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The Gestation Period: 1995 to 1997

Beyond the initial concept, development of the program required roughly two more years. That time was devoted to establishing partnership arrangements in Russian medical centers, settling on the format of professional interactions, establishing administrative arrangements and reaching understandings and terms of agreements with Russian medical centers and, most important, arranging for financial support.

Several events occurred during this period that turned out to be highly beneficial to the eventual program. One of these was a series of early trips to centers in the Russian Far East in cooperation with the University of Alaska. Shortly following the breakup up of the Soviet Union, the University of Alaska, with the encouragement of the late Senator Ted Stevens, established the American-Russian Center to encourage commerce across the Bering Straits and to bring American business practices to Russia. In behalf of this project, the University of Alaska established four centers in the Russian Far East—Republic of Sakha (Yakutia), Magadan, Khabarovsk, and Yuzhno-Sakhalinsk. In 1994, the physician community in Sakha (Yakutia) prevailed upon the University of Alaska to provide some advisors to acquaint the Russian community with successful models of medical organization and financing. The Russian Federation had just introduced a new constitution in 1993 and a new health insurance law, which aimed at partially financing medicine from payroll taxes. One result of the latter was to distribute a large portion of financial resources for health to the regions. But anticipation of this change was the cause of much concern among practicing physicians.

Remuneration for physician services and support of medicine generally appeared increasingly precarious. As a result, the founders of the Eurasian Medical Education Program were recruited to travel in March 1995 to Yakutsk, the capital of Sakha (Yakutia), to spend ten days in lectures and discussions of successful patterns of medical organization and financing in other parts of the world.

The Republic of Sakha(Yakutia) is six times the size of France, or about the land mass of western Europe. It stretches from the northern end of Lake Baikal to the Arctic Ocean but contains only one million inhabitants, a mixture of ethnic Russians and national minorities. The ethnic Russians are an interesting combination of historical circumstances—grandchildren of earlier explorers and fur traders, children of prisoners exiled to the Far East and, most recently, Russians lured to that part of the world by financial emoluments.

Yakutia is a major source of gem diamonds and gold. The Yakut government, having negotiated with Moscow its share of the revenue stream from diamond mining operations, had embarked on a series of ambitious social projects including housing and medical care. The per capita income of the residents was nearly twice that of the nation as a whole. Because of the far northern location of the capital, Yakutsk, the permafrost is two hundred meters deep. As one of the consequences, the traditional houses, constructed of massive, squared tamarack logs, have been sinking into the permafrost for years. First-floor windowsills are typically at ground level. Modern construction relies on elevating the first floor many feet above the ground to prevent the heat of the building from warming the permafrost surface below.

Because the only hotel was under reconstruction, we were installed in the Diagnostic Center—an ultramodern setting built only a few years earlier by an Austrian firm. Its design conformed to the far north construction practice of isolation from the ground.

In Sakha-Yakutia we encountered several instances of a neverending series of humorous and paradoxical discoveries in Russia. First, we noticed that a small building adjacent to the Yakutsk airport was still named the Lend-Lease Building -- a reference to the period when the United States supplied aircraft to Russia during World War II, typically flying them to Yakutia from Nome Alaska.

As a side issue, I had been asked by the National Institutes of Health to combine this educational trip with a task associated with an unusual neurological disease, Vilius encephalomyelitis. This neurological disease was endemic in the vicinity of the Viliui River, near the capital city. It was believed to be of infectious origin, but the causative agent was unclear. The National Institute of Neurological Disorders and Stroke, a part of the U.S. National Institutes of Health (NIH), had undertaken a collaborative research project to learn more about this disease. I was asked by NIH to return from Yakutia with an insulated box containing brain tissue samples packed in dry ice for further study at NIH. That mission proceeded without incident until we were stopped at the departure gate of the airport in Moscow. The specimen then had to be transported back across the country to be exited out of the Russian Far East to Alaska.

Finally, the weather was another source of wonderful cultural disconnects. The day of our departure from Yakutsk to Moscow, March 18, was recognized as the official end of winter. The temperature had risen to -36ºF. However, this low temperature did not limit human activity. The streets were filled with pedestrians. The accompanying photograph shows two elegantly dressed Russian women standing in an open air market, eating one Russians' favorite foods—ice cream.

Women in fur coats in the open air market eating ice cream at -36ºF.

We spent ten days in intensive seminar-like discussions with a great deal of back and forth interchange addressing the following issues:

- Provision of affordable care to all of the people
- Improvement of the quality of health care
- Management of costs, especially administrative costs
- Alternatives for a mixture of state and private health care delivery systems
- Alternative patterns of organization and financing of medical care
- Contrast between state-determined standards of care in Russia and the role of the professions in the United States

Our experience in Sakha-Yakutia was apparently well received because the two of us were asked to return a few weeks later for a repeat performance in Yuzhno-Sakhalinsk, the capital of Sakhalin Oblast. Sakhalin is a six-hundred-mile-long island lying east of the mainland of Russia. The area is physically beautiful with two north-south mountain ranges and a great many freshwater lakes, but it was economically depressed. It claims a very interesting history, reflecting wars and treaties in the Far East. Anton Chekhov made his way across Russia to Sakhalin in 1890 in his study of prisons. As a result of the 1905 Treaty of Portsmouth, which settled the Russo-Japanese War, the island was politically divided in half; it became a Russian entity in its entirety after World War II. The former Japanese governor's palace is now a museum.

We held a series of intensive seminars and discussions with members of the physician community over a three-day period. As in Yakutia, topics concentrated on organization of medical care, patterns of financing, and the prominent roles of the profession and professional societies in education, standards setting, and certification.

The majority of questions turned around financing. By now, the new health insurance law was in place, although the Sakhalin Oblast government had elected to adopt the new law gradually. During the three to four months prior to our arrival, physicians had not received any salary. Pensions would deliver only $45 to $50 per

month. One spokesman observed that as many as 30% of the physicians would find themselves with no job. In spite of the depressed economy, there was anticipation of improvement with the prospect of extensive oil and gas reserves at the north end of the island.

The early decision to concentrate the Eurasian Medical Education Program in regions of Russia rather than in the major population centers turned out to be of enormous importance for the effectiveness and success of the program. The regions selected were marked by substantial technical strengths. There was a strong desire to embrace professional exchanges. By avoiding Moscow, we bypassed the pronounced political overlay that inevitably marked transactions in that city. A further benefit of this strategy came from the revised pattern of health care financing in Russia. The new health insurance law of 1993 was based on a withholding tax of 3.6%. The law directed that the majority of the tax, 3.4%, would not flow back to Moscow but would reside in "obligatory health insurance funds" in each region to support salaries and services. The remaining 0.2% would be returned to Moscow, but not to the Russian Federation Ministry of Health. This arrangement had an immediate effect of redistributing a substantial portion of funding centrifugally, increasing to some extent the power of the regions.

In 1996, I met with the Russian Federation Ministry of Health in Moscow and explained the sense of the then-proposed Eurasian Medical Education Program. The Ministry's response was an offer to set up a task force to assist the program. We did not press the Ministry to follow up on its offer. In fact, we independently selected an initial five geographic regions on the basis of the professional reputation of the academic medical center in each region and an expression by the medical and political leadership there of a desire for the program.

We established the individual cooperative agreements and memoranda of understanding with the regional authorities by personally approaching the medical and political leaders in each case. These approaches always returned a positive and enthusiastic invitation for cooperation, reflecting a strong desire for reestablishment of professional interaction following years of isolation. The partnership with the American College of Physicians carried high respect.

Early in this period, I joined a five-person Health Trade Mission to Russia sponsored by the U.S. Department of Commerce. The overall goal of this mission was to explore business opportunities in the pharmaceutical and medical device sectors in two regions, Nizhny Novgorod and Kazan, and to test the receptivity among the political and medical leadership for a cooperative program in postgraduate medical education. Thus, over a nine-day period, the delegation held discussions in Moscow, Nizhny Novgorod, and Kazan. One of our numbers, Michael Herzen, then a resident of California, was the great-grandson of Alexander Herzen, a famous nineteenth century Russian writer and thinker.

In the two regional centers, the delegation visited hospitals, polyclinics, and manufacturing firms. We met at length with regional governors and academic medical leaders. In each case, I would present the concept of a two-way, cooperative program, including physician exchanges for the purpose of sharing knowledge and experience. What was apparent in these visits was a strong desire to embrace professional contacts and learn about contemporary understanding of the management of disease. Ultimately, one of these regions, Tatarstan, was incorporated into the program of the Eurasian Medical Education Program.

The initial five regional academic medical centers selected for the program were Tula; Kazan; Ekaterinburg; and two regions in the Russian Far East, Khabarovsk and Birobidzhan.

Tula, 125 miles south of Moscow, was the home of Leo Tolstoy and was known as the samovar capital of Russia and the location of a small armament facility. The medical academic affiliation was with the Moscow Medical Academy.

Ekaterinburg, the capital of Sverdlovsk Oblast in the Ural Mountains, a large industrial center, is the birthplace of Boris Yeltsin and the site of the assassination of the last czar. The Ural State Medical University was considered outstanding with a particular contribution to the management of infectious diseases, including tuberculosis.

Kazan, the capital of the Republic of Tatarstan, is located on the Volga River, roughly five hundred miles east of Moscow. The city is physically beautiful with much attractive, old architecture reflecting its history as a prosperous Volga port. Kazan is one of then

twenty-one semiautonomous republics within the Russian Federation enjoying an extra degree of political autonomy in governance. Notably, half of the population of Tatarstan is Muslim (Tatars). The remarkable aspect was the striking harmony between the Muslim and Orthodox sects. Much of this was said to be due to a long-standing political leader, President Mintimer Shaimiev. Symptomatic of this remarkable harmony, a mosque was constructed within the walls of the kremlin (citadel) of the city. Kazan claimed two academic medical teaching facilities—the Kazan State Medical Academy, devoted to postgraduate training, and the Kazan State Medical University. The cardiovascular physicians had already built and equipped a very impressive, new regional cardiovascular center, partly completed with backing from the U.S. Export-Import Bank.

Khabarovsk, on the Amur River in the Russian Far East, also boasted a well-respected medical and academic leadership. The Khabarovsk Krai is looked to as a leading center of the Far East. Its capital lies approximately 250 miles north of Vladivostok. The faculty of the Far Eastern Medical University was of high standing.

Birobidzhan is the capital of the Jewish Autonomous Region which was the product of a Stalin policy of concentrating Jews in that area . Street signs are in both Cyrillic and Hebrew. Currently, only about 2% of the population is Jewish. Birobidzhan was chosen to be one of the first five regions because of its high level of tuberculosis and the fact that it includes a prison. The medical community looks to Khabarovsk about a three-hour east, for its academic connection.

Our initial reception in nearly every case was one of warm welcome. At the same time, our hosts indicated a concern that the first visit would not be our last. Continuity of this endeavor over a prolonged period of time, not unexpectedly, turned out to be of great importance. Well-meaning individual physicians, church groups, and hospitals had already built a reputation of single visits. The pattern we adopted of returning became an important element in the success of the program.

The program quickly settled into a pattern of bringing one to three physician experts to each center for a period of one to two weeks. The sessions were in part didactic and, in many cases, seminars and discussion in form. Active participation and questioning

by members of the physician audience in an academic setting was not traditional in Russia. We broke that pattern by encouraging active challenging and questioning. We always scheduled at least one session of clinical teaching rounds including at patients' bedside.

The choices of clinical subjects were made in consultation with our hosts. In general, however, we tended to concentrate on four clinical areas: cardiovascular disease, diabetes, tuberculosis, and HIV/AIDS. These were among the major contributors to premature or excess mortality in Russia and were amenable to medical intervention. From time to time, there were some important further additions. The rector of the medical university in Khabarovsk, on his own initiative, had established a department and a training program for family medicine. At his request, the Eurasian Medical Education Program brought one of the United States' best experts on family medicine to collaborate on that subject.

The administrative arrangements adopted were, by design, very simple. A staff of five in Washington included three physicians plus financial and administrative persons. An important element was the contribution of one or two Russian-speaking interns. The key, however, was the pattern of appointing and reimbursing, in most of the Russian regions, a person to serve as program coordinator. In general, these were young or middle-aged physicians, recommended by the medical center leadership, who had the respect of the faculty in each case. They performed two important functions: they could deal effectively with the academic hierarchy, and they were responsible for simple administrative tasks, such as scheduling and accommodations.

Financial Support

Simultaneous with developing the program and establishing the understandings and cooperative arrangements with the Russian centers, a strategy for financial support was established. From the beginning, as a principle, the founders were determined to see the program maintained by a balance of private and governmental support. This strategy achieved a level of funding approaching $1 million per year. An important element was an early grant of nearly $2 million from the Bill and Melinda Gates Foundation. This was

followed by additional support from other foundations and from individuals who were interested in U.S.-Russian relations and saw Russian demographic trends and social instability as security issues.

U.S. federal government support became a challenge of a different sort. We recognized a parallel between the goals and strategies of the Eurasian Medical Education Program and those of a similar program concerned with the rule of law. Somewhat earlier, the leadership of the American Bar Association put in place a program initially known as the Central and East European Law Initiative (CEELI). That program, designed to encourage an effective and independent judiciary, brought pro bono professors of law and judges to various centers in Russia. The funding was almost entirely from the U.S. Agency for International Development. The parallel with our own program in medical education seemed obvious.

The founders of the Eurasian Medical Education Program proposed an early meeting with one of the senior spokesmen for USAID to outline the goals of the program, the strategy proposed, the partnership with the American College of Physicians, and the opportunity to enjoy the active participation of some America's most highly recognized medical talent. The initial response to that inquiry was lack of interest. Subsequently, it was apparent that USAID was not enamored by the prospect of voluntary contributions, entertained something of an aversion to clinical medicine, and was not interested in initiatives that originated outside the agency.

That response left two alternatives—retreat or go to Congress. We chose the latter. As a result, the State, Foreign Operations, and Related Programs Subcommittee of the U.S. Senate Appropriations Committee became a strong and consistent supporter of the program for the next fifteen years, realizing the value of medical diplomacy it represented and its potential for engagement with Russia. The result was an immediate reversal of USAID's position and a year-by-year support by the agency over the next fifteen years.

The relationship with USAID might be described as one of constructive tension. The agency influenced the choice of regions to be visited. The Eurasian Medical Education Program participated actively in periodic reviews of USAID's and other donors' reviews of investments and strategies in Russia. The program was subject-

ed to never-ending changes in political thinking on emphasis and focus in Russia. A frequent disagreement occurred over emphasis on clinical subjects and diseases. The overwhelming political focus dictated by USAID was on HIV/AIDS. This overshadowed any logical ranking of importance. Hence, maintaining a balance between concentration on AIDS or on heart attacks and stroke (the latter overwhelmingly the principal impacts on Russian health and amenable to prevention and treatment) was a constant struggle.