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СОВРЕМЕННОЕ СОСТОЯНИЕ ЗДРАВООХРАНЕНИЯ В РОССИИ И ЗА РУБЕЖОМ

Аннотация: огромные политические, экономические и социальные изменения произошли в России к настоящему моменту. Эти изменения привели к реструктуризации российского здравоохранения в целом. Государственная приоритетная программа информатизации российского здравоохранения разработана Минздравом в ответ на новые задачи. За последние годы в Российской Федерации накоплен значительный опыт эксплуатации и внедрения информационных систем, используемых в работе некоторых лечебно-профилактических учреждений и управления здравоохранением различного уровня.

Ключевые слова: здравоохранение, Россия.

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CURRENT STATE OF HEALTHCARE IN RUSSIA AND ABROAD

Abstract: huge political, economic and social changes have occurred in Russia to the current moment. These changes led to restructuring of Russian healthcare as a whole and caused new demands on healthcare informatics. The state priority program

of informatics of Russian healthcare has been created by the Ministry of Health in order to respond to the new tasks. During the last years in the Russian Federation, considerable experience has been gained in the exploitation and introduction of information systems used in the working of some medical and preventive establishments and healthcare management at various levels.

Key words: healthcare, Russia

Healthcare in Russia is free to all residents through a compulsory state health insurance program. However, the public healthcare system has faced much criticism due to poor organizational structure, lack of government funds, outdated medical equipment, and poorly paid staff. Because of this, many expats in Russia choose to take out private medical treatment which is widely available in many areas. Patients access doctors, dentists, and medical specialists through the state system or privately. In recent years, some state facilities have begun to offer private treatment to those with insurance. Some private providers also offer some public healthcare services. Russia's consolidated budget spending on healthcare exceeded 4.9 trillion Russian rubles in 2020, up from 3.8 trillion Russian rubles in the previous year. A significant increase in the spending was attributed to the COVID-19 pandemic. Federal budget expenses on healthcare nearly doubled, reaching over 1.3 trillion Russian rubles. The spending of state non-budgetary funds was measured at nearly 2.4 trillion Russian rubles. The largest share of state healthcare spending in Russia came from the Federal Obligatory Medical Insurance Fund. Russia counted nearly 22.3 million cases of COVID-19 as of February 28, 2023. That was the tenth highest number of disease cases worldwide. The country's health officials reported that the level of collective immunity of Russians against the disease stood at 7.4 percent as of August 12, 2022[2].

In recent years, some state facilities have begun to offer private treatment to those with insurance. Some private providers also offer some public healthcare services. Another important part of WHO's work with global expert networks is the Research and Development Blueprint (R&D Blueprint), a global strategy and

preparedness plan that triggers the rapid activation of research and development activities during outbreaks.

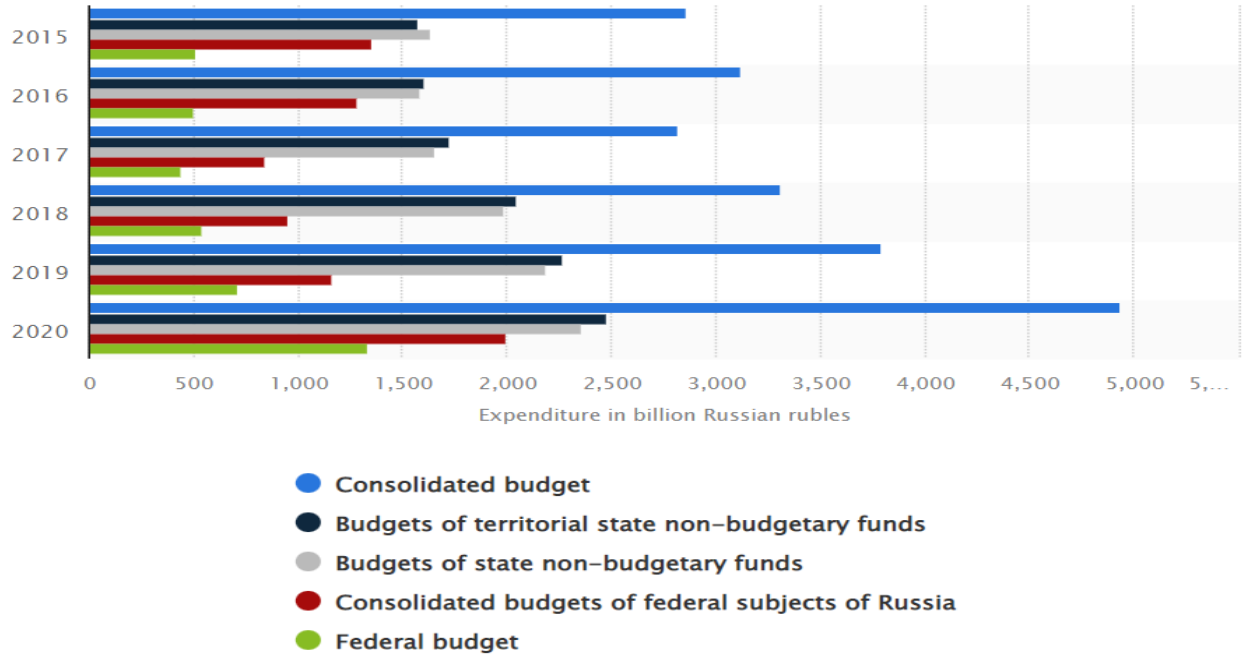

Figure1: Expenditure of Russia in 2015-2020 [3]

This includes fast-track development of effective diagnostic tests, vaccines and medicines that can save lives and prevent the spread of large-scale epidemics. The most important amongst them is that they also devised various tools to access and analyse data about COVID-19 called the Access to COVID-19 Tools (ACT) Accelerator. As COVID-19 continues to highlight inequities within and across countries, the world's commitment to health as a human right will largely determine the sustainability of economies and societies we build and rebuild, during the pandemic and far into the future. Accelerating progress towards universal health coverage (UHC) relies on greater investments in primary health care (PHC) to bring services closer to people. The UHC Partnership, one of WHO's largest initiatives for international cooperation for UHC and PHC, is providing vital and timely support to help countries to take advantage of the opportunity to emerge stronger from the pandemic. The Partnership works in 115 countries with funding from the European Union, the Grand Duchy of Luxembourg, Irish Aid, the French Ministry for Europe and Foreign Affairs, the Government of Japan - Ministry of Health, Labour and Welfare, the United Kingdom - Foreign, Commonwealth & Development Office, Belgium, Canada and Germany.

Many of these countries are demonstrating that PHC best serves communities and empowers them to choose healthier lifestyles, prevent diseases or access early detection, treatment and recovery. People-centred PHC, with equity in service delivery, ultimately paves the way for a fairer, healthier world for all. Country experiences and lessons from COVID-19 are documented in the UHC Partnership's special series of stories from the field on the COVID-19 response. WHO Eastern Mediterranean Region: Sudan is empowering people to voice their health needs by implementing community dialogues where they can take part in finding solutions and hold their local health authorities accountable. WHO Western Pacific Region: Mongolia is bringing health services to remote communities by using mobile health technologies to reach nomadic populations, migrants and unregistered people. WHO Africa Region: Zimbabwe is maintaining essential health services by using real-time data to assess the needs of the population and ensure responsive and timely actions. WHO Americas Region: Caribbean countries are improving the availability and quality of care for critical care patients by training and empowering their health workforce. WHO South-East Asia Region: India is bringing health services closer to communities by strengthening its network of primary health care centres. WHO European Region: Uzbekistan is maintaining strong momentum to reform its health system and reduce out-of-pocket expenses for its population with a state health insurance fund that covers primary health care services [4].

WHO launched their Transition Plan in October 2022, setting out adjustments to its way of working, as countries move from managing COVID-19 as an acute emergency to integration into longer term disease control programmes. Apart from the existing system, several other factors have been instrumented in broadening the health governance agenda. From health governance to governance for health: Health Governance addresses many of the issues essentially coordinating, directing and performing internal coherence functions. While governance for health is an advocacy and public policy function which seeks to influence governance in other sectors in ways that positively impact on human health. Research on the major determinants of disease in Russia, and published in the international literature, appears to have had little impact.

The need for reform to enhance the public health response is recognized. Goals of reform have been described but are poorly defined and there is typically little relationship between a stated goal and the strategy proposed to achieve it. There is a lack of clarity about what is meant by public health, and key concepts, such as inter-sectoral and multi-disciplinary working, are either ignored or misunderstood. Evidence of capacity for managed change is weak. There is an urgent need to create a shared awareness of evidence on the nature of the health challenges facing Russia and the evidence base for both the content of potential responses and the strategies that might be adopted to implement them [3].

The visualization summarises available life expectancy data over the last few centuries. The estimates from the UK – the country for which we have the longest time-series – show that life expectancy before 1800 was very low, but since then it has increased drastically. We can see that in less than 200 years the UK doubled life expectancy at birth. And the data shows that similarly remarkable improvements also took place in other European countries during the same period. The chart also shows large historical changes in life expectancy estimates for other countries. You can switch to the map view in this visualization by clicking on the corresponding tab, in order to compare life expectancy across countries [4]. The map shows that, despite long-run cross-country convergence, there are still huge differences between countries: people in some sub-Saharan African countries have a life expectancy of less than 50 years, compared to 80 years in countries such as Japan. The increase in life expectancy happened to a significant extent because of changing mortality patterns at a young age, but this was not the only reason: life expectancy increased for people at all agesFor 1800 (red line) we see that the countries on the left – including India and also South Korea – have a life expectancy of around 25 years. And on the very right we see that in 1800 no country had a life expectancy above 40 (Belgium had the highest life expectancy with just 40 years).In 1950 life expectancy in all countries was higher than in 1800, but we can see that inequality grew substantially. This happened because very large improvements in health outcomes took place in some countries (mainly the richer countries in Europe and North America), while others (notably India and China) made

only little progress. In 2012 (green line), we can see again an improvement in life expectancy across all countries; yet interestingly, improvements in this last period implied a reduction in inequality. This happened through very large recent improvements in life expectancy across developing countries. The conclusion is that the world developed from equally poor health in 1800, to great inequality in 1950, and back to more equality today – but equality at a much higher level [5].

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