SEMASHKO MODEL: CRITICAL OVERVIEW

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Brief: The structural and functional nominations of the Semashko model characterize the ideological remnants of the Soviet past. The socio-medical dimension of the Semashko model is not applicable for comparison with other healthcare models. Understanding of healthcare entity in the world needs to be defined, measured and evaluated separately in a unified thesaurus for different approaches and models. A unified system of tensors, a certain set of values characterizing a particular approach to the organization of healthcare (a healthcare model) with a pre-understood set of options for its transformations is necessary.

Key words: healthcare, Semashko model, healthcare system formation

In the past, Soviet healthcare demonstrated high efficiency and serious achievements.

But Semashko's model turned out to be suitable only for the USSR, and at the present time, post-Soviet Russia's healthcare is undergoing consistent degradation.

The measures taken by the government do not stop it, and the healthcare organization scientists continue to offer nothing more than cosmetic amendments.

The purpose of the publication is to clarify the reasons why post-Soviet healthcare in Russia is inoperable.

The subject of this work is to establish the factors determining the Semashko healthcare model.

The object of the study is the determinants of healthcare in the world and their implementation in the approaches of different countries.

The research methodology is based on a critical, comparative analysis, content analysis of well-known provisions of the main models of healthcare.

The foundations of healthcare based on the N.A. Semashko model were laid more than a hundred years ago.

Then the young Soviet State concentrated all medicine resources in the country under its jurisdiction, combining with it the sanitary control, and later the production of medical supplies (from medicines to medical equipment).

Since then, the state does not let medicine go of its hands in its possession and subordination.

In fact, this is what characterizes the Semashko model.

Formation of the WHO in 1948 created an organizational base for comparing health models.

Unlike in the USSR, the term "health care" was not originally used abroad.

In fact, the WHO disseminated the achievements of the USSR in the global information space.

The coordinate systems in which the mechanism of healthcare functioned in other countries began to be assessed according to the pattern established in the paradigm of Soviet healthcare.

Does it mean that such an assessment is correct in relation to models other than the Semashko model?

Far from it, and it is the circumstance that has determined the actuality of this work.

The approaches to healthcare generally accepted in the world are simple and clear.

A state that is constitutionally non-social (for example, the United States) does not assume obligations regarding health care and does not collect taxes for these purposes (in addition to social welfare).

The social state collects targeted taxes, redistributes them and returns them to society to pay for medical services and medical supplies.

Each citizen, as a patient, becomes a beneficiary of these funds in the amounts due to him.

At the same time, the state does not undertake obligations to provide citizens with medical care or medical supplies.

In some cases, citizens themselves are carriers of the funds owed to them by the state treasury to pay for medical care or medical supplies (Germany, Israel).

Medical providers are outside the relations of the state with citizens.

In other cases, the government finances directly medical providers (Great Britain).

There is no question of medical providers subjectness anywhere in the world.

These are medical organizations – clinics (polyclinics) and hospitals – and doctors.

Medical organizations in one way or another serve as an infrastructure base for doctors with whom they interact on different terms of cooperation.

As a general rule, doctors are equal participants in civil turnover along with medical organizations, with whom together they bear equal responsibility, each for one's own.

Doctors (a part of them) may not be participants in economic relations, being government employees (Brazil, Scandinavian countries).

Doctors and other specialists form a medical community, whose bodies create the rules of the profession and control their implementation by their members, as well as represent the community externally, including before the state.

For example, the relevant ministry and the bodies of the country's medical community conclude agreements, in particular, on tariffs.

It should be noted that the turnover of medical care and medical supplies in the world is represented by different markets (B2C and B2B) outside of public governance.

So, schematically, it is possible to characterize the common approaches to health protection in different countries abroad.

The commonality of approaches to the healthcare organization in Western countries does not depend on differences in their domestic law and legal systems in general, including through time.

The universality of these approaches has long been shown, in particular, by the example of such countries of the British Commonwealth, which have largely assimilated the paradigm of continental law, as South Africa [1].

The pragmatism of the Western approach to healthcare did not allow demonstrating the ideological superiority of the USSR (affordable, specialized, qualified medical care, etc.).

Socio-medical accents were the priorities of Soviet state (governmental) administration, but not Western market homeostasis.

And the WHO's statutory duality turned out to be very opportunely, combining the focus on health and healthcare equally.

However, both are by no means identical.

Health is the goal of society as a condition for survival.

And healthcare is just one of the means to achieve this goal.

The health of citizens in the country depends on health care to a very small extent (otherwise, health is influenced by ecology, social factors, etc.).

Health is the goal of healthcare only within these limits.

Beyond these limits, the health of citizens is out of healthcare influence.

Accordingly, a measure of health status is not suitable for assessing the level of healthcare, and vice versa.

Meanwhile, the WHO Constitution does not distinguish functions for health and healthcare (art. 2).

The doctrine of the Semashko model does not imply such differences either, covering health and healthcare with common and uniform socio-medical indicators.

As a result, the dynamics of morbidity rates, etc., is to be correlated with the dynamics of hospital bed utilization and outpatient visits.

In the circumstances of the command administrative management system in the USSR, this had to explain the efficiency of the organizational vertical.

The centralized management of medicine was based on the hierarchy of state bodies in the healthcare, descending to the grassroots, local level.

The totalitarian state permeated the entire society.

And healthcare, like any other branch of the industrial and non-industrial sphere, was a subsystem of a unified political mechanism.

In this sense, the Semashko model was considered as a healthcare system.

At the same time, the system-forming basis was no longer socio-medical, but state-organizational one.

1. CENTRALIZED UNITY OF THE SOVIET ORGANIZATION OF HEALTHCARE.

Healthcare has the same unified structure throughout the country.

This applies equally to the form and content, to the structure and functions, to the organization and financing, to the management apparatus and executive elements in the branch, etc.

Healthcare in such conditions is built like a pyramid, the top of which is a government structure, the base is subordinate terminals, and between them are intermediate control nodes.

Such a pyramid outside the vertical hierarchy – like all its constituent elements from the center to the periphery – is inoperable without a triggering signal, but it also does not allow unauthorized activity of these elements.

Any partial, selective, local changes, corrections, improvements of separate elements of the system are impossible – sine qua non (all or nothing).

2. SOVIET HEALTHCARE IS THE HETEROGENEITY OF A CONGLOMERATE, NOT THE INTEGRITY OF A MONOLITH.

Despite the fact that the area of responsibility of healthcare is objectively limited to a few, its composition includes everything that is nominally related to health and medicine.

Along with medicine, this includes pharmacy, medical equipment, sanitary and epidemiological regime, and medical education, etc.

It is as if McDonald's, instead of cooperation, would include, in addition to fast food outlets, the production of meat, vegetables and other products, including salt and sugar, as well as processing equipment and real estate for accommodation, etc.

Expansive omnivorousness does not allow healthcare to focus on the subject of its activities

3. STATE MEDICAL ORGANIZATIONS – THE STUMBLING BLOCK OF THE SEMASHKO MODEL

The word "UCHREZHDENIE" (further – Institution U for simplicity) is not translated into English and French (“Institution” is not an analogue); the German words Etablissement, Einrichtung, Anstalt do not have the same meaning as the Russian one.

Institution U is not a generalized term; it is the designation of a separate, special legal form of organization (Article 120 of the Civil Code of the Russian Federation).

The Institution U has no right of ownership of the property belonging to it.

This property remains in the ownership of the one who created the Institution U (this is practically the state alone).

The Institution U does not earn, does not receive income and does not build expenses on them – as in Soviet period, it masters receipts of funds, functioning according to strict regulation.

Marketing, competition, bankruptcy, and full legal liability are excluded for Institution U – it is not independent and does not be in free civil turnover.

The owner is responsible for the financial maintenance of the institution and subsidiary responsibility for its debts.

Both state bodies endowed with public competence and state organizations have the form of the Institution U and the limited right to the property of the owner who had created them.

Under the Soviet regime state organizations in form of Institution U acted as structures for the realization of orders of state bodies in form of Institution U.

In modern times, only few organizations in form of Institution U in the public sphere have been left with the role of provision the needs of state bodies.

State organizations of the social sphere (further - social organizations), including those of healthcare, in form of Institution U found themselves in unfamiliar conditions of economic activities.

With the emergence of the legal category of services, new to post-Soviet Russia, social organizations in form of Institution U have been switched to serving citizens.

With the reduction of the post-Soviet state to the boundaries of public space in the country, social organizations in form of Institution U found themselves outside these boundaries.

But medical organizations in form of Institution U have not switched to operating within the framework of income and expenses, as in non-governmental clinics and hospitals.

Medical organizations in form of Institution U did not become equally remote from the state like private medical organizations: as in Soviet time, they, remained on budget support, only in new forms of financial traffic.

The state finances medical organizations in form of Institution U both by ownership (it leaves them in its ownership and on its maintenance) and on quasi-contractual grounds under mandatory health insurance (MHI) programs as well.

In fact, the state pays itself – from one pocket (from the Treasury) to another (its own medical organizations in form of Institution U).

In general, the mechanism of budgetary financing of social organizations in form of Institution U has remained the same.

The formation of special (extra-budgetary) funds, including MHI funds, has only changed the trajectory of budgetary financing of medical organizations in form of Institution U.

The inclusion of private health insurance companies in traffic from state extra-budgetary funds of mandatory health insurance to medical organizations in form of Institution U only increased costs.

High costs, along with low tariffs that do not cover the cost of production and realization of medical services in free turnover, have deprived MHI of attractiveness for private clinics.

The MHI has formed a separate, parallel turnover of medical services – for medical organizations in form of Institution U operating under the care of the state as owner.

The MHI is devoid of insurance meaning initially, being nothing more than an intermediary transfer link in the traffic of budgetary funds.

The government bodies used private legal opportunities (ownership of medical organizations in form of Institution U by the state) for the purposes of public administration and directive management of them.

The positions of heads of medical organizations in form of Institution U remained assigned to the Nomenclature of positions of state bodies.

Financing of medical organizations in form of Institution U in general also remains a traditional tool for public management of them.

To this was added, perhaps, the tools of licensing and state supervision, unknown in Soviet epoch.

Despite the opposite opinions [2], the Russian healthcare of modern times is the same Semashko model, even if in changed interiors.

That is the same centralization of healthcare across the country, the same combined heterogeneity of components and the same publicly administered medical organizations in form of Institution U unsuitable for economic activity.

The above generally indicates that the organization of healthcare is not understood in the same way and unambiguously in different countries, especially within the framework of a particular model or system of healthcare.

There are also no criteria, signs, guide marks of system-forming principles of organization of healthcare.

The common goal of organization of healthcare everywhere is the conversion of an economic result into a social one.

Such a goal cannot be achieved through directives, orders, or prescriptions.

The economy develops as a result of the mutual correspondence of opposite interests.

Organization of healthcare is not a directive guide for its financing and/or manufacturing of medical services and medical supplies.

Organization of healthcare can mean only management, only financing, or both, or a permissive regime of health activities and state supervision.

Healthcare financing can be carried out from the state treasury or from private sources, centralized and decentralized, through medical and personal, risk and social insurance, etc.

Healthcare is a function of the social state, consisting in the management of targeted taxes distributed in the budget per beneficiary in the order of social insurance.

Without targeted taxation, budget redistribution and social insurance, healthcare is meaningless.

Civil, risky insurance is not identical and does not replace social insurance.

And such a confusing mix of heterogeneities as in the Soviet Semashko model is no in any healthcare model and in any country.

The fact that the Semashko model was formed in its most perfect phase on the patern of military medicine during World War II explains, but does not justify its generalizing and subordinating nature.

What does aforesaid be in need for?

Firstly, the borrowing of the Semashko model or its elements into the healthcare mechanism of any other country is doomed.

It is known that in 1978, WHO recommended the Semashko model for use in other countries, but only socialist Cuba borrowed it (the heyday of which turned out to be short-lived).

Secondly, it is impossible to compare the Semashko model health care with any other models of healthcare.

This is due to the following reasons:

- everywhere – management of objects (property, first of all, finances), but in the Semashko model – management of both objects and subjects (medical organizations in form of Institution U);

- everywhere, healthcare is represented by the coordination of the parties to the agreement, and in the Semashko model, healthcare subordinates everything as its component parts;

- everywhere doctors, if they are not government employees, are connected with the state in healthcare no more than by tariffs, and in the Semashko model – by administrative and labor slavery with some turbid status.

Thirdly, any reform of healthcare organized according to the Semashko model is hopeless.

The reduction of healthcare to the function of managing targeted financing means the withdrawal of commodity exchange, the economy in the industry beyond the publicly administered sphere.

Changing the financing of medicine mechanism means placing the funds of the state treasury intended for it in civil turnover, outside the traffic of budgetary funds.

The reorganization of medical organizations in form of Institution U means at the same time the privatization of state property.

Bringing the status of a doctor to the certainty that exists in the world means publicly choosing for him the role of a government employee or an independent economic agent.

There is no other way but to get away from the Semashko model: in the current realities, either the health of citizens or the Semashko model.

Within the framework of inconsistent healthcare reform, the necessary changes are unattainable – a radical industrial transformation of the branch is required, with a transition from subordination relations to coordination relations.

In general, the present work, using the example of the Semashko model, shows that inherent in it structural and functional nominations characterize not it, but the ideological remnants of the Soviet past.

The socio-medical dimension of the Semashko model is not applicable for comparison with other health care models.

The meaningful guide marks for the comparative analysis of different approaches to healthcare remain beyond the exploration.

And this work is just the only one on this path, although the author has devoted many publications to both criticism of domestic healthcare [3] and possible prospects for its modernization [4].

Understanding of health needs in each country of the world is to be defined, measured and evaluated separately in a unified thesaurus for different approaches and models.

And such an understanding can only be pragmatic, utilitarian, diversified in goals and results, depending on the influencing factors.

A unified system of tensors, a certain set of values characterizing a particular approach to the organization of healthcare (a healthcare model) with a pre-understood set of options for its transformations is needed.

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