Assessing the Needs of the Elderly in Integrated Health and Social Services in the Russian Federation

Prepared by E.V. Selezneva, O.V. Sinyavskaya, and E.S. Gorvat

Moscow, 2020
EXECUTIVE SUMMARY

The populations of both developed and developing countries are aging—a trend that means that all countries need to pay particular attention to providing health and social care to the elderly. The world already has nearly 1 billion elderly people. Globally, the number of older persons is growing faster than any other age group; the number of persons aged over 60 is expected to rise from 962 million in 2017 to 2.1 billion in 2050. In the countries of Europe and Central Asia the share of people 65 and older in the total population rose from 6 percent in 1950 to 12 percent in 2015 and, according to the United Nations’ medium-fertility demographic scenario, it could reach 21 percent by 2050. The Russian population is expected to age significantly over the next few decades because of declining fertility and increasing life expectancy. According to the United Nations’ projection, the share of older people will increase from 14 percent of Russian population in 2019 to 23 percent in 2050.

The aging of the population is one of the key global drivers for integration of care. The increasing incidence of chronic diseases and comorbidities requires more coordination across care providers and settings. Global experience suggests that effective health service delivery systems are proactive and cross-sectoral and have a patient-centric approach. It has become evident that to provide truly people-centered services promoting health, the scope of integrated care needs to be expanded to bridge the gaps not only within the health system, but also between the health and social systems.

Improving health and social services for elderly people is one of the priorities for the Government of the Russian Federation. This is reflected in the National Demography Project, for which one of the key objectives is to encourage healthy and active aging.

According to the Russian Statistic Agency data, 14% of Russia’s population of 146 million people are over the age of 65. There is limited empirical evidence about the quality of life of elderly people in Russia. Such issues as the living standards of the elderly, their behaviours in the labor market, and their social activities have been quite thoroughly covered by many authors, but much less information is available about other important dimensions of longevity, including the delivery of health and social services.

This report attempts to address that gap by presenting the results of a study conducted in three Russian regions – the Republic of Karelia, Republic of North Ossetia-Alania, and Oryol Oblast – to assess the needs of the elderly for integrated health and social services. The main objective of this study is to find out to what extent the national social and health care policies targeting the elderly meet their needs and consider their abilities. The specific objectives are as follows:

(a) to assess older people’s needs for health and social services and their satisfaction with their access to and the quality of such services in different regions of the Russian Federation;

(b) to assess the integration of social and health services and identify barriers, with a view to enhancing the integration; and

(c) to prepare proposals for government agencies to make older people more active and capable and to ensure the provision of appropriate services and information.

This study was conducted in two stages. The first stage involved analyzing quantitative data on the health of older people and the provision of health and social services to them. The second stage used the qualitative methods of a social survey that was conducted in the three regions to assess older people’s satisfaction with health and social services and to identify barriers to their utilization. The assessment included interviews and focus groups with the elderly (women aged 55 and over, and men aged 60 and over), as well as interviews with different stakeholders of active aging policy: relatives of the elderly, medical and social workers, and health care and social service managers at different levels. The report records the needs expressed by the elderly, identifies gaps in health and social service delivery, assesses the level of integration of health and social services, and discusses barriers to integration. It proposes strategies and recommendations for policymakers to strengthen the provision of relevant services to elderly people.

The study shows how older people perceive aging and old age. In all three regions many pensioners are very optimistic, relying on themselves and demonstrating an optimistic approach to life. Some associate old age with inferiority and a loss of interest in life. Real fears are primarily associated with becoming dependent on the services of other people because of a deterioration in health, and with loneliness and isolation from their usual social contacts.

Most older people are not satisfied with their standards of living. Their key problems are their small pensions and the high costs of pharmaceuticals and health services. When elderly people are short of money, they first try to save on food. However, spending on pharmaceuticals and health care is less elastic and it is difficult to make savings on them. In spite of the small size of their pensions, many older people in Russia provide financial support to their children and grandchildren.

Older people in Russia have poorer health than their peers in other countries, which may explain their higher demand for health care and social services and their shorter life expectancy. To maintain their health, many elderly people rely primarily (and perhaps excessively) on nonmedical measures. One of the fundamental anti-aging remedies for Russia’s older population is a positive attitude to life; they believe that a good mood and social relations make it possible to prevent health problems and cope with the diseases one has. At the same time, elderly people exhibit low motivation to do physical exercises and lead a healthy lifestyle, and they lack knowledge about a healthy diet.

Demand for health services is higher among the elderly because their health is worse than that of younger individuals, and they have a higher number of chronic diseases. Among the working-age population, 7.5 percent visit a doctor once a month or more often. By the age of 65, this percentage increases to 25.5 percent, and in the age group of 75 or older, it reaches 29.9 percent. During recent years there has been an upward trend in the average number of ambulance calls and hospital admissions for older people over 75 in Russia. This trend may indicate both improved access to such services and reduced access to and lower quality of outpatient care.

Elderly people have relatively good access to primary care—general practitioners or catchment area doctors. However, there are barriers impairing access to outpatient care for Russia’s older population: many older people prefer self-treatment even when they admit they need specialist care; 30 percent of the elderly are dissatisfied with the health care delivery processes (the need for pre-registration, long lines, inattentive attitude, poor conditions for staying in hospital); and around a fourth of the elderly do not think the prescribed treatment will be effective. The importance of mobility issues increases with age: among those aged 75+, there is a substantial increase in the percentage of those who do not receive necessary treatment because they cannot get to the place of care delivery.
Elderly people who participated in the qualitative study conducted by the WB, IFRC, and HSE reported the following barriers to health care:

- unavailability of necessary medical care near the place of residence;
- shortage of specialists and diagnostic equipment at public health care facilities (in the opinion of both patients and doctors);
- transportation networks that are inadequate to patients’ needs;
- problems with obtaining the documents required for access to inpatient care and high-tech care; and
- absence of an elder-friendly environment at inpatient facilities.

Telemedicine could be considered as one way to reduce barriers to health services. There is demand from the elderly for the introduction of telemedicine consultations, which could mitigate the spatial barrier to medical services, although some older people would have difficulty using it. When this technology is introduced into public sector health facilities, it is essential to also give the elderly people the opportunity to visit a doctor in person.

In addition to lower access to health services, another issue that concerns the elderly is access to pharmaceuticals. According to RLMS-HSE data, spending on pharmaceuticals accounts for over 80 percent of households’ expenses on medical treatment in Russia. Pharmaceuticals used for hospital and emergency care are covered by the Health Benefit Package, but most pharmaceuticals for outpatient care are paid for by patients. Drug benefit packages (for outpatient treatment) cover only some categories of citizens: the disabled, persons with outstanding merits for the nation, and patients with certain diseases. In a 2017 survey, only 18.8 percent of Russia’s elderly respondents reported that they were eligible for free or subsidized drug supply. The results of this study confirm that the low accessibility of medicines is one of the most acute problems for the elderly in Russia. The high cost of medication does not always fit well into the elderly person’s budget. Unable to adhere to a doctor’s prescriptions (undergo an examination or buy a medicine), up to 20 percent of elderly people do not see any point in seeking medical care at all—a strategy that results in too-late detection and treatment of diseases and, consequently, more expensive medical treatment for the older population.

Though older people are generally satisfied with the quality of medical care, they express negative emotions about (a) problems with health care delivery, long waits for care to be provided, and the need to adhere to certain prescriptions and re-execute certain papers; (b) lack of correlation between the expected and actual outcomes of the treatment; and (c) a rude and inconsiderate attitude of some medical workers, and their reluctance to take into account physical and cognitive disorders affecting the elderly. Medical workers, on their part, often recognize that it is difficult for them to establish contact and communicate with elderly patients. The study showed that medical workers, though provided with sufficient information about elderly patients’ diseases, needed training to develop communication skills for dealing with elderly patients.

According to the study, the demand for social services is not fully met. Typically, people under 75 years of age are still capable of self-maintenance and do not need others’ help. After 75 years health problems and the need for care have been increasing. Older people prefer getting help from their family and relatives, and they apply for the help of a social worker if they have no relatives or when relatives live far away or work. The respondents spoke about serious problems associated with the inconsistent availability of family care and the lack of other forms of social services. At present, social workers are not obliged, and do not have time, to provide required services, and they acknowledge that they cannot always identify those in need of care. In addition, the social service system does not have sufficient resources to provide such assistance.
Only half of the elderly who need social service get it from social service organizations. The elderly and health care workers point to lack of supply of social services of all types, and primarily nursing services. Social service managers recognize only a shortage of beds in inpatient service facilities. The main barriers to receiving social services are (a) the time-consuming paperwork necessary to obtain the service; (b) the cost; (c) the inconvenient location of social service institutions; and (d) the population’s lack of awareness that social service centers exist.

One of the most acute problems is the limited availability of services for older people with limited mobility who need long-term care. It is important to allow elderly people with limited mobility to be in a familiar environment where they live without hospitalization. It is also important to ensure psychological and financial support to caregivers who take care of elderly people at home. The study raised the important issue of training for caregivers for seriously ill elderly people – both relatives and social workers.

Providing high-quality and effective health and social care to the elderly population requires changes in the organization of the service delivery process. One of the necessary transformations is to improve the integration and cooperation between health and social workers in assisting the elderly. Older people often suffer from several diseases at the same time, and therefore, a doctor treating one disease must take into account the recommendations of the doctors who are responsible for treating the others. Chronic illness and physical limitations due to age mean that there must be cooperation among rehabilitation services, doctors, and nonmedical specialists in the provision of health care services to the elderly. Cooperation among health workers and workers in other specialties requires interagency cooperation and the adoption of special administrative regulations at various levels of service delivery.

The following are the main recommendations for improving the delivery of health and social care to the elderly.

For health care management:

- Develop premedical examinations.
- Split patients’ flows by age (under 75 years and over 75 years).
- Increase the standard visit time for older patients aged 75+.
- Implement older patients’ checkups by multidisciplinary teams, with a psychologist included.

For increasing the accessibility of health services:

- Simplify the procedures for hospitalizing older patients and referring them for high-tech medical care.
- Implement telemedicine consultations (doctor-patient contacts).
- Ensure an accessible environment at hospitals and polyclinics.
- Provide escorting for older patients with referrals to high-tech care centers or hospitals/other centers.
- Expand the coverage of subsidized drugs.
- Provide for full or partial refunds of private expenses on medical tests whenever it proves impossible to undergo such tests at public health care facilities.
- Upgrade the transport and social infrastructure (free rides, new stops of public transport, affordable and regular transportation from the rural area to the region’s population center).
For improving satisfaction with health services and ensuring the system’s responsiveness to the needs of the elderly:

- Develop a communication strategy (set of recommendations for medical workers) for interacting with older patients, taking into account the psychological features of older people, their abilities, and their needs to receive information about their health and expected treatment outcomes.
- Include expanded modules on the psychology of older people, and practical modules on communication with older people, in the educational programs for training and retraining doctors and nursing staff.
- Develop geriatric care.
- Increase the accessibility of psychological care to older people.
- Introduce/add psychologists’ positions in public health care centers.
- Raise awareness among elderly about the availability of psychologist consultations.

For social services:

- Ensure that the people who have practically no contacts with social services are included in the social service system. The “application-based” principle of receiving social services should be complemented by the “identification-based” principle that should apply to senior-age people (aged 75+ or 80+) and solitary old people.
- Develop hospital-replacing technologies enabling low-mobility older people to stay in their familiar home environment without hospitalization, and follow their usual mode of life.
- Ensure the availability of the services of professional attending nurses who are skilled enough to ensure quality care to older people.
- Develop uniform standards and mechanisms to monitor the performance of public and non-public providers of social services.
- Ensure adequate financial compensation to relatives attending to the elderly.
- To prevent burnout of caregiver relatives, the government should make it possible for relatives looking after a bedridden person to have him/her admitted to a hospital in order to get a brief rest.
- Organize short-term courses to provide training to caregivers in the necessary care skills.
- Provide psychological and social support to both low-mobility elderly (particularly, lonely seniors) and the relatives looking after them, possibly by adding psychologist positions in health and social institutions.

On integrating health and social services:

- Strengthen regulations on interdepartmental collaboration.
- Identify coordinating center and professionals responsible for coordination of health care and social workers.
- Improve information exchange between providers and elderly people.
- Develop geriatrician training programs, increase the numbers of attending training and retraining courses in this specialty area.
- Update clinical protocols to ensure the intensification of integration processes.
- Revise the health care and social service provider payment models to take into account the need to establish multidisciplinary teams to provide services to the older population.
INTRODUCTION

Healthy and active aging is at the top of Russia’s social and economic development agenda for the coming years. This priority is identified in the Strategy of Action for the Benefit of Senior Citizens in the Russian Federation, adopted in February 2016 (Стратегия, 2016). In addition, the Demography and Health National Projects propose measures to strengthen the provision of services to the elderly to safeguard their health and prolong their active life—measures that include health care, geriatric care, social services, and permanent physical assistance (long-term care), as well as educational, awareness, and active leisure services.

This report presents the results of a study conducted in three Russian regions to assess elderly people’s needs for integrated health and social services. There is limited empirical evidence about the quality of life of elderly people in Russia. Such issues as the living standards of the elderly, their behaviours in the labor market, and their social activities have been quite thoroughly covered by many authors, but much less information is available about other important dimensions of longevity, including health and the provision of social assistance. In recent years, age-specific epidemiological studies and surveys of older populations have been conducted at the local level, providing data only on the populations of the biggest cities – Moscow (Tkacheva et al., 2018) and St. Petersburg (Gurina et al., 2011). An older morbidity review based on official statistics (Соколовская 2013) and a representative survey of older populations (Рогозин 2018) give an idea of the health status of all older Russian citizens, but do not assess their needs for social care and services. The same is true of studies built on the Russian Longitudinal Monitoring Survey undertaken by the Higher School of Economics National Research University/HSE (Лежнина, 2008; Козырева и др., 2012).

In Russia, the most extensive study to survey the health and functional status of elderly people was conducted as part of the Study on Global Ageing and Adult Health (SAGE), using questionnaire-based surveys. Its findings and the publications based on it allow us to assess older people’s needs for health care and social services and their access to health services, as well as to make international comparisons across the SAGE countries (Ghana, India, China, Mexico, and South Africa). However, since the time of the survey (2007-2010), its findings may have become partially outdated as a result of changes in the Russian health sector and in the health status of older populations. Another relevant effort is the project Improving the Planning of Medical and Social Services within Elder Care in St. Petersburg/IPSE (Пиетилй и др., 2002), which assessed the needs of senior-aged people for social services. However, its timeframe (March-April 2000) and small sample (the older population of St. Petersburg) prevent its use to evaluate today’s policy for healthy and active aging.

Existing studies of the health of the elderly fail to close the knowledge gap on the needs of older people—that is, their opinions and perceptions. Some authors (Максимова, Лушина, 2012) used official statistics and SAGE data to undertake an extensive analysis of senior-age health outcomes in Russia, including the subjects’ health status, their access to health care, and the effectiveness of the health care they received, but they identify issues primarily from the perspective of the health system and medical community.

Russian publications about social care and services are also rather scarce. Developments and changes in the provision of social care to the elderly and people with disabilities are evaluated mostly by reviewing laws and regulations, statistics on social care infrastructure, or the number of people provided with inpatient and home care and services, or by analyzing data from representative surveys (Рагозина, Цацура, 2015; Гришина, Цацура, 2019; Самофатова, 2019). Publicly available data (both sector-specific statistics and survey data) assess the utilization of social services but cannot assess unmet demand for these services, or needs for nursing care in
accordance with standard scales adopted under international best practices (ADL/IADL). Indirect assessments of needs in social care may be derived from data of the 2015 Microcensus and from data of the Sample Survey to Assess the Quality of and Access to Services in Education, Health Care, Social Service and Employment Assistance (QAS) for 2013, 2015, and 2017, conducted by the Russian Federal State Statistics Service (Rosstat). QAS is the only publicly accessible source of information about users’ satisfaction with the quality of social services provided. However, none of the publicly accessible information sources allows us to identify people’s motivation in choosing specific delivery modes of nursing services or to assess the system’s opportunities for integrating health and social services and continuity of care delivery to people in need of nursing care.

The main objective of this study is to draw on findings from selected regions of the Russian Federation to find out to what extent the national social and health care policies designed for elderly people actually meet the needs and consider the abilities of older people.

The target population for the study consists of people above the working age (as of 2018, women aged 55 and over, and men aged 60 and over) in three Russian regions: the Republic of Karelia, the Republic of North Ossetia-Alania (North Ossestia), and Oryol Oblast. Special attention is paid to people aged 65 and over. In this report, the terms the elderly and senior/older people are used as synonyms.

The specific objectives of the study are the following:

- To assess older people’s needs in health and social services and their satisfaction with their access to and the quality of such services in different regions of the Russian Federation;
- To assess the integration of social and health services and identify barriers with a view to enhancing the integration; and
- To prepare proposals for government agencies to help older people be more active and capable and to ensure the provision of appropriate services and information.

This study was conducted in two stages. The first stage involved analyzing quantitative data on the health of older people and the provision of health and social services to them. The second used the qualitative methods of a social survey that was conducted in the three regions of the Russian Federation to assess older people’s satisfaction with health and social services and to identify barriers to their utilization. The findings from the study allow us to offer policy recommendations on the development of these services, which may be used to improve the policies and the design of programs to support senior people in Russia.
1. INTERNATIONAL PRACTICES OF HEALTH AND SOCIAL CARE DELIVERY TO THE ELDERLY IN THE CONTEXT OF RUSSIAN POLICIES

The populations of both developed and developing countries are aging—a trend that means that all countries need to pay particular attention to providing health and social care to the elderly and people with disabilities. The world already has nearly 1 billion elderly people. Globally, the number of older persons is growing faster than any other age group; the number of persons aged over 60 is expected to rise from 962 million in 2017 to 2.1 billion in 2050. In the countries of Europe and Central Asia the share of people 65 and older in the total population rose from 6 percent in 1950 to 12 percent in 2015 and, according to the United Nations’ medium-fertility demographic scenario, it could reach 21 percent by 2050. The Russian population is expected to age significantly over the next few decades because of declining fertility and increasing life expectancy. According to the United Nations’ projection, the share of older people will increase from 14 percent of Russian population in 2019 to 23 percent in 2050. In the global ranking of the quality of life of the older population, the Russian Federation ranks 65th among 96 countries on the overall indicators, 82nd for enabling environment, and 86th for the health status of the older people.

Recent decades have revealed several key trends in the field of medical and social services delivery to older people (Allen et al., 2011; Merlis 2000).

- Deinstitutionalization of care—that is, the shift in the delivery of care to elderly people and people with disabilities from inpatient settings to day care and home settings. A major principle of aging in the today’s societies is aging in place.

- It has been recognized that the family and surrounding community play an important role in the provision of care to older adults. For this reason, some reforms of social services include creating incentives to provide informal care and support caregiving families.

- Most countries have been privatizing social services, but these processes vary in intensity and level in different countries. As a rule, privatization occurs at the level of service delivery, but in some countries, it occurs at the level of financing as well. Private providers of services (both for-profit and not-for-profit entities) may be selected through open tendering and may compete with public sector providers.

- In many countries, the idea of consumer-centered care has been increasingly popular, acting as a driving force for expanding consumer rights to seek social services and to choose care programs and providers. In some countries, consumers are engaged in the quality assessment of provided services.

- Some countries promote the notion of healthy and active aging, which shifts the focus toward the prevention of conditions requiring social care, early diagnosis of health worsening, and rehabilitation of people even with limited functional abilities.

- And finally, many countries have been enhancing their efforts to integrate social and health services under such pressures as the growing number of people with chronic diseases and comorbidities and the increasing burden of expenditures on their treatment and social care, as well as the development of patient-centered care to improve the quality of life of people of older ages.

According to the World Health Organization (WHO), integrated care is “a concept bringing together inputs, delivery, management and organization of services to improve the services in

---


relation to access, quality, user satisfaction and efficiency” (Grone 2001). Integration of services can help to address such issues as funding, cost-sharing, service provision coordination, adoption of unified approaches to assessing health status and needs for services, and establishment of multidisciplinary teams (Merlis, 2000; Johri et al., 2003). Mira Johri and others (Johri et al., 2003) identify the following common features of a good integrated system of health and social services for older people: (a) having a case manager in place as part of multidisciplinary teams that consist of geriatricians and health and social workers; (b) a single-entry-point system or a single-care-provision program, or concentration of the management of community-based geriatric needs assessment teams in one agency; and (c) financial incentives (capitation-based financing).

Russia began reforming its system of social services and establishing an effective and efficient system of long-term care somewhat later than most other developed countries in both Europe and Asia. However, the past five years have seen vibrant development of the national policies in this area. Since January 1, 2015, Federal Law # 442-FZ of December 28, 2013, On the Basic Principles of Provision of Social Services in the Russian Federation, has been in force, and it accommodates many up-to-date trends in the area of social service provision. In February 2016, the Strategy of Action for the Benefit of Senior Citizens in the Russian Federation for the Period up to 2025 was adopted.

The Main Activities of the Government of the Russian Federation for the Period up to 2024 identify coherent measures to reduce mortality and increase healthy life expectancy: interventions to improve access to health care, advance a prevention-focused approach to health care delivery, and encourage physical activity and healthy lifestyles. The Main Activities and the core national projects and Government programs have a special focus on promoting healthy and active aging by putting in place a system of long-term care and long-term assistance, developing the network of gerontology units, improving the performance and work quality of providers of social services, and so on.

The needs of older people are also addressed in Decree of the President of the Russian Federation # 204 of May 7, 2018, On the National Goals and Strategic Development Objectives of the Russian Federation for the Period up to 2024, and as a consequence, in the Demography National Project. This National Project includes five federal projects, of which three are designed to benefit the elderly: the Older Generation Federal Project, Public Health Improving Federal Project, and Sports as Part of Normal Life Federal Project. The Older Generation Federal Project is called to create enabling conditions for active aging/longevity, to develop and implement programs of systemic support, and to improve the quality of life of older people. This objective is to be met by putting in place a system of long-term care for the elderly and disabled and improving the conditions and performance, including eliminating the waiting lists, of social service organizations in Russian regions.

The COVID-19 pandemic has brought new challenges for the delivery of health and social care to elderly people. The worldometer data source shows that the death rates of older persons and those with underlying chronic medical conditions are much higher than those of younger and healthier

---


8 See https://www.worldometers.info/coronavirus/coronavirus-age-sex-demographics/
people. The fatality rate increases from 3.6 percent for the age group 60-69 years old to 14.8 percent for those aged 80 years old and above, but it is 0.2 percent for the age group 10-49 years old and almost zero for the age group below 10 years old. The increasing numbers of cases in elderly care residential facilities in China, South Korea, Italy, Spain, United States, Canada, Australia, Germany, and France indicate that those places are at high risk for the spread of COVID-19. Residents in nursing homes and long-term care facilities live in close physical proximity and are more vulnerable; therefore, these facilities must take special precautions to protect their residents, employees, and visitors and minimize risks. Guidance from WHO and the European Centre for Disease Prevention and Control provides technical advice related to nursing homes and long-term care facilities. Another challenge for the elderly is the need to introduce quarantine and social distancing measures that increase social isolation; for elderly people, in particular, such measures could aggravate mental health problems and decrease their access to health and social services.
2. METHODOLOGY

This study combines quantitative and qualitative research methods. The first stage of the study involved analyzing quantitative data on elderly people’s potential demand for health and social services, the availability/accessibility of such services, and consumer satisfaction with them. The empirical base of this analysis consisted of official statistics published by the Ministry of Health of the Russian Federation and of data from the following sample surveys that represent the population of Russia in terms of key social and demographic indicators:

- The Russian Longitudinal Monitoring Survey, which is a nationally representative sample-based series of surveys, conducted annually since 1994 by the Higher School of Economics (RLMS-HSE), that provides information about the population’s health status, utilization of health services, and healthy practices. The sizes of the samples for one wave of the survey vary by year, ranging from 3,200 to 6,500 households and from 8,300 to 12,600 individuals within the households, including 1,700-3,000 individuals above working age.

- The Comprehensive Monitoring of Living Conditions conducted by the Russian Federal State Statistics Service (Rosstat) in 2011, 2014, and 2016, providing data on infrastructure and the availability of socially important services in communities of residence. The last wave of the survey with microdata available (2016) covers 60,000 households with 134,900 individuals, including 70,300 people above working age.

- The Sample Survey of the Quality of and Access to of Services in Education, Health Care, Social Services and Employment Assistance (QAS) was undertaken by Rosstat to assess the services provided in the named sectors. The survey was conducted in 2011 (pilot wave), 2015, and 2017. The sample for the last wave includes 48,000 households with 115,200 individuals of all ages and 30,700 elderly people.

The second (main) stage of this study used the qualitative methods of a social survey to assess elderly people’s satisfaction with health and social services and to identify key barriers to their utilization by reviewing the perceptions and assessments of older people and specialists who are responsible for the provision of health services to this age group. Another focus of the qualitative stage was to evaluate the integration of health and social care provision to the elderly. For this stage, two data collection methods were used: focus groups to identify positions typical of the elderly as a social group; and semi-structured interviews to discuss more specific (personal) health issues with older people, to reach people who could not participate in the group discussions because of their age (over 75) and disabilities, and to discuss the problems of the elderly with personnel of various specialties.

Communication with representatives of various social and professional groups – both those who consume and those who provide services, as well as those who make the related policies – enables us to draw a more comprehensive and valid picture of the problems faced by the elderly and to work out recommendations for the development of programs to promote healthy and active aging, with due regard to the needs and abilities of all stakeholder groups.

For the purposes of the study, three pilot regions with different population densities and living standards were selected to represent the northern, southern, and central parts of European Russia. The survey was conducted in the Oryol Oblast, Republic of Karelia, and Republic of North Ossetia-Alania. It should be noted that none of the three regions participates in a geriatric care development pilot project or a long-term care development project. Thus the data collected in these regions reflect the most common baseline situation as regards health and social care provision to the elderly in Russian regions before any interventions. (More information about the regions is provided in Chapter 3.) Survey respondents live in the administrative centers of the selected
regions and rural communities near the administrative centers. (Table 1.1 shows the number of focus groups and interviews in each region and provides information about their participants.)

All the interviews and focus group discussions were conducted in April 2019. The functions of focus group moderators and interviewers and the preparation of audio and video recordings and transcriptions of the interviews rested with personnel of the Regional Offices of the Russian Red Cross Society, who had been preliminarily trained in the basics of conducting high-quality social surveys. Data quality was checked by supervisors during their visits to the regions by phoning the respondents (to check the profiles of the selected persons) and when reviewing the recordings of the interviews and focus group discussions.

The respondents were selected by “snowballing”: that is, participants in the interviews and focus groups were asked to refer to 1-3 friends (the elderly) or colleagues (workers in health facilities and social care institutions providing services to the elderly). If a person aged 75 or older could not answer the questions on his/her own, his/her relative was interviewed instead. Participants in the focus groups were selected among older people with different health status and levels of income, and each group had an equal or almost equal number of men and women.
Table 1.1. The number of focus groups and interviews under the project

<table>
<thead>
<tr>
<th>Interview/focus group code</th>
<th>Oryol Oblast</th>
<th>Karelia</th>
<th>North Ossetia</th>
<th>All pilot regions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21</td>
<td>24</td>
<td>21</td>
<td>66</td>
</tr>
<tr>
<td><strong>Total number of interviews,</strong></td>
<td><strong>including</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1. Interviews with older people</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 The elderly under 65, men and women</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>1.2 The elderly aged 65-74, men and women</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>1.3 The elderly aged 75 and over, men and women (or their relatives)</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td><strong>2. Interviews with employees of organizations working with the elderly</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Primary care physicians from polyclinics</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Secondary care physicians (specialists) from polyclinics</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2.3 Physicians from inpatient facilities</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2.4 Nurses/feldshers(^{10}) (based in cities and rural communities)</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2.5 Social workers</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>3. Interviews with health and social care managers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Chief physicians of polyclinics</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3.2 Chief physicians of inpatient facilities</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3.3 Directors (deputy directors) of the Regional Health Departments</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3.4 Directors of social service centers</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3.5 Directors (deputy directors) of the Regional Social Service Department</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3.6 Directors of nonprofit (civil society) organizations addressing problems of the elderly</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total number of focus groups,</strong></td>
<td><strong>including</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Focus groups with the elderly under 65, living in cities</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2 Focus groups with the elderly under 65, living in rural areas</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3 Focus groups with the elderly aged 65-74, living in cities</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>4 Focus groups with the elderly aged 65-74, living in rural areas</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>5 Focus groups with the elderly under 75 with disabilities</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

\(^9\) Throughout the paper, this code is used in the descriptions of the study results to denote the source of the citation: [I/FG (abbreviated name of the region) (code of the interview or focus-group)].

\(^{10}\) According to the World Health Organization, a feldsher is a health care professional who provides various medical services limited to emergency treatment and ambulance practice.
3. BRIEF DESCRIPTIONS OF THE SELECTED REGIONS

According to Rosstat, in 2018 there were only minor differences in the shares of people above the working age\(^{11}\) in the total populations of the pilot regions, Moscow, and the Russian Federation as a whole. While in the country as a whole, people above the working age accounted for 25.4 percent, in North Ossetia their share was 23.2 percent, in Karelia it was 27.1 percent, and in the Oryol Oblast it was 29.3 percent (Figure 3.1). In all the pilot regions, the shares of urban residents in the total older populations were approximately twice as large as those of rural residents, similar to the national average.

Figure 3.1. Rural versus urban populations above the working age, %

Sources: Calculations of the authors based on Rosstat data (from the Bulletin on Population of the Russian Federation, by sex and age).

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Российская Федерация</td>
<td>Russian Federation</td>
</tr>
<tr>
<td>Москва</td>
<td>Moscow</td>
</tr>
<tr>
<td>Орловская область</td>
<td>Oryol Oblast</td>
</tr>
<tr>
<td>Республика Карелия</td>
<td>Republic of Karelia</td>
</tr>
<tr>
<td>Республика Осетия-Алания</td>
<td>Republic of Ossetia-Alania</td>
</tr>
<tr>
<td>Доля сельского населения</td>
<td>Rural population, %</td>
</tr>
<tr>
<td>Доля городского населения</td>
<td>Urban population, %</td>
</tr>
<tr>
<td>Доля населения старше трудоспособного возраста</td>
<td>Population above the working age, %</td>
</tr>
</tbody>
</table>

Figure 3.2 shows that in the Oryol Oblast the older population is more evenly distributed among age groups than in the other regions, while Karelia has a larger share of the elderly aged 55(60)-64 and 65-74, and North Ossetia has a larger share of people aged 75 and over.

---

\(^{11}\) Men aged 60 and over and women aged 55 and over.
According to Rosstat’s data for 2017, the average per capita income was comparable in all three regions, but below the national average. The lowest per capita income, in North Ossetia, is about 71 percent of the national average. In 2018 Karelia had the largest share of the population with incomes below the subsistence minimum (17%), followed by North Ossetia (14.2%); Oryol Oblast had the lowest share of poor people, (13.7%), though it was still larger than the average for Russia (12.9%).

As of 2017, the longest age-adjusted life expectancy was in North Ossetia—18.3 years for men aged 60 and 27.4 years for women aged 55 years; it was above the level for Russia as a whole, but below the Moscow level. In the Oryol Oblast and Karelia, the life expectancy of pensioners was a little below the national averages.

Publicly accessible statistics contain indicators characterizing social care infrastructure (the number of places in facilities/institutions of different types) and the number of people provided with services. Because data are lacking on the number of people in need of social care (among other things, with a breakdown by their specific need and by needed service), the availability of places and the number of people provided with services are correlated with the total population in particular age groups. This practice undoubtedly distorts the actual demand and supply pattern. According to Rosstat’s data for 2017, Russia had 0.2 places in temporary stay centers of social care per 1,000 people above the working age, and 0.5 places in day care centers of social services per 1,000 people above the working age (Table 3.1). The utilization rates of these places were, respectively, 0.6 and 5.4 elderly and disabled people provided with services in temporary stay social care centers and in day care centers of social services, per 1,000 people above the working age.

According to the statistics, Karelia has the highest availability of places in social care centers (2.5 places per 1000 in temporary stay centers and 0.4 places in day care centers), and North Ossetia the lowest (0.2 places in day care centers). The utilization rate is higher in temporary stay social care centers in Karelia (5.3 elderly and disabled people provided with services per 1,000...
population) and in day care centers in North Ossetia (3.0 elderly and disabled people provided with services per 1,000 population) (Table 3.1).

Table 3.1. The number of social care centers per 1,000 people above the working age, 2017

<table>
<thead>
<tr>
<th></th>
<th>Temporary stay centers of social care per 1,000 people</th>
<th>Day care centers of social services per 1,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of places</td>
<td># of the elderly and people with disabilities provided with services</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>0.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Oryol Oblast</td>
<td>1.6</td>
<td>2.2</td>
</tr>
<tr>
<td>Karelia</td>
<td>2.5</td>
<td>5.3</td>
</tr>
<tr>
<td>North Ossetia</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Calculations of the authors based on Rosstat data.

The adaptation of regional infrastructure for use by people with physical disabilities may be assessed only with the help of specific indicators. For example, as of the end of 2016, 11.2 percent of passenger buses in Russia as a whole were equipped to transport such people, whereas in Moscow, the share was as large as 76.7 percent. In North Ossetia and the Oryol Oblast, the shares were much smaller: 3.7 percent and 1.3 percent, respectively.

It is well known that statistics alone are not sufficient either for assessing needs in health and in social and nursing care or for understanding whether the life of an older adult has improved after receiving needed care. Some qualitative characteristics of the needs in health and social care services may be derived from the results of QAS-2017.

Among the regions studied, Karelia has the largest share of people above the working age in need of home-based medical and personal hygiene procedures (8.3%), compared with the national average of just 4.8 percent. In the three regions, large shares of people with disabilities were in need of such procedures: 18.5 percent in North Ossetia, 23.3 percent in Karelia, and 24.1 percent in the Oryol Oblast.

Judging by the distribution of the elderly provided with home-based medical and personal hygiene procedures in 2017, they sought such care from relatives and acquaintances. For example, in the Oryol Oblast, their share was 75.2 percent of the elderly in need of such procedures, and in Karelia, it was 81.3 percent, both of which significantly exceeded the national average (66.7%). In North Ossetia, however, home-based care was not a widespread practice: only 11.6 percent sought such assistance from relatives. However, in North Ossetia, the share of those seeking care from their family doctors (health workers) was much larger (51.7%) than in the other regions and Russia as a whole: it was 12.3 percent in the Oryol Oblast, 2.1 percent in Karelia, and 7.9 percent in the Russian Federation on the average. Fewer people sought such care from attending doctors (up to 4% in the regions of the study), and significantly more sought such care from staff (visiting) nurses: 7.9 percent in Karelia, 31.9 percent in the Oryol Oblast, and 35.3 percent in North Ossetia. Population surveys show that residents of Karelia most frequently sought assistance from social workers and people hired to provide medical and personal hygiene services: 18.5 percent and 10.8 percent, respectively. Among people in need, the smallest share of the elderly provided with such services was in North Ossetia (1.8%).
However, overall, when home-based medical or personal hygiene procedures were needed, the older population of the Oryol Oblast most frequently (41.2%) sought these services from their formal providers (social workers, attending physicians and nurses); the lowest share was found in Karelia (30.5%), and the national average was 33.5 percent.

People in need of social care include those who are registered as recipients of social care and are provided with services and those who are on the waiting list for service provision or who declare their need when registering as recipients of social care at the social protection offices. According to QAS-2017, in the regions participating in the study, the greatest share of elderly people in need of social care was in Karelia (4.4%); in the Oryol Oblast the share was 3.4 percent, and in North Ossetia, it was only 0.9 percent.

In Russia on average, almost half (49.8%) of the elderly in need of care are provided with required services through social protection offices. In North Ossetia, with its smaller share of people in need, the access rate for social services is close to the average national rate: 41.6 percent of people in need of social services are provided with them. In the Oryol Oblast, less than one-third (29.2%) of the elderly people in need are provided with social services, while in Karelia most of them (80.6%) receive needed services. As a comparison: in Moscow in 2017, when the survey was conducted, services were provided to a bit more than half (52.2%) of those reported to be in need of them.

So, according to the statistics, Karelia is leading in terms of the availability of places in the centers of social care and the share of elderly people and people with disabilities provided with services in such centers. North Ossetia is leading in the number of elderly people and people with disabilities provided with services in day care centers of social services.

Analysis of the QAS-2017 data shows that in 2016, Karelia had the greatest number of older people in need of both home-based medical and personal hygiene procedures and social services. But in this region, the gap between the demand for and supply of medical and personal hygiene procedures by formal health care providers was wider than in the other two regions, although the needs for social services were met better than in the other two regions.

---

12 Per 1,000 people above the working age
4. STATUS OF THE ELDERLY IN SOCIETY

4.1. Aging as a milestone in human life

Various social studies show that the definitions of the beginning of old age are rather blurred in Russia, with some of them relating to specific, individual situations rather than to the actual age. For example, some people argue that old age begins at the age of retirement, while others associate it with the actual exit from the labor market or with ill health. This study demonstrates that old age is associated with apathy, frailty, and inferiority; therefore, people try to deny its beginning.

“People deem themselves old when they are unable to take care of themselves, but I am not old.” [FG_Kar_5]

Like other authors (Рогозин, 2018), we have found that work is of great importance for the self-esteem of the elderly. Many respondents note that they feel like “discarded resources” when they cease to be able to produce anything (to work at full capacity) and are forced only to consume, which means that they are of no use to society.

“Elderly people suffer from a lot of things: firstly, the retirement itself is painful for many of them because it means that they are at once labelled as the elderly, so to say. It offends the ear....” [I_Or_1.1_2]

At the same time, if people are in good health, the retirement age is associated, rather, with new prospects owing to independence and freedom: there is no need to adjust to management or to go to work, and there are broadened opportunities to “live for oneself” and spend time with children and grandchildren.

“Older people have more time to spend for themselves or their children. It is also good, this is a purpose of life.” [I_Os_1.2_3]

However, the desire of pensioners to “live for their own pleasure” or to relax is in discord with the actual financial opportunities of older people in the three regions.

“Though I am an old woman, I also want to live adequately, but how can you live adequately on a pension amounting to RUR 10,000?” [FG_Os_2]

People do not believe that the government can ensure them a decent old age, and they count only on themselves – their optimism, their energy, and their ability to earn a living for themselves and their children or grandchildren.

Drastic deterioration in health is perceived almost as a disaster. First of all, it is associated with uselessness, and it frightens with the prospect of dependence on others and the high costs of treatment and care.

“I believe that when you are in good health, your life is only beginning after retirement, but that is so if you are in good health. And if you are a pensioner and have grave health problems, God forbid, life would be very hard because of very expensive health care. And where would you find time and people to take care of you?” [I_Or_1.2_1]

Another frightening aspect of old age is the disintegration of traditional social bonds and loneliness—particularly when children and grandchildren move away or when the spouse dies.
“I am suffering from lack of communication. The children grew up, and I am left all alone in a confined space.” [FG_Or_5]

It is difficult to face the fear of loneliness and ill health, and it is even more difficult to put up with the impossibility of having your own future health under full control. For this reason, older respondents often report that in old age, their condition depends on their lifestyle rather than on their actual age and health status: an active person can always find something to do and care about and is not discouraged.

“I enjoy the post-retirement life. I do not give up in the face of illnesses, trying to forget about them. I do morning exercises and something else. So, I am not complaining.” [FG_Or_5]

“I do not think that the age matters. What really matters is your lifestyle. If you are an active person, you will always find some work to do, someone to care about apart from yourself. And it has nothing to do with the age. If you are a ‘homebody’ or a depression-prone person, then yes.” [I_Or_1.1_2]

4.2. Social status of older people

A respectful attitude from other members of society is very important for senior-age people.

“The most important thing is to be well treated by society.” [I_Or_1.1_1]

“The only thing we need is a respectful attitude. It is necessary to respect old age.” [I_Kar_1.3_1]

Older people themselves are, in principle, satisfied with the attitude toward them of society as a whole and of younger generations. However, they feel the gap between themselves and younger people; there is no genuine contact. It is noteworthy that older respondents point to both their professional superiority in comparison with younger people, which enables them to remain employed, and a negative attitude to older employees on the part of employers.

“Young people are always respectful… They cannot do quite simple things, e.g., with a car: to improve something, to dismantle, to assemble and drive.” [I_Or_1.1_1]

Some older respondents clearly distinguish the attitude on the part of other people from the attitude of government.

“...But as regards the attitude of society to older people, I would say it is not bad. The bad attitude is from the government.” [FG_Os_5]

“… Earlier, during the Soviet time, it was noticeable: older people were esteemed and respected, and now, nobody cares about the elderly. Nobody cares about them, nobody pays any attention to them: the administration does not help them.” [I_Or_1.1_3]

Accordingly, some respondents refer to having received coarse treatment and lack of respect from those who represent government at the local level, including the staff of social assistance offices and health workers. Older respondents think that such coarse treatment of the elderly is attributable to the fact that, on the one hand, the elderly are more demanding about the quality of the services provided, and, on the other hand, many older people cannot stand up for themselves and therefore feel helpless.
4.3. Financial situation in old age

It is no wonder that most of the older people covered in this study are not satisfied with their living standards. Their key problems are small pensions and the high costs of pharmaceuticals and health services.

“My pension is good, but small. My pharmaceutical is expensive, and I have not learned how to live ‘from pension to pension.’ I have to refrain from some things.” [FG_Kar_3]

“As regards the pension as a source of income, it is sufficient only for survival. You cannot feel like a person of worth with such a pension.” [FG_Or_4]

When elderly people are short of money, they first try to save on the costs of food. Instead of buying food in big quantities, they buy food products at discounted prices and during promotional events, both for immediate and more distant future consumption. For elderly people who have household plots/dachas, saving on food is easier: they can produce the bulk of food products for themselves and support their children in this way as well. Spending on pharmaceuticals and health care is, on the contrary, less elastic:

“Health care appears to be an essential good. And the rest is better spent on food products.” [FG_Os_2]

Continuing to work is accounted for, primarily, by the need for additional income.

“In principle, should the pension be decent, I would not have to work. Certainly, I would prefer to do something else on my own. I would work in my kitchen garden or find some other engagement.” [FG_Or_1]

Some older people agree to receive financial aid from their children to meet their basic needs (for food, medical treatment, etc.) and also their needs for recreation/travelling. However, such a situation is much less common than situations in which elderly people support younger relatives who have no jobs (or poorly paid jobs) or who have disabilities. This tends to be typical of extended families.

“Vice-versa, we help the children. They are either unemployed or have low-paid jobs. My daughter lives with me, she has two children, I cannot but help them.” [FG_Os_2]

“No, the children do not help us. Rather, we help them both financially and through sharing food products. We grow potato and other vegetables in our kitchen garden.” [FG_Or_5]

If pensions were increased, older people would most likely use this incremental income to provide additional support to their adult children rather than to improve the quality of their own lives (to have more diverse nutrition, better health services, etc.). Such a situation may become an obstacle to improving the quality of life for the elderly until the more serious issue of the labor market as whole is resolved.13

Most older people try to accumulate savings, but few of them manage to do so. The main purposes for savings they reported are funerals, contingencies, and “a rainy day.” If necessary, elderly people borrow money from relatives or acquaintances. Most people try to refrain from taking

---

13 According the Household Income Survey by Rosstat, the poverty rate among the elderly is 2.4 percent, while the average poverty rate in Russia is 10.9 percent.
credit, but for some older people such practices are a strategic approach to overcoming financial restraints.

4.4. Key conclusions

The findings from this study show that many elderly people perceive old age rather negatively, associating it with apathy, frailty, and inferiority. To some extent, older people try to find confirmation of their worth and value outside—it is important for them to see a respectful attitude on the part of other people and the government. And while overall they are satisfied with the attitude of younger generations, they have a low opinion of the attitude of government, given their small pensions and the high costs of pharmaceuticals and health care.

The fear of being left behind in this life is the main driver of efforts to remain healthy and active. Therefore, most respondents say that they do not deem themselves old, being quite active, keen to live, and capable of being useful to society or their families. Accordingly, positive perceptions of life, optimism, and energy are held up as ways to run from old age or postpone it. Ill health is associated with uselessness, and it frightens with potential dependence on others and concerns about the high costs of treatment and care. Another frightening aspect of old age is the disintegration of traditional social bonds and loneliness.

Given the small size of pensions, most of the older respondents of this study are not satisfied with their living standards. When elderly people are short of money, they first try to save on food products. Spending on pharmaceuticals and health services is cut last of all. Many older people provide material support to their children/ grandchildren. Almost all of them say that the government should increase pensions and prevent price rises for pharmaceuticals.
5. HEALTH STATUS AND HEALTH CARE IN OLD AGE

5.1. Health status in old age

Older people in Russia have poorer health than their peers in other countries, which may explain their higher demand for health care and social services and their shorter life expectancy. To maintain their health, many elderly people rely primarily (and perhaps excessively) on nonmedical measures. One of the fundamental anti-aging remedies for Russia’s older population is a positive attitude to life; they believe that a good mood and social relations make it possible to prevent health problems and cope with the diseases one has. At the same time, elderly people exhibit low motivation to do physical exercises and lead a healthy lifestyle, and they lack knowledge about a healthy diet.

The World Health Organization distinguishes three characteristics of older people who are in contact with the health care system: (a) they suffer from multiple chronic diseases and comorbidities, (b) they have limited body resources to fight diseases, and (c) they find it difficult to interact with medical workers and adhere to doctors’ prescriptions because of physical, sensory, and cognitive impairments.

The study extended the list of special features of the elderly as clients of healthcare system. The elderly who are 65 years and over and health workers reported that old people tend to neglect their diseases. Seeking health care when it is too late may be a result of both insufficient availability of services and a habit of “enduring” formed in response to problems with obtaining the necessary care. Health workers reported that elderly patients typically have a lower level of trust in both physicians and medicine. Such an attitude may be due to their accumulated negative experience in seeking help from health facilities, and lack of knowledge about the treatment process.

Elderly people also have specific psychological problems. Elderly patients tend to need understanding and sympathy more than middle-aged individuals. In the absence of such an attitude and in response to a doctor’s careless statements, they quickly take offense. It can be assumed that this peculiarity of the elderly may result from (a) natural brain and nervous system impairments that develop with age, (b) the relatively high prevalence of mental problems among the elderly in Russia due to the low availability/affordability of psychologists’ services, (c) lack of social contacts and attention and their desire to make up for this shortage through communication with health workers, and (d) objective difficulties with receiving health care assistance.

The study results show that psychological problems, negative emotions, and bad mood strongly affect the condition of the elderly. Quite often, it is because of these factors rather than real health issues that elderly people visit a doctor: they seek “care” consisting in listening to their problems, showing sympathy, and providing necessary information, and it proves quite effective.

In Russia, older people have poorer health than their peers in other countries—a fact that may result in higher demand for health care and social services and shorter life expectancy. According to findings from SAGE, conducted in Russia, Ghana, India, China, Mexico, and South Africa in 2007-2010, Russian people’s health declines more rapidly with age than that of people in the other countries covered by the study (Figure 5.1). And as regards the prevalence of physical and cognitive limitations after the age of 50, Russia is ranked between China, with its relatively healthy older population, and India, with its extremely poor health indicators (Table 5.1).
Figure 5.1. Mean health scores for population aged 20 and over, by age (2007-2010)

Source: SAGE (He et al., 2012).
Note: 0 = worst health, 100 = best health.

Table 5.1. Disability and depression for population aged 50 and over: 2007-2010, %

<table>
<thead>
<tr>
<th></th>
<th>Russia</th>
<th>India</th>
<th>Mexico</th>
<th>South Africa</th>
<th>China</th>
<th>Ghana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any disability</td>
<td>91.3</td>
<td>93.4</td>
<td>79.1</td>
<td>75.9</td>
<td>68.1</td>
<td>77.9</td>
</tr>
<tr>
<td>Difficulty with moving around</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>48.1</td>
<td>44.0</td>
<td>61.5</td>
<td>66.2</td>
<td>79.0</td>
<td>52.6</td>
</tr>
<tr>
<td>Mild to moderate</td>
<td>42.0</td>
<td>39.1</td>
<td>32.7</td>
<td>27.7</td>
<td>16.6</td>
<td>40.1</td>
</tr>
<tr>
<td>Severe</td>
<td>9.9</td>
<td>16.8</td>
<td>5.8</td>
<td>6.1</td>
<td>1.5</td>
<td>7.3</td>
</tr>
<tr>
<td>Difficulty with self-care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>72.9</td>
<td>77.2</td>
<td>80.3</td>
<td>83.5</td>
<td>91.8</td>
<td>75.0</td>
</tr>
<tr>
<td>Mild to moderate</td>
<td>22.8</td>
<td>19.2</td>
<td>15.9</td>
<td>14.7</td>
<td>7.4</td>
<td>22.5</td>
</tr>
<tr>
<td>Severe</td>
<td>4.2</td>
<td>3.6</td>
<td>3.7</td>
<td>1.8</td>
<td>0.8</td>
<td>2.5</td>
</tr>
<tr>
<td>Bodily aches or pains</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>38.0</td>
<td>25.6</td>
<td>45.9</td>
<td>36.1</td>
<td>51.7</td>
<td>20.0</td>
</tr>
<tr>
<td>Mild to moderate</td>
<td>52.1</td>
<td>53.7</td>
<td>45.4</td>
<td>51.4</td>
<td>45.3</td>
<td>65.0</td>
</tr>
<tr>
<td>Severe</td>
<td>9.8</td>
<td>20.7</td>
<td>8.8</td>
<td>12.5</td>
<td>3.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Cognition: difficulty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>49.7</td>
<td>32.5</td>
<td>51.0</td>
<td>44.4</td>
<td>52.2</td>
<td>38.3</td>
</tr>
<tr>
<td>Mild to moderate</td>
<td>45.5</td>
<td>53.4</td>
<td>47.0</td>
<td>47.3</td>
<td>44.7</td>
<td>54.9</td>
</tr>
<tr>
<td>Severe</td>
<td>4.8</td>
<td>14.1</td>
<td>2.0</td>
<td>8.3</td>
<td>3.1</td>
<td>6.8</td>
</tr>
<tr>
<td>Percentage feeling depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>29.4</td>
<td>54.5</td>
<td>43.0</td>
<td>45.8</td>
<td>17.1</td>
<td>49.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>48.3</td>
<td>67.8</td>
<td>58.1</td>
<td>55.6</td>
<td>27.8</td>
<td>58.4</td>
</tr>
</tbody>
</table>

Source: SAGE (He et al., 2012).
The 2000s saw an improvement in the health status of the elderly in Russia, evidenced by official data on disease incidence and results of surveys (Figure 5.2) and noted by some authors (Максимова, Лушкина, 2012). Nevertheless, by 2016, Russia remained significantly behind other developed countries in terms of life expectancy at the age of 60. In 2016, according to WHO data, Russia’s health-adjusted life expectancy for the elderly of both sexes was 14.9 years (as in Guatemala), and it was 12.4 years for men (as in Zimbabwe); in this respect, Russia was ranked 89th among the 183 countries for the entire population, and 135th for men.

Figure 5.2. Shares of the population reporting “poor” or “very poor” health, %

Source: Russian Longitudinal Monitoring Survey, Higher School of Economics (RLMS-HSE).

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Мужчины - трудоспособного возраста</td>
<td>Men of working age</td>
</tr>
<tr>
<td>Мужчины – старше трудоспособного возраста</td>
<td>Men above working age</td>
</tr>
<tr>
<td>Женщины - трудоспособного возраста</td>
<td>Women of working age</td>
</tr>
<tr>
<td>Женщины – старше трудоспособного возраста</td>
<td>Women above working age</td>
</tr>
</tbody>
</table>

5.1.1. Ways to maintain good health in older age: opinions of older people

Elderly individuals who took part in the qualitative survey assess their health in a very restrained manner. They recognize that it has deteriorated with age but do not see any reason to be concerned about it or grounds to take any special action. They believe that aging and deterioration of body condition are inevitable. Under the circumstances, they believe that the key objective for themselves, and for medical workers and public authorities, is avoiding problems that could accelerate aging, such as low quality of life and waiting until it is too late to consult doctors.

14 According to data from the Ministry of Health of the Russian Federation, in 2011-2016, the crude national disease incidence rate for people above the working age decreased from 206,488.7 cases per 100,000 population to 200,371. Those years saw fewer recurrent infarctions, injuries and poisonings, and cases of full or partial loss of eyesight (ЦНИИОИЗ, 2013-2018).
The elderly believe they should take care of their health not only for their own good but also, in large measure, for the sake of their family members who have to bear the burden of looking after them in case of serious diseases.

“In old age, you are limited by your health, that’s it. But certainly when growing old you should think not only about your own comfort but also try to make life more comfortable for your relatives, your family – yes, try to.” [FG_Or_3]

While actively helping their children and grandchildren—above all, with money—the elderly aspire to live longer so as not to leave their family members without support.

“…I wish I could live a bit longer because I don’t know how my gals [daughter and granddaughter] would live without me.” [I_Or_1.3]

However, when answering the question about what could be done to delay aging, the elderly mostly mentioned actions beyond the competence of the health care system and beyond the scope of healthy lifestyle. One of the fundamental anti-aging remedies for Russia’s older population is a positive attitude to life. A good mood makes it possible to prevent health problems and cope with diseases they already have.

“I believe that to put off aging one should anyway change one’s mentality. One’s own mentality, and if we change it, then aging will be really postponed. If one can see positive things in this world – the body will recover a little bit.” [FG_Or_1]

“A good mood, a positive view. It is essential to think in the right way. Your thoughts will materialize. And if you’re already sick you should not think it is your last hour, your last day.” [FG_Or_3]

“But we are used to thinking that pills are a panacea for all misfortunes. But that is not true! What matters is peace, outdoor walks, and also your friends who are not moaning about their illnesses but charge you with optimism!” [FG_Or_4]

A positive view of life comes to Russian older people primarily through communication with their relatives or with friends at leisure centers.

“When I go to the (community) center I feel dizzy, I can hardly walk. However, after mixing with the people I feel better. This kind of communication is most important for us!” [FG_Or_5]

“My mother-in-law loved going to singing parties every weekend. So sometimes, when I spoke to her, she would say: “I’m going to a singing party today.” She cheered up herself. She lived by herself. Her husband and son had died but she always kept strong. It all depends on one’s disposition.” [FG_Or_5]

A source of positive emotions for older women is their good appearance. Being attractive means “feeling younger,” getting back to the age when one had no health problems.

“… dress up, you need to get out your best dress, your best perfume – everything should be the best. Dress up and feel your soul is somewhat young.” [FG_Or_3]

For some of the elderly, an effective remedy against aging and loss of health is the presence of a life goal or commitments to others. For the elderly of both genders the source of such goals or
commitments may be their work. For many women, meaning is given to life by their family duties, such as nurturing their grandchildren.

Speaking about ways to remain healthy, the elderly are less willing to mention a healthy lifestyle and physical exercise. However, even those who recognize that such habits are vital for health may lack inner motivation to practice them regularly on their own; they would rather do it in an organized way, in a group.

**Social services should make better arrangements for pensioners’ leisure.** [FG_Os_2]

The elderly believe that part of the responsibility for their health rests with the government, since they spent their health when working for the benefit of their Motherland.

**“On the one hand, government should provide support because when we were healthy we worked for the benefit of the state. But now we are not the same we used to be, and you are failing us.”** [FG_Os_3]

Such mindsets are due, in part, to the presence of clear demands on the authorities, and in part to the social contract proclaimed in the socialist state—that is, that the authorities assume responsibility for the health of working people and compensate them in older age for losses incurred during their work life.

A prerequisite for ensuring the good health of the senior-age population is healthy food, and the elderly consider quality nutrition to be an essential precondition for good health. During interviews, the respondents in all three regions would usually give a correct answer when asked about a healthy diet and included in it fresh vegetables and fruit, a limited quantity of meat, and occasionally fish. However, quite often during the survey they told the interviewers that they were not sure about the quality of food accessible to them. Short of money and unable to buy food in supermarkets, which are too far away, the elderly buy food at convenience stores and discount shops (e.g., Magnit, Pyatyorochka), though they suspect that discounted prices may adversely affect the properties of foodstuffs.

**“I don’t know if the foodstuffs are of good or low quality.”** [I_Kar_1.1]

**“… when older people save money on food, it aggravates their diseases. When we buy cheap, we are aware that food is made cheaper through adding various supplements that, conversely, increase the blood cholesterol level, as well as the glucose and sugar content.”** [I_Os_2.1]

Some of the focus group participants confessed that they lacked knowledge about healthy eating and said they needed more information.

**“It has been known that food is medicine and medicine is food. Everything depends on what we eat. We never think of how many calories one should eat, whether to have one apple or more. I wish I knew it. It would be so nice, I would have half an apple, a cookie, or a tea. But I have no idea, so I eat whatever turns up.”** [FG_Os_5]

The requirements of the population include better access to the existing and well-known health support facilities (health services and medicines), as well as a higher quality of life.

**“People save on drugs and use herbs for treatment.”** [FG_Os_2]
“Pensioners should be given more opportunities to travel somewhere, get rehabilitation and higher pensions.” [FG_Or_2]

It is interesting that such wishes were voiced in the focus groups consisting of the elderly from rural areas, which may indicate that older rural people are in great need of government support to ensure health protection.

The study showed that to preserve their health the elderly rely primarily on communication, good mood, and life purpose. This attitude may have resulted from the underdeveloped culture of focused health promotion that is typical of Russia’s older population, as well as from the low accessibility of health care services to maintain their health.

Therefore, according to the survey participants, particularly those from the younger group, health preservation in older age is in large measure determined by a correct way of life, an active life stance, and a purpose in life. Older Russians prove very active in supporting their health through such methods, maintaining relations with their family members and friends, trying to find an occupation for themselves, sticking to a special diet, or maintaining a sufficient level of physical activity. However, certain population groups need help from government and society to preserve their health:

- Low-income individuals and rural residents need greater availability of health and leisure infrastructure (health resorts and tours).
- Single elderly people need sports groups and collective workout classes (such classes improve people’s health through direct effect on their body and opportunity to mix with the others).
- Women need beauty services.

Any government health care initiative targeting the elderly is expected to get a positive response from the older generation, which considers it to be in line with the Soviet-era social contract.

Given the needs identified by the elderly, we would recommend the following measures.

For public authorities:

- Developing special health support programs for the elderly living in rural areas and for low-income seniors (higher priority for granting health resort treatment, invitations to free entertainments).
- Enhancing older people’s engagement in healthy lifestyle practices by disseminating special information to them about healthy habits and by improving their access to sporting activities for older people.
- Getting senior-age persons involved in volunteer activities to disseminate information about healthy lifestyles. On the one hand, this type of work improves performance (peer-to-peer information exchange ensures a high level of trust in the information source), and, on the other hand, it contributes to the social activity of senior-age citizens.
- Providing discounts to older women for the services of hairdressers and manicure salons.
- Working with federal food chains to develop healthy food programs for the elderly that will provide a selection of inexpensive and healthy foodstuffs with the label “Healthy eating for the elderly,” with details that an elderly person can easily read regarding the
admissible quantity of the product that can be consumed, particularly by people with certain chronic diseases (diabetes, cardiovascular diseases, osteoporosis, etc.).

- Providing low-income elderly people with food stamps for healthy foods.

For the Russian Red Cross Society:

- Providing healthy leisure opportunities (hiking, sports festivals) for the elderly.
- Taking part in the work of the Schools of Health for the elderly.
- Carrying out an act of charity to provide the elderly with healthy foods.

5.1.2. Older people as special clients of the health care system

The World Health Organization distinguishes three characteristics of older people who are in contact with the health care system: they suffer from multiple chronic diseases and comorbidities, they have limited body resources to fight diseases, and they find it difficult to interact with medical workers and adhere to doctors’ prescriptions because of physical, sensory, and cognitive impairments (BO3, 2016).

Since aging trajectories are personalized—that is, aging individuals may lose health and capacity at different rates—a patient’s age is of secondary importance for health care delivery. With few exceptions, the patient’s status in the health care system, in Russia as elsewhere, is determined by his/her health condition rather than the number of years lived. This understanding can be a justifiable basis for developing treatment schemes, but, from our perspective, in setting up the process of health services delivery, elderly patients should be deemed a special group. When receiving health services, senior-age patients face typical problems that need to be taken into account as health care programs for the elderly are developed.

During our study, we supplemented WHO’s list of characteristics with special needs that Russia’s elderly people may have because of their cultural specifics, or problems with the availability of health promotion services in Russia. We based the list on the responses from people in different stakeholder groups: elderly people, health and social workers, and leaders from the health system and social sector. This strategy enabled us to assess the needs of senior-age patients objectively, without overestimating their needs (as can be typical of health service users) or underestimating them (as may occur when the situation is assessed by leaders or workers of health and social service organizations).

In focus group sessions with representatives of the “younger” senior-age group (under 65), some participants reported that they did not see any significant difference between older and younger patients, and suggested that people seeking care from health facilities should not be differentiated by age. This viewpoint confirms that when developing special health care programs for the elderly, the minimum age of the target group may not necessarily coincide with the traditional boundaries of the working age; it may be higher.

Some senior-age people believe that when receiving health care, the elderly are less demanding. Aware of the difficulties others may have in dealing with them, they do not expect much attention and are ready to be content with little.

“I myself try to behave differently, correctly. I keep saying ‘Excuse me’ a thousand times even if I’m not wrong.” [FG_Or_3]

However, most respondents felt that older people require more efforts from physicians.
Besides the fact that elderly patients have more serious health problems because of their age, in Russia neglect of diseases is typical of the elderly, as both health workers and the elderly themselves report. Seeking health care when it is too late may be a result of both insufficient availability of services and a habit of “enduring” formed in response to chronic problems with obtaining the necessary care.

“... we neglect the disease – that’s the key difference. If a young person falls ill – he/she seeks medical care, but an old person does not, he/she would prefer enduring, until the disease advances.” [FG_Os_5]

“... many people, most probably it is true about those over 80-85, nearing 90, were of a relatively conscious age, when the [Second World] War broke out. They got used to endure and hold something back to avoid being taken to hospital. For instance, my grandmother is exactly like this. She would keep enduring to the end, knowing she is unwell, until she finally collapses, but visually it is impossible to understand that she is really sick.” [I_Or_2.4]

According to the study participants, elderly patients with low levels of education or lack of access to the Internet can have insufficient information about medical technology. Such patients need more detailed explanations before manipulations and may experience more fear during an intervention.

Conversely, some respondents believe that the elderly are more involved in the treatment process, and thus are more demanding. This attitude may result from better awareness, because the patient has suffered from his/her illness for a longer time.

“Young patients are not so demanding compared to us because the elderly know their sicknesses and demand more things while young people are content with the first medicine prescribed by their doctor.” [FG_Or_2]

In older age, people have free time to take an interest in their health and treatment process.

In Russia, elderly patients are not just older people, but they are also representatives of a special generation that relies on the values and standards of the socialist state, with more generous benefits. The older a person is, the later he/she started living in a market economy, and the higher the probability that he/she will not succeed in adopting the new society values and modern principles of the health system.

“One should simply join the new lifestyle, but many people from our generation have not assimilated into this life. They are still based on the old conventions and have not reformed themselves. And they demand free food from Heaven and the like, just like in the Soviet era.” [FG_Os_3]

“Because they still remember the time when they went to see their doctor and stay talking with him for 40 minutes. Well, everything changes; there are certain standards we must adhere to....” [I_Os_3.3]

This difference in expectations may become a serious issue if there is a large age gap between the doctor and patient. In addition, physicians say, without an opportunity to find things in common and understand how the patient perceives, it is impossible to build up interpersonal contacts – a vital precondition for successful treatment.

“...there is some kind of a time gap between young specialists and these people, and some of their life concepts [differ]. They still retain a Soviet mindset, and Soviet upbringing, while ours are quite
different. It would be difficult to find entry points even to convince him, make that old person trust you. And in the medical profession, success of treatment is achieved, primarily, through communication and the patient’s trust in the attending doctor.” [I_Or_2.4]

Health workers from two regions (Karelia and Oryol Oblast) reported that elderly patients typically had a lower level of trust in both physicians and medicine. Such an attitude may be due to their accumulated negative experience in seeking help from health facilities, and lack of knowledge about the treatment process.

“… some of the patients are rather grumbling and sullen, with a negative attitude to doctors and examinations, they basically do not want to be touched, tortured – as they think.” [I_Kar_2.4]

Recognizing that it is more difficult to provide care to elderly patients because of their physical limitations, a doctor notes that it creates extra problems not only for physicians, but for the patients as well. A disease and its treatment may create problems with movement, meals, micturition and defecation, and other daily needs. With the elderly, such problems are compounded by age-specific issues that existed before the treatment began and make it more difficult for the patient to adapt to a challenging treatment.

“Well, for instance, an elderly person and a young person have a leg broken. The young man today has more opportunities to adapt to the situation for a while, and adjust to, say, self-care. An elderly man will experience problems: for instance, how to crutch, because it can be already difficult for him to move, he is less skilful in moving than a younger person.” [I_Kar_2.3]

When characterizing the elderly as a special group of patients, all the study participants, including the elderly, mentioned psychological problems and specific characteristic of senior-age persons. Discussing problems of the elderly seeking care from health facilities, the respondents frequently referred to vulnerability. Elderly patients need understanding and sympathy in larger measure than middle-aged individuals. In the absence of such an attitude and in response to a doctor’s ill-conceived and careless statements, they quickly take offense.

“We, the elderly, are really more vulnerable… Anyhow, we need a more tolerant, careful, and polite treatment, that’s right. It is really pleasant when you come and there are more kind words....” [FG_Or_3]

“The elderly become just like kids. Even if they have no ache, they want to be talked to and given more attention to. They fear they are dying so they want attention.” [FG_Os_2]

This phenomenon needs more detailed study and discussion with physicians and psychologists. At the current phase of research, it can be assumed that this peculiarity of the elderly may result from (a) natural brain and nervous system impairments that develop with age, (b) the relatively high prevalence of mental problems among the elderly in Russia due to the low availability/affordability of psychologists’ services, (c) lack of social contacts and attention and their desire to make up for this shortage through communication with health workers, and (d) objective difficulties with receiving health care assistance.

The study results show that psychological problems, negative emotions, and bad mood strongly affect the condition of the elderly. Quite often, it is because of these factors rather than real health issues that the elderly visit a doctor: they seek “care” consisting in listening to their problems, showing sympathy, and providing necessary information, and it proves quite effective.

15 This is also confirmed by the results of epidemiological examinations of the elderly (Gurina et al., 2011).
A doctor quoting his patients: “You see, I haven’t even taken my medicines yet, I’ll talk with you, and I will feel better.” [I_Or_2.2]

“…many elderly people call the ambulance not because they are really sick but because they have nobody to speak to.” [I_Or_2.4]

“They need care, attention, sometimes they come simply to talk, to discuss a problem, that is to say they do not even need a doctor but rather a skilled social worker, psychologist, gerontologist… you listen to them, help them, tell them and talk with them – and they already feel better, with their blood pressure back to normal.” [I_Kar_2.1]

The study results show that older people (particularly those over 75) need a special health care mode that both respects the dignity of the elderly and ensures that younger patients’ access to health care is not impaired.

Health authorities can undertake the following initiatives to improve the quality of health care provided to older people:

- Increase the standard time of visits for patients aged over 75.
- Separate patient flows by age (under 75, and over 75).
- Develop premedical examinations.
- Arrange examinations of elderly people by multidisciplinary teams of health workers, including psychologists.
- Provide access to psychologists’ services and psychological assistance services for the elderly (in public sector health facilities and/or social service institutions in the region). It would be appropriate to complement such access with special training for staff of psychological centers in how to work with the elderly.
- Undertake a public awareness campaign on available psychological assistance.

The departments of the Russian Red Cross Society can:

- Cause psychological assistance to be provided to older people.
- Send volunteers to health facilities in the region to help doctors and senior-age patients communicate.

5.1.3. Potential demand of older people for geriatric care and rehabilitation

The national old-age health policies for the coming years cover not only health care to treat diseases, but also the development of preventive and rehabilitative programs for senior-age people. The Strategy of Action for the Benefit of Senior Citizens, its implementation plan, and the Demography National Project include the development of health promotion and restoration services for the elderly, such as geriatric care and rehabilitation, as well as leisure programs for elderly people with higher levels of physical activity. As part of this study, we tried to find out to what extent the elderly seek the health promotion services provided by government.

The study participants demonstrated different attitudes to such initiatives, from the moderately sceptical to the expressly positive.

The provision of such services is supported, first of all, by those who believe that the leisure management problem is relevant. The study results suggest that those people are relatively younger persons who recently entered the older age group and do not have any major health problems. For
such persons, attending health promotion events provides, above all, a good reason to leave their home and mix with their peers.

“My attitude is positive – instead of staying at home. Even when I’m talking to you now I enjoy it. Definitely, when you do exercises time passes faster. Certainly, it is good.” [FG_Os_3]

Second, the introduction of new services is welcomed by the elderly with debilitating health conditions who need rehabilitation but cannot obtain relevant services under the existing health benefit package or cannot afford to pay for them.

“The social protection institution has [rehabilitation] centers, but they are intended for war veterans. For war veterans and the disabled. I went there, and they said: “Bring a disabled person and we’ll admit you.” That’s it, it should be those who are disabled. But if one is not disabled....” [FG_Or_3]

“You see, there are lots of centers in this city helping elderly people to improve their health and have fun, but all of them are for-profit businesses, they are very, very expensive. That is why I wish there were centers affordable for us. We want to use such centers, but they are unaffordable for me. With a pension like mine, of 10,000 roubles, I cannot afford it. There are plenty of them, but I can’t go to such centers.” [FG_Or_5]

Third, the elderly welcome the development of health promotion programs for the older generation because they perceive such measures as a symbolic recognition of their value to the state.

A more cautious attitude to the initiative was shown by people who did not believe that their health could be significantly improved in this way, or those who think that they can provide themselves with the workout activities that are necessary for healthy longevity using their own resources.

Negative opinions were voiced by survey participants living in Ossetia, the region where the most acute problem is lack of basic health care resources such as health services and medicines. In such a context, the population may give low priority to an initiative to promote preventive and rehabilitative services.

The study results show that the development of geriatric care basically meets the needs of older people and gets a positive response from them, except in the regions and communities with poor access to basic health services for senior-age people. People generally perceive geriatric care and rehabilitation as something helpful, but not of primary importance for their health—that is, something that can be replaced with quality leisure if necessary.

5.2. Access to health care

Demand for health services is higher among the elderly because their health is worse than that of younger individuals, and they have a higher number of chronic diseases. Among the working-age population, 7.5 percent visit a doctor once a month or more often. By the age of 65, this percentage increases to 25.5 percent, and in the age group of 75 or older, it reaches 29.9 percent. During recent years there has been an upward trend in the average number of ambulance calls and hospital admissions for older people over 75 in Russia. This trend may indicate both improved access to such services and reduced access to and lower quality of outpatient care.

Elderly people have relatively good access to primary care—general practitioners or catchment area doctors. However, there are barriers impairing access to outpatient care for Russia’s older population: 30 percent of the elderly are dissatisfied with the health care delivery processes (the need for pre-registration, long lines, inattentive attitude, poor conditions for staying in hospital); and around a fourth of the elderly do not think the prescribed treatment will be effective. The importance of mobility issues increases with
Among those aged 75+, there is a substantial increase in the share who do not receive necessary treatment because they cannot get to the place of care delivery.

Elderly people who participated in the qualitative study conducted by the WB, IFRC, and HSE reported the following barriers to health care:

- unavailability of necessary medical care near the place of residence;
- shortage of specialists and diagnostic equipment at public health care facilities (in the opinion of both patients and doctors);
- transportation networks that are inadequate to patients’ needs;
- problems with obtaining the documents required for access to inpatient care and high-tech care; and
- absence of an elder-friendly environment at inpatient facilities.

Telemedicine could be considered as one way to reduce barriers to health services. There is demand from the elderly for the introduction of telemedicine consultations, which could mitigate the spatial barrier to medical services, although some older people would have difficulty using the technology. When this technology is introduced into public sector health facilities, it is essential to also give the elderly people the opportunity to visit a doctor in person.

Besides access to health services, another issue that concerns the elderly is access to pharmaceuticals. According to RLMS-HSE data, spending on pharmaceuticals accounts for over 80 percent of households’ expenses on medical treatment in Russia. Drug benefit packages (for outpatient treatment) cover only some categories of citizens: the disabled, persons with outstanding merits for the nation, and patients with certain diseases. The results of this study confirm that the low accessibility of medicines is one of the most acute problems for the elderly in Russia. The high cost of medication does not always fit well into the elderly person’s budget. Unable to adhere to a doctor’s prescriptions (undergo an examination or buy a medicine), up to 20 percent of elderly people do not see any point in seeking medical care at all—a strategy that results in too-late detection and treatment of diseases and, consequently, more expensive medical treatment for the older population.

5.2.1. Demand of different age groups for health services and opportunities to meet the demand

Older people seek medical care more often than younger people because their general health condition is worse, and they have more chronic diseases. Among working age population, 7.5 percent visit a doctor once a month or more often. By the age of 65, this percentage increases to 25.5 percent, and in the age group of 75 or older, it reaches 29.9 percent (Figure 5.3).
Figure 5.3. Distribution of age groups according to the frequency of visits to a doctor in 2017, %

The sample survey data show that demand for emergency care and outpatient care grows with age. Compared with a person of working age, an elderly person aged 75 or older calls the ambulance, on average, 8 times more often; those aged 65-74, 4 times more often; and the elderly under 65, 2 times more often (Figure 5.4).

According to the RLMS-HSE data, in 2017, 2.9 percent of working-age people were admitted to the hospital during the three months before the survey date. For those under 65, between 65 and 74, and 75 or older, the percentages were 5.2 percent, 8.1 percent, and 9.7 percent, respectively (Figure 5.5).

In recent years there has been an upward trend in the average number of ambulance calls and the likelihood of hospital admission for older people over 75 in Russia. This trend may indicate improved access to such services, on the one hand, and reduced access to and lowered quality of outpatient care, on the other.
Figure 5.4. Average numbers of ambulance calls per year, by age group

Source: RLMS-HSE

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Население трудоспособного возраста</td>
<td>Working age population</td>
</tr>
<tr>
<td>Пожилые до 65 лет</td>
<td>Elderly people under 65</td>
</tr>
<tr>
<td>Пожилые 65-74 лет</td>
<td>Elderly people aged 65 to 74</td>
</tr>
<tr>
<td>Пожилые 75 лет и старше</td>
<td>Elderly people aged 75 or older</td>
</tr>
</tbody>
</table>

Figure 5.5. Average numbers of hospital admissions during the last three months before the survey, by age group

Source: RLMS-HSE

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Население трудоспособного возраста</td>
<td>Working-age population</td>
</tr>
<tr>
<td>Пожилые до 65 лет</td>
<td>Elderly people under 65</td>
</tr>
<tr>
<td>Пожилые 65-74 лет</td>
<td>Elderly people aged 65 to 74</td>
</tr>
<tr>
<td>Пожилые 75 лет и старше</td>
<td>Elderly people aged 75 or older</td>
</tr>
</tbody>
</table>
In Russia, the elderly are forced to give up necessary health care more often than working age people. According to data of the Comprehensive Monitoring of Living Conditions (CMLC) conducted in 2016, between 38.9 percent and 43.5 percent of the elderly did not seek necessary health care at least once during the previous year. Among working-age people, only 30.1 percent did not seek care. In 2011-2016, decisions against seeking needed health services were less widespread (Figure 5.6), but their number still remained significant, particularly among elderly persons over 75.

Figure 5.6. Shares of those who did not seek needed primary health care (medical examination or consultation) during the current year, %

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>35.2</td>
<td>42.7</td>
</tr>
</tbody>
</table>

In 2016, nearly half of the elderly assessing their health as “poor” or “very poor,” and nearly one-fourth of senior-age people assessing their health as “good” or “very good,” faced reduced access to primary health care in Russia (Table 5.2). The more frequently the person needs treatment, the higher is their risk of not receiving it in primary care settings. Problems with obtaining needed care are also more typical of elderly women, low-income elderly persons, and the residents of large cities with a population of more than 500,000—possibly because of the need to travel long distances in large cities to get medical care. Elderly people helping their children with money also decide against necessary treatment more often.

Table 5.2. Shares of people above working age who did not seek necessary primary health care (medical examination or consultation) during the current year (2016), by social and demographic group, %

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>35.2</td>
<td>42.7</td>
</tr>
</tbody>
</table>

Source: CMLC (Rosstat).
<table>
<thead>
<tr>
<th>Quality Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- good or very good</td>
<td>25.7</td>
</tr>
<tr>
<td>- average, neither good nor poor</td>
<td>38.7</td>
</tr>
<tr>
<td>- poor or very poor</td>
<td>50.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household Income Level (Quintile Groups)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 1 (poor)</td>
<td>40.9</td>
</tr>
<tr>
<td>- 2</td>
<td>41.9</td>
</tr>
<tr>
<td>- 3</td>
<td>42.5</td>
</tr>
<tr>
<td>- 4</td>
<td>39.4</td>
</tr>
<tr>
<td>- 5 (rich)</td>
<td>37.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Populated Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Moscow and St. Petersburg</td>
<td>38.1</td>
</tr>
<tr>
<td>- cities with a population of 500,000 or more</td>
<td>44.3</td>
</tr>
<tr>
<td>- cities with a population of 50,000-499,000</td>
<td>39.7</td>
</tr>
<tr>
<td>- cities with a population of less than 50,000</td>
<td>40.7</td>
</tr>
<tr>
<td>- rural area</td>
<td>39.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provide Financial Assistance to Their Children</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- yes</td>
<td>44.2</td>
</tr>
<tr>
<td>- no</td>
<td>39.8</td>
</tr>
</tbody>
</table>

*Source: CMLC-2016 (Rosstat).*

Unlike access to primary care, access to secondary outpatient care and inpatient care differs much less between working-age people and the elderly. Among senior-age people, 74.9 percent of those referred to local polyclinics and hospitals can count on complete compliance with the referrals, although the shares are lower among those referred to tertiary health facilities (specialized medical centers) and to high-tech care: 64.3 percent and 58.2 percent, respectively. Access to these medical services for the working-age population is similar to that for the elderly (Table 5.3).
Table 5.3. Chances to receive medical care (treatment or examination) upon doctor’s referral to health facilities of different levels in 2015-2016, %

<table>
<thead>
<tr>
<th></th>
<th>Among those referred to treatment or examination</th>
<th>Among those who have not managed to undergo treatment or examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully examined or treated</td>
<td>Partially examined or treated</td>
</tr>
<tr>
<td>Referred to a territorial polyclinic/hospital</td>
<td>71.0</td>
<td>20.3</td>
</tr>
<tr>
<td>Referred to a tertiary care provider</td>
<td>68.1</td>
<td>22.5</td>
</tr>
<tr>
<td>Referred to a special medical center for high-tech treatment</td>
<td>54.6</td>
<td>28.5</td>
</tr>
</tbody>
</table>

The CMLC data show that on average elderly citizens have to wait longer to visit a district doctor or to be admitted to a hospital (Table 5.4). The differences can be due both to the fact that the elderly who have stopped working have more free time and to the lack of resources that would allow reducing the waiting time (extra money to pay for treatment without a waiting list, physical ability to look for another treatment facility).

### 5.2.2. Barriers hindering access to health care for the elderly

The data from sample surveys show that after contacting the health care system, the elderly receive prescribed treatment no less successfully than working-age individuals. But as the qualitative survey data confirm, the very entry into the system—the first contacts with it to address a health problem—may be difficult. During the focus group sessions and interviews, both elderly people and health workers point to problems with getting consultation from a specialist and undergoing diagnostic examinations recommended by the primary care doctor or general practitioner.

Elderly people have relatively good access to primary care—general practitioners or catchment area doctors. Participants in the study reported no problems with access to these doctors. Barriers to primary health care would be lower if older people were able to call a doctor (for a home visit). Few rural residents report that they can get consultations from their local feldshers, saying that their community-based feldsher and midwife facility is in place, but it is not operational because it is staffed with a medical worker who was reappointed to another facility.

Source: CMLC-2016 (Rosstat).
The CMLC data convey a general idea of the barriers to accessing primary care for Russia’s older population. The survey results show that approximately half of the population deciding against treatment prefer self-treatment, even when they are ready to admit that they need specialist care (although in the most senior group of 75+, the percentage is slightly lower 46.9%) (Figure 5.7). The most widespread reason for reluctance to get medical treatment—on the part of both working-age and older people—is dissatisfaction with the health care delivery processes.

Around a fourth of the elderly who decide against medical treatment do not deem prescribed treatment to be effective; this reason is less common among the working-age population. It is possible that more elderly people have more serious health problems that are difficult to address, as well as previous negative experience with medical treatment. The survey results show that in the older age groups, time shortage as a health care barrier becomes less important, while the importance of mobility issues grows: by the age of 75+, a substantially greater percentage of people do not receive necessary treatment because they are unable to get to the place of care delivery.
Figure 5.7. Reasons for deciding against seeking necessary health care (medical examination or consultation), %

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Не рассчитываю на эффективное лечение (нет нужных специалистов, необходимых медикаментов или оборудования)</td>
<td>I do not count on effective treatment (there are no necessary specialists, medicines, or equipment)</td>
</tr>
<tr>
<td>Не удовлетворяет работа медорганизации</td>
<td>I am not satisfied with the performance of the health facility (need for making an appointment beforehand, long waiting lines, lack of consideration, inadequate settings of the consultation, or…)</td>
</tr>
<tr>
<td>Не могу добираться до медорганизации без посторонней помощи</td>
<td>I cannot get to the health facility without other people’s help</td>
</tr>
<tr>
<td>Было тяжело добраться до медорганизации</td>
<td>It was difficult to get to the health facility</td>
</tr>
<tr>
<td>Не расположал информацией о том, где можно получить не-обходимую медицинскую помощь</td>
<td></td>
</tr>
<tr>
<td>Не было времени</td>
<td></td>
</tr>
<tr>
<td>Необходимое лечение можно получить только на платной основе</td>
<td></td>
</tr>
<tr>
<td>Предпочитаю лечься сам (сама)</td>
<td></td>
</tr>
<tr>
<td>Другие причины</td>
<td></td>
</tr>
</tbody>
</table>

Source: CMLC-2016 (Rosstat).
Most study participants attributed their problems with diagnostic examinations and consultations of specialists to the need to cover long distances. It is not always possible to provide such services within a walking distance from the residence or during a doctor’s home visits. Traveling to a remote health facility may be a problem for an elderly person.

“…we only have a general practitioner, now they are called family doctors. With any health problem we go to see the general practitioner, and she refers you to rayon health center... And we should travel to Pervomaysky.” [FG_Kar_4]

“…it mostly affects people with limited mobility because a general practitioner can visit such a person any day and examine him/her. But a specialist doctor cannot visit them at home.” [I_Or_2.4]

The problem is aggravated by the shortage of medical specialists and impossibility of undergoing all necessary examinations at public sector health facilities. It should be noted that not only patients reported reduced accessibility to the services concerned (some patients count on obtaining all possible services from polyclinics at the place of residence despite the principles of multi-tier health care delivery); insufficient availability of medical staff and diagnostic equipment for public polyclinics is also reported by physicians taking part in the study.

“Few specialists. A shortage. A great shortage of specialists. Very long waiting lists, appointments are to be made nearly one or two months in advance.” [I_Or_2.1]

“What is available to us free of charge under mandatory health insurance sometimes is insufficient to establish a diagnosis. And sometimes, patients have to... It is a number of laboratory tests when it is necessary to make the meaning perfectly plain i.e. to have the diagnosis confirmed with laboratory tests. Unfortunately, not all of those tests are done here.” [I_Or_2.1]

“And we cannot always provide diagnostic services. Certainly, it is MRI, Contrast CT that gives a better picture. And definitely, it is proctologic examinations. There are a lot of intestinal cancers, and unfortunately, when the patients come, they are already at an advanced stage. Because proctology is about areas difficult to reach, and it is not always possible to do... In addition, accordingly, there is a long waiting list for the examination. It is X-ray, irrigoscopy, Holter monitoring... Many patients need Holter monitoring of blood pressure, ECG – we also have long waiting lines.” [I_Or_2.1]

Another barrier to delivering health care to the elderly is underdeveloped transport networks, including within a city or village.

“A friend of mine went to a medical examination – she did not know how she could get back home after 8:30 pm.” [FG_Kar_4]
Of the regions under review, the problem of low transport accessibility is greater in Karelia, where the population density is low and a large number of remote localities have no health care infrastructure. The study participants from North Ossetia more often mentioned high treatment costs and problems with getting free services, which may result from a more significant shortage of health workers or medical equipment in the region (it is impossible to get free medical care even in another locality). Cost is a particularly important factor for the people of North Ossetia, which has the lowest per capita income of the three regions under study.

Writing about the lower mobility of the elderly in Russia, D. Rogozin (Рогозин, 2018б) agrees that age-related factors, limiting physical abilities, and low incomes all contribute to it. At the same time, this author also attaches some blame to elderly people themselves, who, he believes, may be prone to inertia because of their attitude that there is no sense in being active in older age because their lives have already “run their course” (Рогозин 2018а, б). Although D. Rogozin raises the issue of inertia in the context of older people’s reluctance to travel and explore the world, part of their refusal to seek health care may be attributable to inertia as well.

When older people suffer from a disease (and, as we have seen, many elderly persons postpone their visits to a doctor until their health condition significantly worsens), and it is impossible to wait for their turn on the waiting list for consultation or examination, senior-age people seek paid services, which can strongly affect their budget.

“I paid a fee to see a neuropathologist… When one feels really unwell, and it is impossible to get an appointment [at a public sector polyclinic], then one has to find a way to see a doctor, and if the right doctor is not available, then you pay for the visit.” [I_Kar_1.3]

“…all doctors want your test results, and tests are done in laboratories for pay. There is an ultrasound investigation room on the ground floor of almost every house in town. The prices are exorbitant. Tests cost lots of money.” [FG_Os_5]

Older people express particular indignation over informal out-of-pocket payments for unknown benefits – cases when the necessity to pay is established personally by the physician rather than by the health facility. In such cases, a health worker does not explicitly and directly require a payment, but just hints at it in a non-transparent manner. Being excluded from part of the information flows, the elderly may be unable to guess on what conditions the services are provided until the physician spells them out.

During the study, problems with access to high-tech medical care were not frequently reported. However, the informants mentioned a number of problems that a senior-age person may face when undergoing such treatment, besides the problem of getting a quota for free treatment. First, an elderly individual may face problems when getting ready for treatment because high-tech medical care is preceded by multiple tests and examinations that require effort and, possibly, extra costs. In addition, referrals to high-tech medical care often require complicated documentary processing.

“One has to undergo examinations, lots of tests, lots of consultations. That is why not everybody is able to undergo such a large volume of examinations to make it to the next stage [of treatment].” [I.Or_2.2]

Second, since high-tech medical care is not provided everywhere, to undergo such treatment a patient has to incur extra costs for travelling to a high-tech care center and staying there; it is also necessary to have a good sense of direction in an unknown area. And although a middle-aged person can easily cope with these problems, an elderly person may perceive them as an impassable barrier to receiving necessary care.
Limited mobility can be a barrier to an elderly person’s receiving medical services not only in outpatient settings (when the place of treatment is other than their place of permanent residence) but also in inpatient settings. Health facilities are not always accessible environments: a person with disabilities may have to walk long distances for necessary diagnostic services, medical procedures, and even personal hygiene procedures. If the health facility has no personnel to help patients to move around and these functions cannot be performed by a relative, mobility may turn into a serious issue for the patient, or may result in his refusal to undergo necessary treatment.

“For instance, somebody has low mobility, they suggest he should go to hospital for treatment. And he refuses. The question is – why? He explains: ‘My ward is in one part of the corridor, and the bathroom is in the other part of the corridor.’ And he suffers from low mobility. The others somehow make it from one part of the corridor to the other. If he could get a room with a bath, it would not happen. That’s why they often refuse: it's a problem for them. He needs treatment under some kind of medical supervision that would be good for him because they have nurses and doctors there. So it would be better for him, but as there are no proper conditions there, he refuses to stay at hospital.”

5.2.3. Access to pharmaceuticals for the elderly

In addition to lower access to certain health services, another burning issue for the elderly is access to pharmaceuticals. According to RLMS-HSE data, spending on pharmaceuticals accounts for over 80 percent of households’ expenses on health services in Russia. In 2017, an average Russian household with an elderly person spent 2.5 times more on health services, including pharmaceuticals, than an average household with only working-age and younger members. In 2008-2017, households with elderly members increased their health care spending by 70 percent in real terms (Figure 5.8); the increase for households with middle-age and younger members was less significant, around 17 percent.

Pharmaceuticals used for hospital and emergency care are covered by the Health Benefit Package. But most pharmaceuticals for outpatient care are paid for by patients. The existing drug supply benefit packages (for outpatient treatment) cover only certain eligible categories of citizens: the disabled, persons with outstanding merits for the nation, and patients with certain diseases. Not all prescribed pharmaceuticals are made available. During QAS-2017, only 18.8 percent of Russia’s elderly respondents reported that they were eligible for free or subsidized drugs; most of them have the cost of drugs covered from the bundle of social services (Table 5.5). People eligible to have drug supply benefits for outpatient treatment accounted for 12.2 percent of the elderly under 65, 23.2 percent of those between 65 and 74, and 33.7 percent of those aged 75+.

According to the study results, among Russia’s elderly people without permanent disability, only 8.3 percent have drug supply coverage, and half of them are persons with certain diseases.

---

16 The assessment did not take into account households’ spending on long-term nursing care because the RLMS-HSE questionnaire lacked questions on that subject.
18 Under the federal legislation (Federal Laws No.178-FZ, No.77-FZ, No.38-FZ, No.323-FZ, and Resolution of the Government of the Russian Federation No.890), the following diagnoses make patients eligible for subsidized medicines: tuberculosis, HIV, malignant neoplasms of lymphoid, hematopoietic and related tissues, hemophilia, mucoviscidosis (cystic fibrosis), pituitary dwarfism, Gaucher disease, multiple sclerosis, organ (tissue)
Figure 5.8. Increase in households’ per capita spending on treatment in real terms relative to 2008, %

![Graph showing the increase in households' per capita spending on treatment in real terms relative to 2008.]

*Source:* RLMS-HSE.

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Домохозяйства с пожилыми</td>
<td>Households with elderly members</td>
</tr>
<tr>
<td>Домохозяйства без пожилых</td>
<td>Households without elderly members</td>
</tr>
</tbody>
</table>

Table 5.5. Percentage of older population eligible for fully or partially subsidized drug supply, %

<table>
<thead>
<tr>
<th></th>
<th>Eligible for a drug supply benefit</th>
<th>including as part of the bundle of social services</th>
<th>as a patient with a chronic disease</th>
<th>for other reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population over working age</td>
<td>18.8</td>
<td>10.9</td>
<td>6.1</td>
<td>1.8</td>
</tr>
<tr>
<td>Older population without disability</td>
<td>8.3</td>
<td>1.8</td>
<td>4.6</td>
<td>1.8</td>
</tr>
</tbody>
</table>

*Source:* QAS-2017 (Rosstat).

The results of the quality survey confirm that reduced accessibility of medicines is one of the most acute and widespread problems for the elderly in Russia. The study participants, even those who have just entered the elderly cohort, report that they take a lot of medications prescribed by their doctors. The high cost of medication (1,000 roubles or more for each) does not always fit well into the elderly person’s budget.

“I spend a third of my pension on medications alone. I only get free medications for diabetes. The rest has to be bought, you see?” [FG_Kar_4]

“What does a pensioner spend his pension on? Food and medicines. The cheapest medicines cost 500 roubles but our pension is 10-12 thousand.” [FG_Or_5]

“We’d rather not buy some food, but we buy medications.” [FG_Kar_4]

transplantation, cerebral paralysis, hematological diseases, bronchial asthma, rheumatic and hemorrhagic diseases, rheumatism, diabetes, Parkinson disease, glaucoma and cataract, schizophrenia and epilepsy, and acute myocardial infarction (for the first six months of treatment).
The shortage of money can make an elderly person give up taking some of prescribed medicines and replace them with cheaper generics—a practice that, as doctors recognize, may adversely affect the patient’s health.

“…medications are sometimes very expensive. But the patient has to take not just one or two medications. The elderly quite often have comorbidities, they suffer from multiple diseases. They certainly try to use cheaper products, but unfortunately sometimes they do not have a positive effect.” [I_Or_2.1]

“They don’t know whether they should buy something to eat or some medication. And, incidentally, many of them give up vital medications.” [I_Or_2.2]

One of the strategies to cope with the circumstances is obtaining disability status. In that way, the elderly try to acquire a formal status that would entitle them to a higher pension or allow them to get some of their medications at a subsidized price. But even the elderly who are eligible for subsidized provision of medicines are not happy with the drug supply. For various reasons, it is not guaranteed that they will get the necessary medicine.

“I have quite a complicated and grave disease for which free treatment should be provided under our laws. Since last October, and today is the end of April, our government has not been able to provide me with this medication free of charge. The laws were adopted in such a way that it is next to impossible to get such a drug.” [FG_Or_1]

Polypharmacy—that is, the simultaneous prescription of multiple (sometimes excessive) drugs—is another reason for the high costs elderly people incur for their pharmaceuticals. An elderly person suffering from a variety of chronic diseases gets pharmaceutical prescriptions from several specialists at once. Unless the total number of administered pharmaceuticals for a patient is under control, the treatment may not only inflict economic damage, but also be detrimental to the patient’s health. A health worker who participated in the survey admits that such a problem exists, but thinks that the present day health care system is not adequately resourced to counteract it. For this reason, older people may decide on their own to quit using prescribed pharmaceuticals—but if such a decision is taken without consulting the attending physician, it may harm the patient.

“Once a truckload of pharmaceuticals was prescribed, and another truckload to lower cholesterol. But I decided against taking those drugs.” [I_Or_1.2]

Some people over 75 have to give up taking some of prescribed medicines because of their inconvenient dosage formulation. Problems with the mouth cavity and difficulties with swallowing can make taking pills inconvenient and dangerous for some patients. Not knowing how to resolve the problem, their relatives decide to stop administering drugs.

“She started choking on pills. You give her a pill, she cannot swallow it, and we had problems. Then we started crumbling and dissolving [the pills]. And of late there has been something generally wrong about it so we give her pills only if badly needed.” [I_Kar_1.3]

Unable to adhere to doctors’ prescriptions (undergo an examination or buy a medicine), the elderly do not see any point in seeking medical care at all. Given reduced access to health services and medications, self-treatment turns into a popular strategy for senior-age persons who want to remain healthy.

“The doctor prescribes you something. You go to a pharmacy, look at the prices, and start self-treatment. And then you think: why did I go to see a doctor?
Patients’ stories help to understand the emergence of the group of elderly people who refuse to seek necessary health care and say that they prefer self-treatment (Figure 5.7). But this strategy results in too-late detection and treatment of diseases, and consequently, more expensive medical treatment for older people. It is important to underline that this dangerous health strategy is quite widespread – according to the sample surveys, it is practiced by up to 20 percent of older people.

5.2.4. Remote consultations as a means of improving access to health care: opinions of the elderly

The Federal Law On Amending Selected Laws of the Russian Federation Related to the Use of Information Technology in Health Care introduced telemedicine as a new mode of service delivery. This amendment allows monitoring and consulting the patient remotely if the diagnosis was made earlier during a visit to the doctor in person. This technology has the potential to improve access to medical care for older people: people with low mobility may “visit” a doctor without leaving their home. While the use of such technology helps overcome the spatial barrier to necessary treatment, which is most important for the elderly in Russia, it highlights another barrier: many elderly people find it difficult to learn how to use advanced technology. A question about the attractiveness of telemedicine was asked during our study.

Although some of focus group participants provided negative feedback in response to the description of the technology, there were also some who supported its development—particularly those under 65 (they seem to be more confident IT users) and disabled people (the problem of limited mobility is more familiar to them).

Older people welcome the introduction of remote consultations as they:

- do not deem it too difficult to learn how to use new technology – today computer literacy courses are available to the elderly;
- may have grave diseases that considerably limit their mobility;
- believe that polyclinics are overloaded, and technology will help to reduce the number of patients seeking care; and
- have experience in remote consultations – perhaps over the phone when calling an ambulance.

One important factor in favor of introducing remote consultations is elderly people’s lack of awareness of their health and of the side effects of treatment. This issue was repeatedly raised during the focus group discussions and interviews. At present, in the few minutes most physicians can spend communicating with the patient, older patients may not be able to get answers to all their questions (and there is little possibility of getting a prompt follow-up appointment, even if necessary). The elderly often have difficulties adhering to outpatient treatment prescribed by the doctor (for example, there may be unexpected adverse drug reactions and complications), and the problem cannot be discussed promptly with health workers.
“Upon making an appointment, you come to the clinic and always have to wait to see the doctor there for hours ... It would be good to have such a center where a medical doctor could be available for consultations about pharmaceuticals.” [FG-Or_5]

In particular, survey participants reported about such situations when talking about chemotherapy in day-care settings: after the drug is administered, they go home on their own and have to cope with the consequences of the treatment also on their own, trying to guess whether they are normal or should seek a follow-up visit with the doctor. Remote medical consultations can help to address this issue, enabling a patient to contact a doctor promptly.

Quite expectedly, those older people who are against the introduction of new technology mention that elderly people often have limited access to the Internet. In addition, the proposed technology leaves elderly patients without the communication component of health care that is so important for them and includes personal contact and the opportunity to see the doctor’s empathy or to establish relations of trust.

“We need communication in person. We need to talk, to get advice. And I don’t know how the Internet can help, I need to see the person.” [FG_Os_3]

Both elderly patients and medical workers believe that the remote nature of such communication may hinder information exchange – a process that in itself is difficult for senior-age patients.

“The distance is huge, he doesn’t seem to understand you.” [FG_Os_2]

“… it is not always possible to bring the idea home to them even when talking to them directly, to make sure they understand you correctly. And when it is all from a distance it’s even more difficult, I don’t know. It seems impossible to me!” [I_Or_2.3]

In summary, the study showed that there is demand from senior-age people for the introduction of telemedicine consultations, which can help mitigate the spatial barrier to medical services. However, such a service cannot be recommended on a mass scale, to all senior-age people. Even when this technology is introduced into public sector health facilities, it is essential to give the elderly the opportunity to visit a doctor in person.

5.2.5. Recommendations on how to improve access to health care for older people

Results of qualitative and quantitative analyses show that, above all, it is primary care that is inaccessible to the older population in Russia. After senior-age people consult medical workers and comply with their first prescriptions for diagnostics, their chances of receiving further treatment are no lower than those of working-age people. But the transition to the next level of care is difficult because of a lack of medical human resources and required diagnostic equipment in health facilities; poorly developed transport networks; the organization of inpatient treatment without adjustments for elderly people’s low mobility; the high cost of prescribed medicines and certain diagnostic services that may not be provided free of charge; and complicated documentary procedures for processing referrals to high-tech medical care. These barriers often induce older people to rely on self-treatment and to seek medical care only in an emergency. The problems identified by the interviewees and in the focus groups did not include issues with after-care and rehabilitation that follow treatment at the secondary and tertiary levels of care. But we may assume that, while they are important for patients of any age, they may be particularly painful for the elderly who have physical impairments that are due not only to their disease but also to their age.
Over the coming years, the government intends, to improve access to primary care by expanding the Health National Project to include measures to provide medical care to people living in remote areas, and to address the shortage of human resources at public sector health facilities. In addition, the following measures could be taken to improve access to health care for older people.

For public authorities:

- Introduce remote health consultations in big settlements and ensure wide access to the Internet. The target group for such a program can be elderly people with limited mobility who are registered and monitored by health facilities. To provide a more accessible option for communication via the Internet, a 24/7 call center for elderly patients could be established.
- Expand drug supply programs and the list of subsidized pharmaceuticals for the elderly. Drug supply benefits may be provided to the elderly with low income.
- Improve access to diagnostic examinations: provide (partial) compensation for the cost of examinations when it is impossible to undergo them at a public sector health facility.
- Provide support to patients referred to high-tech medical care, including assisting with documentation processing and formalities, accompanying patients going to another city/settlement, and compensating travel expenses for poor senior-age people.
- Create accessible environments in health facilities in the region by:
  - (a) locating the offices of specialists who are in high demand among the elderly on the ground floors of health facilities,
  - (b) locating hospital wards so as to ensure their accessibility for low-mobility patients, and
  - (c) causing civic watch to be in place to monitor health facilities’ performance under the Accessible Environment Program to identify the facilities and departments that fail to meet the program requirements.

For the Russian Red Cross Society departments:

- Develop volunteer work in health facilities, assisting elderly patients with moving inside the health facility, during the doctor’s consultation, and going to other areas to receive high-tech medical care.
- Provide assistance in putting in place a civic watch to monitor performance under the Accessible Environment Program.
- Provide consulting support to older people regarding opportunities for obtaining medical care from health facilities in the community, region, or country.

5.3. Satisfaction with the health services provided

Though older people are generally satisfied with the quality of medical care, they express negative emotions about (a) problems with health care delivery, long waits for care to be provided, and the need to adhere to certain prescriptions and re-execute certain papers; (b) lack of correlation between the expected and actual outcomes of the treatment; and (c) a rude and inconsiderate attitude of some medical workers, and their reluctance to take into account physical and cognitive disorders affecting the elderly. Medical workers, on their part, often recognize that it is difficult for them to establish contact and communicate with elderly patients. The study showed that medical workers, though provided with sufficient information about elderly patients’ diseases, needed training to develop communication skills for dealing with elderly patients.
When there are barriers to obtaining medical care, the problem of satisfaction with medical services takes a back seat for Russia’s older population. For instance, households with elderly members are satisfied with outpatient care to the same extent as households without elderly members (Figure 5.9).

Figure 5.9. Satisfaction of households with members of different ages with the performance of their polyclinics, %

The results of the quality study allow us to rate the level of satisfaction as moderate: during the interviews and focus group sessions, elderly people not only spoke about their problems in communicating with medical workers (when services proved to be worse than they had expected), but were also ready to reward those who treated them. In general, when describing the quality of provided care, people sounded less negative than when describing problems with access to health care.

These findings correspond to results reported by other authors (Максимова Т.М., Лушкина Н.П., 2012). The World Health Survey, conducted in 2003, showed that Russian senior-age people were less fastidious about the specifics of the health services they received than their peers in European countries, India, and China. For this reason, the high rates of satisfaction with provided health services may be regarded as a result of lower standards rather than as a sign of really high-quality of treatment.
5.3.1. Elderly patients’ complaints about the quality and delivery of health care

When positively assessing the care they received, the elderly mostly remembered particular physicians who had proved to be good specialists, or had displayed good personal qualities (attention and empathy to the patient).

Complaints of elderly patients about the quality of medical services are mostly due to:

- malevolent and unreasonably hostile attitudes of medical workers;

  “…. I get in – there is a young woman sitting there with a cup of coffee. So she is sitting, and then barks at me: “Let me finish my tea!” I turned back and left. Is that a doctor?!” [FG_Os_5]

- ineffective (too formal) medical treatment, according to them; and

  “They keep you for two weeks and then discharge, and then bring you back again. They’ll discharge you after two weeks for sure. And the day after you have [to call] the ambulance once again.” [FG_Os_5]

- long waiting time and problems with care delivery.

  I have been going there for five months, and can’t have my samples taken for tests. If a person is ill, take him to hospital, do tests, but they make you hand in the samples. Pay for everything, and then you will have to undergo tests again there [in the hospital]. That’s unfair.” [FG_Os_3]

Elderly people’s complaints about the low effectiveness of treatment should be discussed in more detail. Without special medical knowledge, a patient is incapable of assessing the treatment outcome and adequacy of the prescriptions at a competent level. The problem in this case is that the treatment outcome did not correlate with what the patient had expected. During the study, both elderly people and physicians mentioned that through the Internet, health information has become more accessible to people without a medical background. As a result, patients get more involved in the treatment process, each with his/her own expectations about the treatment process. It seems that elderly people, with more free time and a deeper immersion into their body problems, generate such expectations more actively than middle-aged patients. Therefore, the attending physician needs to get more involved in shaping these expectations by providing more detailed information about the prescriptions and treatment outcomes. Improved knowledge about health turns the patients into more active participants in the treatment process.

5.3.2. Training of health personnel in working with patients of older ages

Elderly people’s satisfaction with medical services depends not only on physicians’ general professionalism, but also on their ability to deal with elderly patients, taking into account their age-related specifics. During the study, we asked medical workers to estimate to what extent they were prepared to deal with senior-age patients.

Most doctors and nurses participating in the study had not had any special training in working with the elderly. Some specialists mentioned that they had attended a brief course in gerontology as part of basic medical education.

“We had a course, yes, only at the college, it was over eight years ago, it was a gerontology course, that was all.” [I_Kar_2.4]
Some doctors manage to obtain special knowledge as part of in-service professional development, and some health facilities have taken their own initiatives to train their personnel in dealing with senior-age patients. A head nurse who spoke about this activity at her hospital described it as a program, though it appeared from what she said that coaching the personnel on how to work with the elderly was part of her daily responsibilities and was not formalized as a training session.

“For instance, as a head nurse I, first of all, always train our nurses according to the schedule. I get together nurses from our unit, train them both individually and in a group. If a difficult situation arises, the nurses come up to me, we find a solution together... and I always give instructions...” [I_Kar_2.4]

The need for such an approach is primarily due to the undersupply of special training programs for delivering care to senior-age patients. The work to develop such programs in the regions is only starting.

“Since 2019, we have been starting this work for geriatrics, that is, we are starting specifically certified cycles. We are planning to provide formal training to physicians to obtain a special certificate, to receive special knowledge, because there is a lot of information required for working with senior-age people.” [I_Kar_3.1]

In reply to the question about missing the knowledge needed to successfully treat the elderly, medical workers often point to programs to develop communication skills. They often feel no need for additional special knowledge on older people’s health.

“It is gerontology and social psychology because knowledge is needed to be able to apply it specifically in your work. Not to lose any time when receiving patients. If we undergo training, we’ll do everything quicker.” [I_Kar_2.1]

“It may lack… some knowledge in psychology. Because older age makes people more vulnerable, some people become more aggressive due to their diseases, more reserved, plus their personality is affected by atherosclerotic changes. And therefore, sometimes you do not feel confident of your knowledge.” [I_Kar_3.1]

5.3.3. Recommendations on how to improve older people’s satisfaction with health services

Although Russia’s older population is generally satisfied with the quality of the medical care they receive, they feel negative emotions during treatment because of (a) problems with health care delivery, having to wait a long time for care to be provided, and the need to adhere to certain prescriptions and re-execute certain papers; (b) lack of correlation between the expected and actual outcomes of the treatment; and (c) a rude and inconsiderate attitude of medical workers and their reluctance to take into account the physical and cognitive disorders that affect the elderly. Medical workers, for their part, often recognize that it is difficult for them to establish contact and communicate with elderly patients. Physicians believe that problems in communicating with patients can impair treatment effectiveness, and that it is important to remove such problems to improve the quality of health care for older persons. The study showed that medical workers, though provided with sufficient information about elderly patients’ diseases, needed training to develop skills in communicating with elderly patients. Since nearly all medical workers taking part in the study recognized the existence of this need, it is likely that there is a large demand for such training programs.
The following measures could help to raise patients’ satisfaction with the health services they receive.

Measures to be taken by public authorities:

- Developing simplified paperwork procedures for senior-age patients to obtain treatment (inpatient care, high-tech medical care).
- Developing a communication strategy (set of recommendations for medical workers) for interacting with older patients with due regard to the psychological peculiarities of the elderly, their abilities, and their needs for information about their health and expected treatment outcomes.
- Developing expanded modules on patient and elderly psychology, and practical training modules on communication with the elderly, and incorporating them into the medical training programs and in-service professional development programs for doctors and nursing staff.
- Improving access to psychologists’ services for senior-age patients and medical and social workers by means of referrals of patients with suspected disorders (by the general practitioner) and training sessions, and by engaging psychologists to settle conflicts between elderly patients and doctors/health facilities.
- Putting forward proposals for health insurance organizations to introduce additional initiatives to protect the rights of senior-age patients.

Measures to be taken by the departments of the Russian Red Cross Society:

- Implementing educational and awareness activities for medical and social workers and elderly people’s relatives to inform them about how to communicate with the elderly.
6. SOCIAL SERVICES

6.1. Needs in social services

The study finds that the demand for social services is not fully met. Typically, people under 75 years of age are still capable of self-maintenance and do not need others’ help. Above 75 years of age, health problems and the need for care increase. Older people prefer getting help from their family and relatives, and they apply for the help of a social worker if they have no relatives or when relatives live far away or work. The respondents spoke about serious problems associated with the inconsistent availability of family care and the lack of other forms of social services. At present, social workers are not obliged, and do not have time, to provide required services, and they acknowledge that they cannot always identify those in need of care. In addition, the social service system does not have sufficient resources to provide such assistance.

For long-term care, relatives’ assistance is a substantial resource: their involvement helps to reduce public spending on home care and increase the satisfaction of the elderly person. The problem is that the government does not provide regular support to relatives. Government support is limited to paying small benefits and does not include training and non-cash benefits.

Most of the elderly prefer to get social services from public sector providers. The advantages of having public social workers are that they are responsible and prepared, and the social protection organization is monitored by the government. According to elderly people, it is easier to exercise control over public social workers; their personnel turnover is lower, so that the same social worker will give care to the person for a longer time. Their explicit disadvantage is that they are overloaded with clients, and their salary is low.

The key barrier for turning to a private provider is the low income of elderly people, on the one hand, and the potentially high rates of commercial caregiving services, on the other hand. Another barrier is the fear that private service providers may prove dishonest. Paid services are often associated with high quality, but in some cases, greater trust in public social protection makes relatives pay the social workers directly rather than turn to for-profit companies.

6.1.1. Needs in nursing care in older age

According to QAS-2017, 44.9 percent of the elderly had physical limitations: 37.2 percent suffered from minor limitations, 7.1 percent were affected by significant limitations in their everyday life, and less than 1 percent of the respondents were confined to bed. However, in 2017, social services were provided to only 2 percent of people above working age, although 7.2 percent of them had a disability status. Another 3.4 percent of the elderly reported that they needed social services (either already provided or desired to be provided). Among disabled elderly people, this percentage was as high as 11.4 percent, and among people aged 75 and older it was 12.3 percent (Table 6.1). The shares of people needing services are particularly high in large cities (Moscow and St. Petersburg), as well as in rural areas with low-level infrastructure.

Table 6.1. Shares of elderly people in need of social services, by group of population: 2017, %

<table>
<thead>
<tr>
<th>Disability:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- those with disability</td>
<td>11.5</td>
</tr>
<tr>
<td>- those without disability</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Data from both the surveys and interviews show that, in general, people under 75 are still capable of self-care and do not need outside help. Sometimes they say that it is difficult for them to lift and carry heavy items or do certain chores at home. Regular assistance is most often required by people over 80; and in their category, not everybody was able even to answer questions during interviews without help.

And yet, even though senior-age people start needing assistance in their everyday chores (if only because they get tired too fast) and communication, too many of them are not willing to ask for help, and are trying to endure pain and inconveniences, and do things on their own. That is typical of both the younger elderly and those over 75. Many elderly people view the ability for self-care without asking for assistance as a kind of marker that shows that they are not too old yet.

What is noticeable is the difference in the assessments of the need for, and accessibility of, outside help even when the person is confined to bed and needs intensive nursing care. The need for assistance in everyday activities when one is quite elderly is nothing to be ashamed of, but the need for intensive nursing care—including the fear of the impossibility of having such care—is seen as a horrible thing. The elderly sometimes try not to think about that option.

“If I live to be like that, I will not live at all. I don’t need help.” [I_Kar_1.2_1]

6.1.2. Family care or professional social services?

According to QAS-2017, 4.8 percent of the entire adult population, and 18.5 percent of elderly people with disability, need medical and sanitary procedures carried out at home. With very few exceptions, all of the elderly who need such procedures receive them, but most often they are provided by informal providers (Figure 6.1). For instance, in most cases (62-72%) medical and sanitary procedures for the elderly, primarily those who are disabled, are provided by their family members or friends. Care from social workers was received by 11.0 percent of the elderly without confirmed disability, and 17.2 percent of the elderly with disability. On the whole, only one-third of social service beneficiaries are provided with medical and personal hygiene procedures by their formal providers: social worker, attending doctor, or medical (liaison) nurse.
Figure 6.1. Distribution of the elderly receiving home-based medical and personal hygiene procedures by service provider: 2017, %

Source: QAS (Rosstat).

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Социальный работник</td>
<td>Social worker</td>
</tr>
<tr>
<td>Лечащий врач</td>
<td>Attending doctor</td>
</tr>
<tr>
<td>Медицинская (патронажная) сестра</td>
<td>Medical (liaison) nurse</td>
</tr>
<tr>
<td>Знакомый врач (медицинский работник)</td>
<td>Physician/medical worker known to the patient</td>
</tr>
<tr>
<td>Специально нанятый человек</td>
<td>Specially hired person</td>
</tr>
<tr>
<td>Родные, знакомые</td>
<td>Family members, friends</td>
</tr>
<tr>
<td>Формальные поставщики социальных услуг</td>
<td>Formal social services providers</td>
</tr>
<tr>
<td>Неформальные поставщики социальных услуг</td>
<td>Informal social services providers</td>
</tr>
<tr>
<td>Помощь никто не оказывал</td>
<td>No assistance provided</td>
</tr>
<tr>
<td>Имеющие инвалидность</td>
<td>Those with disability</td>
</tr>
<tr>
<td>Не имеющие инвалидности</td>
<td>Those without disability</td>
</tr>
</tbody>
</table>

Most senior-age people believe that assistance should be provided to the elderly by their family members, primarily because such caregivers are not indifferent and can emotionally support the person they look after.

“Certainly, it is better when it is relatives, friends, when there is warmth. When a stranger comes, he does everything wrong, he misplaces things. It’s better when it is your family members.” [FG_Or_5]

Demand for family care is higher in North Ossetia, where traditional concepts of care prevail, as well as the principle that children and grandchildren should support their old people.

“If the person has children, it is primarily their responsibility.” [I_Os_1.1_1]
Generally speaking, older people are most ready to ask their children for help in the first place, but only if needed. Notably, the elderly themselves try their best to help their children, mostly in kind (produce grown in their vegetable or fruit gardens), with money, and with arrangements for their grandchildren’s leisure.

The elderly living with their children and a spouse are typically less willing to get outside help. On the one hand, that can be because the younger relatives take care of the senior family members, and on the other hand, the elderly may be helpfully involved in household activities. The main legitimate reason for turning for help to a social worker is the absence of relatives.

“Not everybody has relatives. Then a social worker is needed but he should well-trained, and certainly from a nonprofit organization.” [FG_Or_5]

But the elderly recognize that sometimes their family members are simply unable to help because they work or live too far away, and that is another reason to solicit the services of professional social workers.

“The number of the elderly grows year after year, and the children sometimes live far away.” [FG_Kar_2]

“I believe it should be a social worker. My relatives work, they have their own problems.” [FG_Kar_5]

Overall, many focus group participants deem it ideal to share the burden of caring for the elderly between the extended family and the social worker.

“The social worker should provide services, and the family members should supervise what he does.” [FG_Kar_3]

“It is better if social workers give care, the relatives will help anyway, and the help will be twice as strong.” [FG_Kar_5]

Assistance in looking after a severely ill person is different from helping a bit with everyday home chores. Everyone recognizes that being a caregiver to a bedbound patient is tough work that sometimes requires not only physical and mental strength but also special training and knowledge, and their lack among the relatives is perceived as a barrier to giving helpful care.

“It is hard to give care to those who are sick so it should be done by trained people who should be paid for this.” [FG_Or_4]

“People should be trained how to give at-home care. Society is growing inexorably older.” [I_Or_3.4]

That is why outside help is mentioned increasingly more often when discussing this subject. However, this help is not expected from social workers who, from elderly people’s perspective, are not obligated to provide such services free of charge. As a rule, they mean carers privately hired by relatives.

“Well, in this case, if they are available, close relatives hire carers on a private basis because the social worker cannot give care to a bedbound patient free of charge such as changing pampers, cooking food, or feeding the patient.” [FG_Os_1]

However, giving up the option to use family care is a forced step.
“The way in which care is given by a stranger and by a family member makes a great difference.” [I_Os_1.1_1]

So if the family care fee is increased, the elderly would prefer receiving care from their family members.

“I wish the government paid relatives for giving care, the care would become even better than care provided by any specialist.” [FG_Kar_3]

For long-term care, relatives’ assistance is a substantial resource: their involvement helps to reduce public spending on home care and increase the satisfaction of the elderly person. The problem is that the government does not provide regular support to relatives. Government support is limited to paying small benefits and does not include training and non-cash benefits (e.g., days added to their annual leave).

6.1.3. Value-for-money correlation in professional social care, and sources of its funding

If care is provided to the elderly not by their relatives but by social workers, there is no uniform position as to whose services are preferable: those provided by a social worker from a government organization, a volunteer from a nonprofit entity, or a member of a for-profit entity’s staff. However, most respondents are still in favor of public social workers.

A controversial issue is the cost of services and workers’ motivation: the advantages of having public social workers are that they are responsible and prepared, and that the social protection organization is protected by the government and therefore is more trusted. According to elderly people, it is easier to exercise control over social workers; their personnel turnover is lower, so that the same social worker will give care to the person for a longer time. Their explicit disadvantage is that they are overloaded with clients, and their salary is low.

“Do you think it is easy for them [social workers – Authors]? Yes, I think so. She has to look after not just one or two, but 10 people.” [FG_Or_3]

During the discussion, it was suggested that social workers’ salaries should be raised and that they should be required to undergo a psychological examination.

Key complaints about volunteers concern their frequent rotation, unreliability, and lack of accountability.

Volunteers will not do, it’s better to have somebody from public sector social protection bodies, because they have a different responsibility, and there’ll be some supervision but with volunteers one does not know where they are from, and what they can do – it’s unclear. [FG_Or_4]

Nevertheless, elderly people recognize that the quality of volunteers’ work can be high because people choose to become volunteers. But they want to be cared for only by properly trained volunteers.

The key barrier for turning to a for-profit entity is the low income of elderly people, on the one hand, and the potentially high rates of commercial caregiving services, on the other hand. Another barrier is the fear that private service providers may prove dishonest.
“With social protection workers, one will be protected by government and law. And all for-profit entities would evade the law. They will hire a lawyer and say that the contract was not properly executed.” [FG_Kar_3]

In reality, to give care to very sick people, their relatives may hire carers whom they also have to pay, but apparently they pay less than they would to for-profit firms.

Paid services are often associated with high quality, but in some cases, greater trust in public social protection makes relatives pay the social workers directly rather than turn to for-profit companies.

“We just pay extra to the social worker, to the doctor for better services in hospital or at home. We do it of our free will. We want the doctor to listen attentively without interrupting.” [FG_Or_5]

In fact, all the focus groups gave the biggest support to the viewpoint that government should pay for social services. However, the elderly responded extremely negatively to the idea of introducing a tax or additional insurance fees for funding social care. The key arguments are related to the low size of both the salaries and pensions.

“It is government that should pay for social protection services. We have worked and paid taxes. Our children pay taxes too, and they should not have to pay for the care given to their family members.” [FG_Kar_5]

Besides, the elderly do not experience any positive results from the payment of the existing taxes, they do not feel that it improves the quality of their life to any extent, and they believe they are already paying a lot to the government.

“In the past, when we worked, we paid taxes and they were spent on health care and social protection. Why should we pay one more tax?” [FG_Kar_3]

We should also point to a lack of social solidarity: people do not want to pay for social care, and they try to shift the responsibility for financing caregiving to high-income groups.

6.2. Access to social services

Only half of the elderly who need social service get it from social service organizations. The elderly and health care workers point to lack of supply of social services of all types, and primarily nursing services. Social service managers recognize only a shortage of beds in inpatient service facilities. The main barriers to receiving social services are (a) the time-consuming paperwork necessary to obtain the service; (b) the cost; (c) the inconvenient location of social service institutions; and (d) the population’s lack of awareness that social service centers exist.

One of the most acute problems is the limited availability of services for older people with limited mobility who need long-term care. It is important to allow elderly people with limited mobility to be in a familiar environment where they live without hospitalization. It is also important to ensure psychological and financial support to caregivers who take care of elderly people at home. The study raised the important issue of training for caregivers for seriously ill elderly people – both relatives and social workers.

6.2.1. To what extent is the demand for social services met as a whole?

The studies indicate that the existing demand for social services is not fully met. For instance, in 2017, social services were provided to only half of the elderly who needed them, and to less than
30 percent of older people with the most severe disorders. According to QAS, the elderly from better-off households have more chances of receiving such services (Table 6.2).

Table 6.2. Percentage of the elderly receiving social services, out of those in need: 2017, %

<table>
<thead>
<tr>
<th>Functional status:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- I do not experience any limitations</td>
<td>41.9</td>
</tr>
<tr>
<td>- I experience insignificant limitations</td>
<td>55.9</td>
</tr>
<tr>
<td>- I experience strong limitations</td>
<td>46.9</td>
</tr>
<tr>
<td>- I am bedbound</td>
<td>29.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household income (quintiles)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- 1 (the poor)</td>
<td>49.1</td>
</tr>
<tr>
<td>- 2</td>
<td>46.5</td>
</tr>
<tr>
<td>- 3</td>
<td>46.4</td>
</tr>
<tr>
<td>- 4</td>
<td>53.4</td>
</tr>
<tr>
<td>- 5 (the rich)</td>
<td>53.4</td>
</tr>
</tbody>
</table>

Source: QAS-2017 (Rosstat).

In addition to the social norms, according to which either children or grandchildren should look after their elderly relatives (more pronounced in North Ossetia, and less pronounced in Oryol and Karelia), or family care is associated with higher attention, personal involvement, and affection, demand for professional social services and access to them is also influenced by Federal Law FZ-442: after its adoption, the share of paid social services grew. In spite of the relatively low fees for these services, not all pensioners can afford them.

“The prices went up, and people are trying to give up these services.” [FG_Kar_2]

“When the relatives are at work, and the pensioner needs something, he would need the services of a social worker to buy food, get a prescription form the polyclinic, but all that is paid services.” [FG_Os_1]

Some of the health and social care managers express the same idea.

“... some very sick patients need care round the clock. And we don’t have a hospital so it’s a problem. Sick attendants are a paid service, and some people can’t afford it. Their pension is too small.” [I_Os_3.4]

Generally speaking, the question about the extent to which social services are accessible to the region’s population proved to be difficult for many rank-and-file employees and for managers of health facilities and social organizations to answer. In all three regions, medical workers, more often than social workers, say that most probably the demand for social services is not met in full.

“I believe that we do not have adequate social service for our clients because there are lots of people who are lonely. Many of them live separately from their children so, indeed, the demand is not met.” [I_Kar_2.1]

“We deal with a category of people who need social services, those who are admitted to our hospital, this problem has been existing for a long time, I mean outside of hospitals, at the level of polyclinics to which the patients are attached. Unfortunately, these problems are not being
addressed, or go unnoticed. I have a rather extensive work experience, I simply know about it.” [I_Kar_2.3]

In Karelia, managers of health facilities and social organizations held that the situation was quite satisfactory in the region; any problems, they said, were related to admitting patients to care institutions.

Both people looking after their senior-age relatives and workers of social institutions say that to receive social assistance, a person must prepare a lot of documents and test reports, which may be a factor limiting access to social services.

“It’s been impossible to get a medical report without which they would not admit me for inpatient social service. I cannot get this report from the polyclinic, even for a fee. It’s only possible after visiting my district physician. We’re waiting for the doctor.” [I_Kar_1.1_1]

“Well, last year we also tried to get her admitted to an institution, but there was no way to get a medical report from the psychotherapist: first she was away, then something else was wrong with her. So finally nothing came of it, we did not achieve anything. We’ll try again to get her admitted this year.” [I_Kar_1.3_2]

It should also be noted that one of the risk groups is bedbound patients – those who need permanent care.

“The social worker cannot sit like family members 24 hours per day. If a person is unable to move around the apartment we suggest putting such patients into a nursing home. But for some reason they refuse.” [I_Or_2.1]

Another reason the demand for social services for the elderly is not fully met is the lack of public awareness of the existence of social service centers.

6.2.2. What social services for older people are lacking?

In all three regions, there are no problems with household help at home. Three types of services are missing: social and psychological support to all the elderly, sick attendants for bedbound patients, and rehabilitative and preventive services (i.e., some kind of link between intensive medical care and household social help).

Quite often, social workers mentioned elderly people’s communication deficits, which they may try to make up for by talking with social workers. But social workers have a very strict service time schedule.

“A very strong deficit of communication. When you come to his place and start doing some work, they say: ‘we don’t need anything, talk with me.’” [I_Os_2.5]

Non-disabled persons have a problem with the availability of technical rehabilitation equipment after coming home from a hospital stay.

“They have everything in hospital but it’s impossible to get a wheelchair for personal use.” [I_Os_2.3]

In part, lack of access to some services is due to lack of accessible environments, the remote location of institutions, and a lack of special center-provided vehicles.
“The elderly lack social services: that is, a psychologist, gerontologist. I wish it could be done at the level of our polyclinic: it’s difficult for the elderly to travel elsewhere, to another end of the city, another institution, wait in a line there.” [I_Kar_2.1]

“...I believe it’s necessary to consider the extension of the spectrum and scope of social services to provide. And also the provision of free transportation services to disabled persons of types 1 and 2 with locomotor disorders who move in wheelchairs to social infrastructure facilities.” [I_Kar_3.4]

Most respondents who had the disability status said it was rather easy to obtain the status. However, some people said that they had needed a lot of time and a large number of documents to formalize disability.

“Well, I tried to, but now you are short of time, then you are short of patience. You can’t do it at the location, and it’s impossible to keep travelling to the Oblast institution time after time: the distance is quite long.” [I_Or_1.1_1]

“We were processing the documents... After she broke her femoral neck for the first time, I said that she needed the disability status, they also said it at the hospital. Then she was discharged, she stayed at home for two weeks, then she had a heart attack, once again she stayed in the Republican Hospital. I asked the doctors once again to give her the disability status. She did not have the disability status yet in spite of her age, but once again, they did not grant it, I kept visiting doctors, it was in late April that I filed the papers but we only got her disability granted in November. Huge problems.” [I_Kar_1.3_2]

6.3. Satisfaction with the social services provided

According to the surveys, elderly people’s satisfaction with social services is extremely high. However, assistive devices for rehabilitation provided for free or at reduced prices tend to be of poorer quality. The elderly do not complain about social services at home. There are more complaints about institutions as homes for the elderly.

According to the surveys, elderly people’s satisfaction with social services is extremely high. However, people with disability status give higher assessments than those without a formal status (Figure 6.2).
Figure 6.2. Satisfaction with social services: 2017, %

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Не имеющие инвалидности</td>
<td>Those without disability</td>
</tr>
<tr>
<td>Имеющие инвалидность</td>
<td>Those with disability</td>
</tr>
<tr>
<td>Полностью и в целом удовлетворяет</td>
<td>Fully satisfied</td>
</tr>
<tr>
<td>Удовлетворяет частично</td>
<td>Satisfied in part</td>
</tr>
<tr>
<td>Не удовлетворяет</td>
<td>Unsatisfied</td>
</tr>
</tbody>
</table>

Also, according to QAS, the elderly very much appreciate the quality of assistive devices used for rehabilitation. However, assistive devices for rehabilitation provided for free or at reduced prices tend to be of poorer quality. The elderly who bought assistive devices for rehabilitation at their own expense were fully satisfied: 90.1 percent of the cases (Figure 6.3). If assistive devices for rehabilitation are provided free of charge, particularly by informal suppliers, the likelihood of a positive assessment was lower: down to 57.9 percent. This means that elderly people’s purchasing power determines the quality of their assistive devices.
Figure 6.3. Satisfaction with assistive devices depending on the sources of payment for them: 2017, %

Source: QAS (Rosstat).

<table>
<thead>
<tr>
<th>Russian</th>
<th>English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Только за счет собственных средств</td>
<td>At one’s own expense only</td>
</tr>
<tr>
<td>Частично за счет собственных средств</td>
<td>Partially at one’s own expense</td>
</tr>
<tr>
<td>Полностью бесплатно – за счет средств спонсоров, родственников, знакомых</td>
<td>Entirely free of charge – at the expense of sponsors, relatives, and friends</td>
</tr>
<tr>
<td>Полностью бесплатно – льготный пакет для инвалидов</td>
<td>Entirely free of charge – benefit package for the disabled</td>
</tr>
<tr>
<td>Полностью и в целом удовлетворяет</td>
<td>Fully satisfied</td>
</tr>
<tr>
<td>Удовлетворен не полностью</td>
<td>Satisfied in part</td>
</tr>
<tr>
<td>Не удовлетворяет</td>
<td>Unsatisfied</td>
</tr>
</tbody>
</table>

According to the qualitative sociological survey data, there are no complaints about social services at home.

“Our social worker helps us in what we ask for.” [I_Or_1.2_2]

“The girls suit me very well: they are very considerate and friendly.” [I_Kar_1.2_4]

There are more complaints about institutions as homes for the elderly.

“We were not content with the conditions: well, firstly, the health spa itself was in a deplorable condition, and they did not have all the necessary specialist doctors there.” [I_Or_1.1_2]

6.4. Key conclusions and recommendations on developing the provision of social services

The data provided by both population surveys and interviews of older people showed that most people under 75 were still capable of self-care and needed almost no outside help. In some cases, there was some need for household help to do everyday chores, which was mainly met through support from relatives or social workers.

Most older respondents believe that everyday household help should be provided to the elderly persons by their relatives, preferably a spouse or children. In general, they seek help from their children only if they need it badly. When it proves impossible to get family help, they turn for
everyday support to social workers, in whom they have more trust than in volunteers from nonprofit organizations.

After the age of 75, more serious care is required as people lose some or all of their self-care ability. The situation with this kind of intensive care is by far more challenging. Bedbound patients are one of the risk groups. The elderly said that needing help in everyday chores at quite an old age is not shameful, but needing intensive care is frightening if only for lack of certainty that such care can be granted. Who can and should give such care is not quite clear, either. Everybody understands that looking after a bedbound patient implies hard work, which sometimes requires not only physical and spiritual strength but also a certain training and knowledge, which relatives do not usually have. At the same time, the elderly believe that such care of very sick patients is not the duty of social workers, who, in their opinion, are overloaded with work and poorly paid. Paid services are often associated with higher quality, but people’s low income and higher trust in public institutions lead them to offer informal payments to social workers rather than seeking care provided by for-profit entities. So in reality, families prefer informally hiring nurse attendants (often unprofessional) who do the hard work of looking after bedbound patients but cost less than the services of for-profit entities.

The surveys, interviews, and focus groups show that the demand for social services is not fully met. The officials of regional social protection bodies and social workers do not recognize the fact, but the elderly and medical workers believe that not all those who are in need of social services can get it.

Three types of services are missing: social and psychological support for all the elderly, nursing attendants for bedbound patients, and rehabilitative and preventive services.

The reasons for unmet demand for social services include the following:

- insufficient public awareness of the existence of social service centers;
- transactional costs: to receive social care, it necessary to collect a large number of documents and test reports, and it is not always easy to collect and submit them;
- apparently, insufficiently developed infrastructure and low availability of resources (specialists at centers, equipment, caregivers);
- need to pay for social services in accordance with the rates described in Federal Law FZ-442; and
- lack of accessible environments – lack of special vehicles, remote location of social care facilities/institutions.

In this context, people believe that government should pay for social services. The idea of introducing a tax or additional insurance premiums for care delivery is perceived negatively by the elderly.

These results provide a basis for making the following proposals to further improve the delivery of social services and permanent nursing care.

For public authorities:

- Unmet demand for social services could be addressed through shifting to a criterion-based principle (i.e., based on criteria for identifying eligible populations, e.g., people older than 75 or 80 years, people living alone, people with disabilities) or a combined application-based/criterion-based approach to provision of social services; identifying people in need of social care on the basis of health and functional limitations; and
making the social service network more inclusive to accommodate people who have practically no contacts with social services.

- One of the most acute problems identified in this study is limited access to services for low-mobility senior-age people who are in need of permanent care. Accordingly, the social protection system should strive to put in place and use facilities to deliver care to low-mobility senior-age people in alternative settings without admitting them to inpatient facilities, to ensure that they can stay in a familiar environment and lead their usual way of life. Among other things, it is necessary to ensure the availability of the services of professional nurse attendants who are adequately skilled to provide high-quality care to such people.

- Since family care continues to remain one of the most sought-after and acceptable forms of caregiving to the elderly, measures should be taken to ensure adequate financial reward to the relatives giving such care.

- The survey showed that relatives looking after bedbound elderly people find it impossible to get such an elderly person temporarily admitted to a hospital to have a brief “respite.” To prevent burnout, the problem should be resolved using government policy tools.

- The study revealed lack of trust in nongovernment social care providers because the elderly doubt both the quality of services they provide and their integrity. This problem can be resolved in part by developing uniform standards and mechanisms to supervise the activities of government and nongovernment organizations providing social services, including nursing care.

- The survey raised the important problem of vocational training to be provided to the people looking after very sick elderly persons – both to the relatives and social workers. Short-term courses should be set up to provide training in nursing care skills.

- To improve the life quality of the older population and relatives looking after incapacitated elderly citizens, psychological and social support should be provided both to low-mobility elderly people (particularly the lonely ones) and the relatives looking after them. That may require adding more psychologist positions to the payroll of health and social institutions.

- Granting reduced rates for the services of hairdresser and manicure parlors to elderly women will help improve their quality of life.

For the Russian Red Cross Society:

- Organize educational activities for health workers, social workers, and relatives: strategies for communicating with elderly patients.

- Provide comprehensive services for maintaining the physical and mental health of senior-age people, train them in mental health care skills.

- Promote volunteer work at health care institutions: accompany the elderly during doctors’ consultations and trips to other places to receive high-tech medical assistance.

For older people:

- Assist social service workers by maintaining a constructive dialogue with them about their problems, follow the recommendations and prescriptions they receive.

- For age peers who need outside help, assist them in adhering to doctors’ recommendations and carrying out everyday functions. Elderly people should be
informed that treatment can be prescribed only by a physician, and it is inadmissible to take medications prescribed to other people for similar health problems.
7. INTEGRATION OF HEALTH AND SOCIAL SERVICES TO PROVIDE CARE TO THE ELDERLY: PROBLEMS AND OPPORTUNITIES

Providing high-quality and effective health and social care to the elderly population requires changes in the organization of the service delivery process. One of the necessary transformations is to improve the integration and cooperation between health and social workers in assisting the elderly. Older people often suffer from several diseases at the same time, and therefore, a doctor treating one disease must take into account the recommendations of the doctors who are responsible for treating the others. Chronic illness and physical limitations due to age mean that there must be cooperation among rehabilitation services, doctors, and nonmedical specialists in the provision of health care services to the elderly. Cooperation among health workers and workers in other specialties requires interagency cooperation and the adoption of special administrative regulations at various levels of service delivery.

7.1 Successful integration processes and forms of joint work of the health care and social service systems

Delivering high-quality and effective health care to older people requires not only special professional training of medical workers (in dealing with diseases and health problems arising in senior-age people), but also changes in the health care delivery system. One important change is collaboration between specialists from different areas to deliver care to the elderly. Because elderly people often suffer from multiple diseases, a provider prescribing treatment for one disease must take into account the recommendations of specialists who are responsible for treating the person’s other ailments. Age-related physical limitations and the impossibility of fully curing some of the diseases make it necessary to supplement medical services with rehabilitative and caregiving services and underline the importance of collaboration between physicians and nonmedical workers in delivering health care to older people.

The effective cooperation of health workers and other specialists requires interagency coordination and the adoption of administrative regulations at various levels of service delivery, particularly when services are provided by public sector organizations.

The approved Procedure for Delivering Geriatric Health Care (Порядок…, 2016) requires the collaboration of geriatricians, psychologists, speech therapists, and physical therapists when prescribing treatment. It is the first step toward integrating health and social care for the elderly in Russia. Later on, the joint Administrative Order of the Ministry of Labour and Social Protection and Ministry of Health of the Russian Federation (Методические рекомендации, 2017) recommended that the regional executive authorities in charge of social and health care should establish and maintain interagency collaboration to deliver social services to citizens who have lost their ability to care for themselves, including senior-age persons.

The concept of a long-term care system was developed with inputs from the Old Age in Pleasure charity foundation and is being implemented under an ongoing pilot project (Минтруд РФ 2019). According to this concept, individuals with self-care deficit are to be provided with integrated services by medical and social workers, as well as support in negotiating the care delivery system.

As part of this study, we tried to find out to what extent these principles of integration and collaboration are implemented – whether physicians of different specialties and health and social workers are collaborating to provide care to the elderly, and whether they are aware of the need for such collaboration.
The interviews with health and social workers and leaders of different levels show that interagency collaboration is not well developed, but problems related to interagency collaboration and limited (or nonexistent) integration of social and health services are hushed up by leaders and often even workers of health facilities and social institutions. The study participants mentioned occasional attempts to establish multidisciplinary teams consisting of medical and nonmedical workers. Such teams were put together by geriatricians who started working in Karelia and Oryol Oblast in the last two years. In North Ossetia, study participants reported plans to introduce the geriatrician position in the near future. As in other Russian regions, such specialists are very few and are not yet able to make a significant impact on the quality of the health services provided to the elderly in the region.

During the interviews, participants mentioned the results of collaboration between the social and health care systems to implement preventive activities for older people: health workers are invited to social care institutions to deliver healthy lifestyle training, while social workers assist health personnel during preventive check-ups of the elderly.

“At present, we [at our social care institution] are in a contract with a health facility for maintaining a health group. When they visit our institution, they help people to undergo additional examinations, get competent professional information regarding specific diseases. I mean it is more accessible when they come to our institution, people do not have to wait in line but receive this information [at our institution]. That is very good.” [I_Or_3.4]

Social care managers are aware that their current efforts to establish multidisciplinary and interagency teams are not sufficient to ensure high-quality care for the elderly.

“Everyone should be part of a team. When establishing day-care rehabilitative centers, it is necessary to involve all the stakeholders: medical workers – gerontologists and geriatricians, psychologists, rehabilitation therapists, volunteers, cultural workers – people engaging in arts. Some work is under way at our centers for integrated social care, but that is too little.” [I_Or_3.5]

There are health care specialists and managers who are aware of the need for multidisciplinary teams to provide care to the elderly; however, when attempts are made to implement this idea, medical workers are included in such teams, but not social workers. Hence, multidisciplinary teambuilding is frequently limited to workers from one agency only. Such teams are primarily set up at the visiting nurse level to deliver services to the elderly by the joint efforts of general practitioners, specialist doctors, and nursing staff.

“A lot has been done by this service so there is very close collaboration between this service and medical specialists including district doctors. That is why they are comprehensively addressing the problems of the elderly.” [I_Kar_3.2]

In Karelia, work is under way to make arrangements for multidisciplinary teams of medical doctors to provide care to both senior-age people and other patients with comorbidities.

“Currently we are working toward enabling multidisciplinary teams to attend to senior-age patients, and... also other people with multiple diseases. Because when a patient visits a doctor’s office at a polyclinic to treat a certain disease, he should not have to go to many other offices there. Instead, he should be examined simultaneously by several specialists required for treating the disease. In other words, a hypertension patient comes – he should be examined by a general practitioner and also an eye specialist.” [I_Kar_3.3]
Doctors recognize the need to consult their colleagues of other specialties when providing care to the elderly.

“The district doctor [works jointly with] the clinical pharmacologist, because senior-age patients have a lot of medicines prescribed to them for different diseases so it is necessary to evaluate if they are compatible, effective, and what dose should be administered. That is why the clinical pharmacologist is practically always on guard with the district doctor. It is also possible to collaborate with a cardiologist and neurologist. We do not have a gerontologist of our own yet, but we have been managing like this.” [I_Kar_3.1]

Medical workers also try to create some kind of cooperation or teamwork with relatives of the elderly who have limitations in everyday life.

“It is very promising; it helps to create a kind of team consisting of an attending doctor and relatives who want their loved one to be more mobile, to live a longer life. And when the relatives turn into your active allies, it helps a lot; it improves the patient’s emotional state and certainly allows achieving better treatment outcomes. And the adherence issue, i.e. it becomes possible to get higher ‘yields’ from health care. And it is also important for the doctor when he can see that he is not alone in fighting for the patient... We always try to organize joint talks, and if it is a low-mobility patient with cognitive disorders, and there are relatives ready and willing to help, we always invite them to come to the consultation or ask them to be at home when the doctor comes to have this talk in the presence of the one who cares, to form a sort of efficient tandem.” [I_Kar_3.1]

The interviews with health and social care managers show that efforts to set up multidisciplinary and interagency teams are under way in both types of agencies, but the Russian health system and the Russian social service system are only beginning to work toward integration between health facilities and social care institutions that deliver services to the elderly. However, it appears that medical workers are more familiar with the concept of integration as a principle for health care delivery, so it can be supposed that the health system’s attempts at integration have been somewhat successful, yielded more tangible results for patients, and introduced more diverse forms of care.

Whereas leaders of different levels of the health system and social care system do understand the need for teamwork to deliver services to the elderly and try to some extent to meet this need through their agencies and departments, the advantages of such work are not obvious for rank-and-file workers. During the interviews, doctors, nursing staff, and social workers reported that they occasionally needed assistance from the other agency in delivering services to the elderly, but had never been involved in this teamwork in a purposeful way, and do not feel any need for it.

Social workers sought help from health workers when:

- the patient’s general state worsened – they help him to call a doctor;
- the client is bedridden. Such cases show that in fact social workers are not adequately trained in helping clients with serious health problems.

“Yes, I went once [to consult the doctor] – the granny was bedridden. She needed to have her bedsores treated. So I went and consulted the district doctor.” [I_Or_2.5]

Health workers contacted social workers when:

- there was a communication problem;
or the patient was unable to adhere to the prescribed treatment. In the absence of relatives who could help the elderly man, the social worker turns into a kind of guardian for the old man with disabilities, helping him to receive necessary health services and monitoring the patient’s adherence to the prescriptions in outpatient settings.

“A patient needed a CT examination, which is done at a health facility. The patient phoned us, and we contacted the social worker. She came here to pick up the referral, we explained everything to her, gave her the plans: how, where to, and to whom the patient should be taken... I mean the patient is elderly so sometimes his memory and attention fail him, and he does not remember anything... and he would not write anything down, he has no time for it, he is in a hurry. Well, indeed a social worker may help like this.” [I_Kar_2.4]

7.2 Barriers to cooperation among agencies

The study has revealed that health and social workers may lack understanding of the need for multidisciplinary and interagency teamwork to provide health care to the elderly. It is possible that not all personnel were informed about the principles and objectives of such teamwork. During the interviews, the question about this kind of work either did not receive a substantive response, or interviewees remembered about the occasional contacts with staff from the other type of agency which occurred at somebody’s personal initiative.

Another common answer to the question about interagency cooperation was a reference to geriatricians, who were expected to ensure such cooperation. At present, a significant hurdle for interagency collaboration in service provision to the elderly is a lack of geriatricians and underdevelopment of geriatric care, although the existing policy documents assign responsibility for many aspects of health and social care integration to the geriatric care units. According to data from the Ministry of Health of the Russian Federation, there were 322 geriatricians in Russia in 2018 (ЦНИИОИЗ, 2019) which is only 17.3 percent of the number of geriatricians that would be required for the country’s elderly population. In 2018, one-third of the Russian regions (27 out of 85) had no geriatricians at all.

“Probably, [the key problem is] lack of gerontologists. It is still a new trend in medicine, so there are not too many gerontologists; this is why we decided to train our own specialists to be well-versed in this issue.” [I_Kar_3.1]

The scarcity of health care human resources—geriatricians and doctors of other specialties—is recognized by the health care and social service leaders as the main barrier to joint work by agencies and to establishing multifunctional teams.

When positions of medical doctors are filled only in part (Sheiman, Shevsky, 2017), the doctors are overloaded with their core job duties, and it is difficult to ensure their high involvement in the work of teams. The additional workload due to work on teams creates the risk of impaired access to health services for core patients. This problem is particularly severe for district doctors who, along with geriatricians, are expected to play a significant role in ensuring the integration of treatment processes, according to the existing care delivery procedures. Study participants reported a considerable increase in doctors’ workload in recent years.
Integration of the agencies’ efforts to deliver services to the elderly may be hindered by the general fragmentation of the Russian health care system. Lack of experience and incentives, including economic incentives, to support cooperation with other specialists in care delivery can impede the collaboration of individual specialists and entire work units, not only with their peers but with workers of the social service system as well. Although some health care workers attempt to establish contacts with their colleagues, experts deem the level of integration in Russian health care as a whole to be low – not all physicians are teamwork-oriented (Sheiman, Shevsky, 2019).

One of the major gaps in care delivery arrangements in Russia is the lack of a single authority to coordinate interaction among agencies and evaluate the results of their joint work. The pilot project initiated by the federal government and aimed at establishing a long-term care system envisages setting up coordinating centers in the pilot regions, but these practices have not yet been introduced beyond the regions participating in the pilot project.

The following recommendations would strengthen the integration of health and social care for the elderly. These recommendations draw on the World Bank Policy Note Integrated Health Care: International Experience and Its Relevance for the Russian Health System (2019), which proposed instruments to strengthen teamwork, coordination, and continuity of care based on the best global practice.

1) Development of integrated models for managing elderly patients with chronic and multiple diseases:
   - Organize multidisciplinary teams for elderly patient management.
   - Appoint a disease management program coordinator.
   - Include the function of coordinator in PHC physicians’ or social workers’ job description. Consider providing training for PHC doctors and nonmedical specialists (e.g., social workers) so that they could learn how to coordinate the work of multidisciplinary teams providing services to the elderly.
   - Provide training and in-service retraining for health and social workers to enable them to work in multifunctional teams.
   - Set up chronic patients’ registration system with risk stratification.
   - Promote proactive prevention and managing of chronic conditions.
   - Improve communication with the relatives of elderly patients.
   - Monitor the process and outcomes of activities.
   - Develop programs to train geriatricians, to increase the number of people trained and retrained in this specialty.
   - Mainstream interagency collaboration in the educational programs for health and social workers and health and social care managers.
   - Adjust the standard district doctor/population ratio, taking into account the programs developed to provide care to elderly patients with senile asthenia, and senior-age persons in need of long-term care.

2) Intensification of information exchange between providers:
   - The detailed planning and ongoing assessment of health and social care data integration is needed to ensure accurate and effective coordination of information.
   - The integration of information requires common rules for its use: clearly specified actions of providers in regard to elderly patients, particularly with high risks.
   - Arrange additional forms of information exchange, including feedback of specialists after consultation, provision of information on hospital admissions and ambulance calls, on-line consultations, monitoring of the implementation of recommendations after hospital discharge by PHC physicians and social workers.

3) Development of integrated pathways for service delivery;
- Include in the pathways the algorithms of interaction between individual providers to ensure continuity of care at various stages of service delivery.
- Include process and outcome indicators.
- Ensure compliance with algorithms and indicators in the quality control activities.

4) Development of economic incentives through new provider payment methods:
- Introduce pay-for-performance for polyclinics to complement the current capitation payment method to promote (a) development of disease management activities for elderly patients, (b) more intensive information exchange between providers, (c) coordination function of health and social care providers, and (d) effective after-discharge clinical and social activities.
- Develop bundled payment rate for inpatient care, outpatient care, and social services for a specified period of time after hospital admission.
- Revise the tariffs for social services, taking into account the need for establishing multifunctional teams for delivering services to the elderly.

For the Russian Red Cross Society:

- Prepare volunteers to act as liaisons between patients and their relatives and multidisciplinary teams, and to look for providers of services the elderly need.
- Take part in the performance evaluation of multipurpose teams: patients’ satisfaction assessment, identification of outstanding problems.
Sources

1. «О внесении изменений в отдельные законодательные акты Российской Федерации по вопросам применения информационных технологий в сфере охраны здоровья» (Федеральный закон от 29 июля 2017 г. N 242-ФЗ)


7. Методические рекомендации по организации социального обслуживания и социального сопровождения граждан, полностью или частично утративших способность осуществлять самообслуживание, самостоятельно передвигаться, и оказания им медицинской помощи. Утв. Приказом Министерства труда и социальной защиты населения РФ и Министерства здравоохранения РФ от 21 декабря 2017 г. N 861/1036


11. Порядок оказания медицинской помощи по профилю «гериатрия». Утв. Приказом Министерства здравоохранения РФ от 29 января 2016 года N 38н.


27. Merlis, M. (2000). Caring for The Frail Elderly: An International Review: Faced with similar problems, these industrialized countries have taken different paths toward meeting the needs of their elderly. Health Affairs 19(3): 141-149.


