Russian State.* New York: Harcourt Brace

Kirillov, Valerii (Deputy Chair of the Samara City Duma). 2002. Quoted in *Samarskoe Obozrenie.* 2002. The Drug War May Cost Galina Gusarova her Career and Bring Unpleasantness to Georgii Limanskii [*Lekarstvennaia voina mozhet stoit kar'ery Galine Gusarovoi i prinesti nepriiatnosti Georgiiu Limanskomu*]. Volume 5, 4 February. Author is given as "the political department" (*otdel politiki*) of *Samarskoe Obozrenie.*

Klimovich, Aleksandr. 2004. Hostages of the *Verticale*: Governors Welcome their Future Appointment. [*Zalozhniki vertikali: Gubernatory privetstvuiut svoe budushchee naznachenie*]. Online *Vremia Novostei* 167 (15 September).

Kolomeiskaya, Inna. 2004. Well-to-do Citizens Chose Imports [*Sostoiatel'nye grazhdane vybiraiut importnoe*]. *Financial Izvestiia* 16 March.

Korchagina, Valeria. 2004. New Plan for Cutting Red Tape. *The Moscow Times,* 4 November.

Kotchegura, Alexander. 1999. The Russian Civil Service: Legitimacy and Performance. In *Civil Service Systems in Central and Eastern Europe*, ed. Tony Verheijen. Northampton, MA: Edward Elgar.

Kotchegura, Alexander. 2004. Reducing Corruption in Post-Communist Countries. *International Public Management Review* 5 (1): 138-156.

Ledeneva, Alena. 1998. *Russia's Economy of Favors: Blat, Networking and Informal Exchange,* Cambridge, UK: Cambridge University Press.

Levitsky, Steven and Lucan A. Way. The Rise of Competitive Authoritarianism. *Journal of Democracy* 12: no. 2 (April): 51-66.

Literaturnaya Gazeta. 2001. The Head of the 'Merkator' Group Dmitrii Oreshkin Tells the Secrets of the 'Political Immortality' of Russian Authorities [Vlast' postroilas': O sekretakh 'politicheskogo bessmertiia' rossiiskoi vlasti rasskazyvaet rukovoditel' gruppy 'Merkator' Dmitrii Oreshkin]. No. 1-2 (5817), 10-16 January.

Liubavina, Ekaterina. 2002. Pharmaceutical Professionals Unite for the Fight Against the Fire Inspectors [*Pharmatsevty ob"edinilis' dlia bor'by s pozharnymi*]. *Kommersant* no. 205, 13 November.

Liubimova, Liubov'. 2002. Galina Gusarova: The New System will Help the Entitled [*Galina Gusarova: Novaya sistema pomozhet l'gotnikam*]. *Izvestiia- Samara* 56, 2 April.

Lyman, Rick. 2004. "Once a Model, a Health Plan is Endangered." *New York Times*, 20 November.

Marchenko, Grigory and Olga Machulskaya. 2004. The Investment Ratings for Russia's Regions, 2002-2003. Expert RA website, 3 March. Available at http://www.gateway2russia.com/st/art_218314.php

Mardanov, Rafael'. 2004. Barrier for Pills [*Shlagbaum dlia tabletki*]. *Rossiyskaia gazeta*, 22 April.

McFaul, Michael and Nikolai Petrov. 2004. What the Elections Tell Us. *Journal of Democracy* 15: no. 3 (July): 20-31.

Mereu, Francesca. 2004a. Governors Look for the Silver Lining. *The Moscow Times*, 17 September.

Mereu, Francesca. 2004b. Bill Puts President in Charge of Judges. *The Moscow Times*, 1 October.

Mikhailenko, Natalia, Director of GUP Apteka No. 23. U Krasnykh Vorot, Moscow. 2003. Interviewed in article entitled: A topic for a Doctoral Dissertation? [*Tema dlia doktorskoi dissertatsii?*]. *Pharmindex* no. 34(313), 28 October.

Mitchneck, Beth, Steven L. Solnick, and Kathryn Stoner-Weiss. 2001. Federalization. In *Fragmented Space in the Russian Federation*, ed. A.A. Ruble, J. Koehn and N.E. Popson. Washington, D.C.: Woodrow Wilson Center Press.

Mogun, V.S., V.E. Gimpelson, S.V. Morozkov and A.E. Chirikova. 2003. Young Specialists in Russian Government and Municipal Service. Moscow. mimeo (October).

Moody-Stuart, George.1997. *Grand Corruption in Third World Development.* Oxford: Worldview Publishing.

Natarov, Evgenii. 2004. A Patient for Money or Money for the Patient? [*Bolnoi dlia deneg ili den'gi dlia bol'nogo?*]. *Gazeta.ru*, 8 April. Reprinted in Pharmindex.ru, 9 April. Available at www.pharmindex.ru/newsdetails.asp?id=4347.

Nichols, Thomas M. 1999. *The Russian Presidency: Society and Politics in the Second Russian Republic*. New York: St. Martin's Press.

North, Douglass C. 1990. *Institutions, Institutional Change and Economic Performance*. New York: Cambridge University Press.

North, Douglass C. 1993. Economic Performance through Time. *Nobel Prize Lecture*, 9 December. Available from http://www.nobel.se/economics/laureates/1993/north-lecture.html.

Oates, Wallace E. 1999. An Essay on Fiscal Federalism. *Journal of Economic Literature* 37: no. 3 (September): 1120-1149.

Panfilova, T. 2000. Conference on the Previous Decade [*Zasedanie na predstoiashchee desiatileie*] *Pharmatsevticheskyi Vestnik*, no. 12 (163).

Peltzman, S. 1976. Toward a More General Theory of Regulation. *Journal of Law and Economics* 19: 211-240.

Petersen, Melody. 2001. Three Fake Drugs are Found in Pharmacies, *New York Times*, 5 June.

Pharmatsevticheskyi Vestnik, 26 December 2002. The Opinion of the Director of the Kuzbass Center for Drug Certification V. Tsarikovaia Concerning the Consequences of the Introduction of a New Procedure for Certifying Drugs [*Mnenie direktora Tsentra po sertifikatsii lekarstvennykh sredstv Kuzbassa V. Tsarikovoi otnositel'no posledstvii vvedeniia novogo poriadka sertifikatsii lekarstv*]. Reprint of article by V. Akimova, "Will they 'Bite' Tablets?" [*'Ukusiiat'li tabletki?*]. *Kuzbass*. 11 November 2002.

Pharmatsevticheskyi Vestnik. 23 January 2003. Pharmaceuticals- One of the Most Reliable Domestic Sectors: There are 4 Times Fewer Loss-Making Enterprises Here than in Industry as a Whole – 12.6%. [*Farmatsevtika – odna iz naibolee ustoichivykh otechestvennykh otraslei: ubytochnykh predpriiatii zdes' v 4 raza men'she, chem. v tselom po promyshlennosti, - 12.6%*] With reference to D. Lomakin. 2003. Domestic Naftizin is in Danger [*Otechestvennyi naftizin v opasnosti*]. Rossiia, 21 January 2003.

Pharmatsevticheskyi Vestnik. 28 February 2003. The Association of Russian Pharmaceutical Producers Took Part in the International Conference 'Achievements of the Russian Federation in State-Building. [*Assotsiatsiia Rossiiskikh farmatsevticheskikh proizveditelei (ARFP) priniala uchastie v rabote Mezhdunarodnoi konferentsii 'Dostizheniia Rossiiskoi Federatsii v gosudarstvennom stroitel'stve*].

Pharmindex.ru. 2003. Changes to the Sectoral Standards for Retail Trade of Medications and Parapharmaceuticals have been Confirmed [*Utverzhdeny izmeneniia k otraslevomu standartu roznichnoi torgobli medikamentami i parafarmatsevtikoi*]. October 14. Available at www.pharmindex.ru/newsdetails.asp?id=3655.

Polenov, S. 2004. A Golden Egg for Kurochka? [*Zolotoi iaitsa dlia Kurochki?*]. Simbirskii kur'er (Ul'ianovsk), 20 April.

Puchkova, G.A., Director of MUP Apteka No. 89. Izmailovskaiia, Moscow. 2003. Interviewed in article entitled: A Topic for a Doctoral Dissertation? [*Tema dlia doktorskoi dissertatsii?*]. *Pharmindex* no. 34(313), 28 October.

Quick, Jonathan D., James R. Rankin, Richard O. Laing, Ronald W. O'Connor, Hans V. Hogerzeil, M.N.G. Dukes and Andrew Garnett (ed.). 1997. Management Sciences for Health with the World Health Organization. *Managing Drug Supply: The Selection, Procurement, Distribution and Use of Pharmaceuticals* (2nd Edition). West Hartford, CT: Kumarian Press.

Rabinovich, Igor'. 2000. Bashkiriia and the Russian Federation Agreed to Treat Their Citizens Together. *Nezavisimaya sluzhba novostei.* 13 November. Available at http://nsn.net.ru/print.phtml?id=288&ch=4&sub=3.

Radaev, Vadim. 2000. *Informalization of the Rules in the Russian Economy* (ms).

Radaev, Vadim. 2002. Corruption and Administrative Barriers for Russian Business. In *Political Corruption in Transition: A Skeptics Handbook*, ed. Stephen Kotkin and Andras Sajo. Budapest: Central European University Press.

Raiser, Martin, Alan Rousso and Franklin Steves. 2004. Measuring Trust in Transition: Preliminary Findings from 26 Transition Countries. In *Creating Social Trust in Post-Socialist Transition*, ed. Janos Kornai, Bo Rothstein and Susan Rose-Ackerman. New York: Palgrave MacMillan.

RBK (RosBiznezKonsulting) Information Agency. 2002. Pharmacists Against VAT [*Pharmatsevty protiv NDS*]. 29 October.

Recommendations of Participants of the 'Round Table' on: 'Guaranteeing Drugs to Entitled Categories of Samara Oblast Citizens' [*Rekomendatsii uchastnikov 'kruglogo stola' na temu: 'Ob obespechenii lekarstvennymi sredstvami l'gotnykh kategorii grazhdan Samarskoi oblasti'*]. 2003. Samara Oblast Duma, 9 December.

Remedium, April 2002. A New Unified System for Provision of Drugs to the Entitled: First Results of the Samara Experiment [*Novaya edinaya sistema l'gotnogo obespecheniia lekarstvami: pervye itogi Samarskogo eksperimenta*]. *Remedium.ru*, 29 April. Source for article given as *Vozhskaya communa*, a Samara newspaper, 24 April 2002.

Remedium. October 2002. Since the Beginning of the Year Prices for Drugs in Samara Have Risen by Over 60% [*S nachala goda v Samare tseny na lekarstva vyrosli bole chem na 60 protsentov*] *Remedium.ru*, 2 October. Source for article given as *Samarskaya gazeta*, 21 September 2002.

Roeder, Philip G. 1993. *Red Sunset: The Failure of Soviet Politics.* Princeton, NJ: Princeton University Press.

Rose-Ackerman, Susan. 1999. *Corruption and Government: Causes, Consequences, and Reform.* Cambridge: Cambridge University Press.

Rousso, Alan. 2004. Email correspondence with author.

Rowland, Diane and Alexandre Telyukov. 1991. Soviet Health Care from Two Perspectives. *Health Affairs* 10 (3): 71-86.

Rueschemeyer, Dietrich and Peter Evans. 1985. The State and Economic Transformation: Toward an Analysis of the Conditions Underlying Effective Intervention. In *Bringing the State Back In*, ed. Peter Evans, Dietrich Rueschemeyer and Theda Skocpol. Cambridge: Cambridge University Press.

Ryan, Michael. 1990. *Doctors and the State in the Soviet Union.* New York: St. Martin's Press.

Ryavec, Karl. 2003. *Russian Bureaucracy: Power and Pathology.* Lanham, MD: Rowman and Littlefield.

Salikhov, G. 2001. The Health of the Nation Depends on Us. The Pharmaceutical Service of Bashkortostan has Unresolved Tasks. [*Zdorov'e natsii zavisit ot nas. U pharmatsevticheskoi sluzhby Bashkortostana est' nereshennye zadachi*]. *Pharmvestnik* no. 31 (230), 23 October.

Samarskoe Obozrenie. 2002. The Drug Scandal Continues: Samara Doctors Reported to the Governor that they Are Being Forced to Buy Drugs 1.5x More Expensive than Before [*Lekarstvennyi skandal prodolzhaetsia: Vrachi Samary soobshchili gubernatoru, chto ikh zastavliaiut pokupat' lekarstva v 1,5 raza dorozhe, chem. ran'she*]. Volume 6, 11 February.

Saltman, Richard B., Reinhard Busse. 2002. Balancing Regulation and Entrepreneurialism in Europe's Health Sector: Theory and Practice. In *Regulating Entrepreneurial Behavior in European Health Care Systems,* ed. Richard B. Saltman and Reinhard Busse. Buckingham, UK: Open University Press.

Schiavo-Campo, Salvatore. 1994. Institutional Change and the Public Sector in Transition Economies. *World Bank Discussion Paper 241.*

Sedelkov, V.E. (Executive Director of the Executive Direction of the Oblast LSK with the Kirov Oblast Department of Health). 2002. Problems of Licensing Pharmaceutical Activities in Light of Changes in Federal Legislation [*Problemy litsenzirovaniia farmatsevticheskoi deiatel'nosti v svete izmenenii federal'nogo zakonodatel'stva*]. In Materials of the First Congress of Pharmaceutical Workers of the Russian Federation. Moscow: All-regional Pharmaceutical League, 28-29 November.

Semenov, Vladimir. 2002. Not to Command, But to Coordinate. The Main Tasks of the RF Ministry of Health Representative is to Track Government Policy in the Sphere of Organizing Medical Activities. [*Ne komandovat', a koordinirovat'. Osnovnaia zadacha predstavitelia Minzdrava RF—sledovat' gosudarstvennoi politike v sfere organizatsii meditsinskoi deiatel'nosti*]. *Pharmatsevticheskyi Vestnik*, no.21 (260), 25 June.

Semenov, V. Iu. 2004. The Economy of Health Care [*Ekonomika zdravookhraneniia*]. Moscow: MTsFER.

Sestanovich, Stephen. 2004. Force, Money and Pluralism. *Journal of Democracy* 15: no. 3 (July): 32-42.

Shabrov, A. (Ministry of Health representative to the North-West Federal District). 2001. Representing the Government's Interests in the Regions. On the Main Tasks of the Russian Ministry of Health Representative, Using the Example of the North-West Federal District. [*Otstaivat' interesy gosudarstva v regionakh. O glavnykh zadachakh predstavitelia Minzdrava rossii na primere Severo-Zapadnogo federal'nogo okruga]. Pharmatsevticheskyi Vestnik* 23, no. 2 (201), January.

Shagarova, S.V. and R.T. Zainullin, editors. 1999. The History, Current Situation, and Perspectives for Health Care in the Republic of Bashkortostan [*Istoriia, sovremennoe sostoianiie i perspektivy zdravookhraneniia Respubliki Bashkortostan*]. Ufa: Ministry of Health of the Republic of Bashkortostan.

Shkatov, Dmitrii. 2002. Samara's Experience in Providing Drugs is Recommended for the Volga Region [*Opyt Samary v obespechenii lekarstvami rekomendovan dlia regionov Povolzh'ia*]. Recipe.ru (a pharmaceutical information cited in Russian), 22 April. Source for article given as rcc.ru/Pharmaceutical industry [*Farmatsevticheskaya industriia*].

Shepsle, Kenneth A., and Barry W. Weingast. 1987. The Institutional Foundations of Committee Power. *American Political Science Review* 81:85-104.

Shevtsova, Lilia. 2004. The Limits of Bureaucratic Authoritarianism. *Journal of Democracy* 15: no. 3 (July): 68-77.

Shishkin, Sergei. 1995. Metamorphoses of Reforms of Russian Health Care. [*Metamorfozy reformy rossiiskogo zdravookhraneniia*]. *Voprosy Ekonomiki* No. 9: 26-33.

Shishkin, Sergei. 1998. Priorities of the Russian Health Care Reform. *Croatian Medical Journal* 39, no. 3 (September).

Shishkin, Sergei, ed. 2003. Informal Out-Of-Pocket Payments for Health Care in Russia. Moscow: Moscow Public Science Foundation and Independent Institute for Social Policy.

Shleifer, Andrei and Daniel Treisman. 2000. *Without a Map: Political Tactics and Economic Reform in Russia*. Cambridge, Massachusetts: MIT Press.

Shtanov, Vladimir. 2001. Big Change [*Bolshaya peremena*]. *Delo* online (Samara) newspaper, 7 December.

Shtanov, Vladimir. 2002. Ezhkov is in the Fog [*Ezhkov v tumane*]. *Delo* online (Samara) newspaper, 26 April.

Simon, Herbert A. 1945. *Administrative Behavior: A Study of Decision-Making Processes in Administrative Organizations*. New York: The Free Press.

Slinko, Irina, Evgeny Yakovlev and Ekaterina Zhuravskaya. 2004. Effects of State Capture: Evidence from the Russian Regions. In *Building a Trustworthy State in Post-Socialist Transition*, ed. Janos Kornai and Susan Rose-Ackerman.

Sobolevskaia, T. 2002. The Licensing System: Old and New Problems. What Does the Transition from the Principle of Independent Licensing to a Strategy of 'Department [decides for] Department' Mean for the Pharmaceutical Market? [*Sistema litsenzirovaniia: starye i novye problemy. Chto sulit farmrynku smena preintsipa nezavisimogo litsenzirovaniia perekhod k strategii 'vedomstvam – vedomstva'?*] *Pharmatsveticheskyi Vestnik* 35 (274), 19 November.

Sobolevskaia, T. 2004. We Understand Each Other Very Well: In Novosibirsk the Oblast Departments of Health and Pharmaceutical Activities Have Been United. Conversation with Nikita Tov, Head of the new Main Department for the Protection of the Population's Health (*Glavnoe upravlenie okhrany zdorovye naseleniya administratsii Novosibirskoi oblasti)* Pharmvestnik, 9 March , No.9 (330).

Solnick, Steven L. 1995. Federal Bargaining in Russia. *East European Constitutional Review* 4:4 (Fall).

Solnick, Steven L. 1998. *Stealing the State: Control and Collapse in Soviet Institutions.* Cambridge, Massachusetts: Harvard University Press.

Solnick, Steven. 2000. Is the Center Too Weak or Too Strong in the Russian Federation. In *Building the Russian State: Institutional Crisis and the Quest for Democratic Governance,* ed. Valerie Sperling. Boulder, Colorado: Westview Press.

Solnick, Steven L. 2002. Federalism and State-Building: Post-Communist and Post-Colonial Perspectives. In *Architecture of Democracy*, ed. Andrew Reynolds. Oxford: Oxford University Press.

Stigler, G.J. 1971. *The Citizen and the State: Essays on Regulation.* Chicago: University of Chicago Press.

Stoner-Weiss, Kathryn. 1997. *Local Heroes: The Political Economy of Russian Regional Governance*. Princeton: Princeton University Press.

TACIS. 1997. Creation of a System of Pharmaceutical Product Distribution in Russia [*Sozdanie sistemy distrib'iutsii farmatsevticheskoi produktsii v Rossii*]. Moscow: Remedium Informational Publication Agency.

Tragakes, Ellie and Suszy Lessof. 2003. *Health Care Systems in Transition: Russian Federation.* 5, no. 3. Copenhagen: European Observatory on Health Systems and Policies.

Transparency-International-Russia. 2002. Regional Corruption Indices. Available on www.transparency.org.ru.

Ushakova, Oksana. 2004. For Now, Family Doctors are Only Just Talk. [*O Semeinykh doktorakh poka tol'ko razgovory*]. *Parlamentskaya gazeta* no. 75 (23 April).

Volkov, Vadim. 2002. *Violent Entrepreneurs: The Use of Force in the Making of Russian Capitalism.* Ithaca, NY: Cornell University Press.

Volodin, V.B. 2003. Licensing: A Weapon for Bureaucrats *[Litsenziia – oruzhie biurokrata*]. Moscow: *Natsional'nyi institut sistemnykh issledovanii problem predpreinimatel'stva.*

Weber, Max. 1958. "Bureaucracy." In *From Max Weber: Essays in Sociology*, trans. H. H. Gerth and C. Wright Mills, 196-244. New York: Oxford University Press.

WHO "Health for All" database, available at http://www.euro.who.int/hfadb

Wondemagegnehu, Eshetu. 1999. *Effective Drug Regulation: What Can Countries Do?* Geneva: World Health Organization, 16-19 March.

Zavidova, Svetlana. n.d. An Analysis of the Situation that has Arisen in the Sphere of Ministerial Regulation of the Pharmaceutical Market in Russia [*Analiz situatsii, skladyvaiushcheisia v sfere vedomstvennogo regulirovaniia farmatsevticheskogo rynka v Rossii*]. mimeo. Moscow: International Confederation of Consumer [Protection] Societies (KonFOP)

Zavtra. 2000. People of the Verticale (For What Putin Encourages his Polpreds). [*Liudi Vertikali (Za chto Putin pooshchriaet svoikh polpredov)].* No. 52 (369). 26 December.

INTERVIEWS[1]

Agapitova, Iulia. Head of the Department for Control over the Observation of Anti-Monopoly Legislation and Informatics, Anti-Monopoly Committee, Republic of Marii El. Ioshkar Ola. 2003.

Belokurov, Mr. Head (*Nachalnik otdela*) of an oblast level Licensing Department. 2004.

Belousov, Mr. Moscow-based supervisor of regional offices for a large national distributor. Moscow. 2002.

Bezfamilnoi, Mr. Director of a local pharmacy chain in Marii El. 2002.

Bezotechestvo, Mr. Director, oblast level Center for Quality Control and Drug Certification. 2002.

Bezruchenko, Grant. General Director of a large regional pharmacy chain. Samara. 2004.

Cherepakhin, Mr. Head of a large Volga region distributor/retail operation. 2002.

Cherniavskyi, Viktor. Director for Regional Management, Protek. Moscow. 2002.

Chernogusev, Mr. Director of a regional affiliate of large national distributor. Moscow. 2002.

Chesnokova, Mrs. Head of a regulatory agency that has repeated contacts with pharmacies and distributors in licensing process. Volga region. 2004.

Dmitriuk, Tatiana. Head, Department for Organization of Pharmaceutical Activities and Clinical Pharmacology, Ministry of Health, Republic of Bashkortostan. Ufa. 2004.

Galkin, Rudolf. Head (*Predsedatel'*) of Samara Oblast Health Committee, 1987-2000. Samara. 2004.

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[1] The interviews listed here represent only those that produced critical information used for background or direct attribution in this thesis. Given the sensitivity of the subject matter, additional interviews that did not generate relevant detail have not been listed; these include meetings with officials from regional and municipal SES offices, tax inspectorates, fire departments concerned with pharmacies and distributors, regional legislatures, and journalists. Sources listed by last name only have been given pseudonyms to protect their identity, with qualifications provided in general terms. "Oblast level" is used to indicate that the official works for the regional (i.e. republican or oblast) government, as opposed to a municipality.

Gashimova, Dinara. Head of Licensing Department, Ministry of Health, Republic of Bashkortostan. Ufa. 2004.

Gusarova, Galina. Minister of Health, Samara Oblast. Samara. 2004.

Korotkova, Irina. Deputy Head, Volgograd Territorial Obligatory Medical Insurance Fund (TOMIF). Volgograd. 2002.

Krivopal'tsev, Mr. High ranking municipal official charged with health care. Samara. 2002.

Krivoshapka, Mr. Member of City Council Committee on Health, Head Doctor of a hospital. July 2002.

Krivosheev, Mr., General Director of a large pharmacy chain in Marii El. Ioshkar Ola. 2003.

Krovopustov, Mr. Technical Director of large national producer/distributor. Moscow. 2000.

Kuklin, Anton. Head of Regional Representative Office of Boehringer Ingelheim, an international pharmaceutical manufacturer. 2002.

Pokhmel'kin, Mr. Republican Territorial Obligatory Medical Insurance Fund, Republic of Bashkortostan. Ufa. 2002.

Maknunov, Rinat. General Director, OOO Tabib, a small chain of pharmacies. Ufa. 2004.

Medvedev, Mr. Head of a department, Protek filial. Volgograd. 2002.

Miasoedov, Mr. Highly-placed employee at Volga region distributor. 2002.

Mit'shev, Sergei. General Director of OAO Marii El Pharmatsiia. Ufa. 2002, 2003.

Muzykantyi, Mr. Director of the local office of a national drug distributor. Volga region. 2002.

Nekhoroshaia, Mrs. Commercial Director, large national distributor, oblast level filial. 2002.

Neliubin, Mr. Head of a small pharmacy chain. Ioshkar Ola. 2003.

Nenashev, Mr. Deputy-level manager within the oblast health department. Volgograd. 2002.

Netak, Mr. Deputy Head of a City Health Department. 2002.

Nezhdanov, Mr. Head of an oblast level regulatory agency in close contact with pharmacies. Volga region. 2003.

Orekhov, Mr. Head of a Department (*otdel*), Anti-Monopoly Committee, Republic of Bashkortostan. Ufa. 2004.

Otmakhova, Galina. Director of State Pharmacy #76, former Head of the Drug Department, Ministry of Health, Republic of Marii El. Ioshkar Ola. 2002, 2003.

Samoletov, Mr. General Director of a large regional retail and distribution company. Volga region. 2004.

Sinegubko, Mr. General Director of a significant regional retail chain, Volga region. 2004.

Skorobogat'ko, Mr. General Director of a medium-sized pharmacy chain. Volga region. 2004.

Smetannaia, Mrs. Official in Drug Department (*Upravelenie Lekarstvennikh Sredstva*), Republic of Marii El. Ioshkar Ola. 2003.

Tsaregorodtsev, Mr. Deputy Head, GUP Pharmatsiia. 2002.

Tysiachnyi, Mr. Head of large retail pharmacy group. Ufa. 2002.

Vinogradov, Mr., Head Specialist, Pharmaceutical Department (*otdel*), oblast level. 2004.

Zagidullin, Iskander. General Director of Specialized Government Production Enterprise (GUP) Bashpharmatsiia. Ufa. 2004.

Zavidova, Svetlana. International Confederation of Consumer [Protection] Societies (KonFOP). Moscow. 2001.