Topic 2.12. Healthcare Systems in Russia and Abroad/ Тема 2.12. Система здравоохранения в России и за рубежом

Healthcare is one of the most important sectors of any society, directly affecting the quality of life, life expectancy, and economic development of a country. A healthcare system is a complex of state, public, and private institutions, organisations, and measures aimed at preserving and improving the health of the population. Each country builds its healthcare model according to its economic capabilities, historical traditions, and social policy. Understanding the structure and principles of different healthcare systems is essential for medical professionals, as it enables effective communication with foreign colleagues, participation in international programmes, and the adaptation of advanced foreign experience in domestic practice.

Healthcare System in the Russian Federation

The healthcare system in Russia is based on the principle of compulsory medical insurance (CMI) combined with state financing. The main legislative act regulating the system is the Federal Law "On Compulsory Medical Insurance in the Russian Federation" (2010). The Constitution of the Russian Federation guarantees every citizen the right to health protection and free medical care.

The structure of the Russian healthcare system includes the following levels:

1. **Federal level** — the Ministry of Health of the Russian Federation develops national health policy, establishes medical standards, and coordinates federal health programmes. Federal institutions include large research centres, specialised clinics, and university hospitals.
2. **Regional level** — regional ministries and departments of health manage hospitals, polyclinics, and emergency services within their respective territories.
3. **Municipal level** — local health authorities oversee primary healthcare facilities, ambulatory services, and district physician offices.

The Compulsory Medical Insurance Fund (CMI Fund) collects insurance contributions from employers and the state budget. Every citizen receives a compulsory medical insurance policy (CMI policy), which entitles them to receive free medical care within the framework of the basic programme. The basic programme includes primary healthcare, emergency medical care, specialised medical care, and high-technology medical care.

In addition to compulsory insurance, voluntary medical insurance (VMI) exists in Russia. VMI policies are purchased by individuals or employers and provide access to expanded medical services, including consultations with leading specialists, comfortable hospital conditions, and dental care. Private medical practice is also developing: private clinics, dental offices, diagnostic centres, and beauty medicine clinics operate in large cities.

Primary healthcare is the foundation of the system. It is provided by district physicians (general practitioners — GPs), paediatricians, and specialists in ambulatory-polyclinic institutions. The district physician is the first point of contact for patients and is responsible for initial diagnosis, treatment, and referral to specialists if necessary. Emergency medical care in Russia is provided free of charge and is available to all citizens regardless of insurance status.

One of the serious problems of the Russian healthcare system is the uneven distribution of medical resources: large cities are well provided with qualified personnel and modern equipment, while rural areas often experience a shortage of specialists and diagnostic capabilities. The state is addressing this problem through programmes such as "Zemsky Doctor" and "Zemsky Paramedic", which provide financial incentives for young specialists to work in rural areas.

The dispersion of pharmacies is carried out through a network of state, municipal, and private pharmacies. The state regulates the prices of essential medicines included in the list of vital and essential drugs (Vital and Essential Medicines List — VED).

Healthcare Systems Abroad

Healthcare systems in different countries are generally classified into several main models, each with its own advantages and disadvantages.

Beveridge Model (United Kingdom, Spain, Italy, Scandinavian countries)

In this model, healthcare is financed by the state through general taxation. Medical institutions are owned and managed by the government. Doctors are state employees or work under state contracts. Citizens receive medical care free of charge at the point of use, without bills or insurance claims.

The National Health Service (NHS) in the United Kingdom is the most prominent example of the Beveridge model. It was established in 1948 and is based on the principle that healthcare should be available to all, regardless of ability to pay. General practitioners (GPs) serve as gatekeepers: patients must first consult a GP, who then refers them to specialists if needed. The NHS provides comprehensive services, including hospital care, dental care, and prescriptions (with fixed copayments in England; free in Scotland, Wales, and Northern Ireland).

The main advantage of the Beveridge model is universal coverage and low administrative costs. The main disadvantage is long waiting times for elective procedures and specialist consultations.

Bismarck Model (Germany, France, Japan, the Netherlands)

This model is based on compulsory health insurance funded jointly by employers and employees through payroll deductions. Insurance funds are non-profit organisations regulated by the state. Healthcare providers are mostly private, and patients have a choice of doctors and hospitals.

In Germany, health insurance is mandatory for all citizens. Approximately 90% of the population is covered by statutory health insurance (Gesetzliche Krankenversicherung — GKV), which is organised through more than 100 non-profit sickness funds. The remaining 10% — mainly high-income earners and self-employed individuals — can choose private health insurance (Private Krankenversicherung — PKV). Contributions to the statutory system are based on income (approximately 14.6% of gross salary), shared equally between employer and employee. The system provides comprehensive coverage: outpatient care, inpatient treatment, dental care, rehabilitation, and prescription medications.

The advantage of the Bismarck model is a high level of medical care, freedom of choice for patients, and competition among providers. The disadvantage is rising costs and the complexity of the insurance system.

National Health Insurance Model (Canada, South Korea, Taiwan)

This model combines elements of the Beveridge and Bismarck systems. Healthcare is financed by the state through compulsory insurance premiums, but medical providers remain private. The government acts as a single-payer insurer, negotiating prices and controlling costs.

In Canada, the system is known as Medicare. Each province administers its own health insurance plan, following national standards set by the Canada Health Act (1984). Medical care is free at the

point of use for medically necessary services. Private insurance is prohibited for services covered by the public system, but is available for dental care, vision care, and prescription drugs. The main criticism of the Canadian system is waiting times for certain procedures and specialist visits.

Out-of-Pocket Model (developing countries)

In many low-income countries of Africa, Asia, and Latin America, there is no organised healthcare system accessible to the entire population. Patients pay for medical services directly. In rural areas, traditional healers often serve as the primary source of healthcare. Access to modern medicine is limited to urban centres and affluent segments of the population. International organisations such as the World Health Organization (WHO) and the Red Cross work to improve healthcare infrastructure in these regions.

Mixed Model (United States of America)

The United States does not have a universal healthcare system. Healthcare is financed through a combination of private insurance, employer-sponsored plans, and government programmes. The main government programmes are:

- **Medicare** — federal programme for people aged 65 and older and some younger individuals with disabilities.
- **Medicaid** — joint federal and state programme for low-income individuals and families.
- **CHIP** (Children's Health Insurance Programme) — coverage for children in families that do not qualify for Medicaid but cannot afford private insurance.

Approximately 65% of the population has private health insurance, often obtained through employers. The Affordable Care Act (ACA, also known as "Obamacare"), enacted in 2010, expanded access to insurance and prohibited denial of coverage based on pre-existing conditions. Despite these reforms, the United States has the highest per capita healthcare spending in the world, and a significant portion of the population remains underinsured or uninsured. The quality of medical care in leading American hospitals and research centres is among the best in the world, but access to care remains unequal.

Key Indicators for Comparing Healthcare Systems

When comparing healthcare systems across countries, the following indicators are commonly used:

Indicator	Description
Life expectancy at birth	Average number of years a person is expected to live.
Infant mortality rate	Number of deaths of infants under 1 year per 1,000 live births.
Maternal mortality rate	Number of maternal deaths per 100,000 live births.

Indicator	Description
Total health expenditure (% of GDP)	Share of gross domestic product spent on healthcare.
Out-of-pocket expenditure	Share of health spending paid directly by patients.
Physician density	Number of physicians per 1,000 population.
Hospital bed density	Number of hospital beds per 1,000 population.
Vaccination coverage	Percentage of the target population fully vaccinated.

The World Health Organization (WHO) regularly publishes the World Health Statistics report, which compiles and analyses these indicators for all member states.

Current Trends in Global Healthcare

Modern healthcare systems worldwide face common challenges: ageing populations, rising costs of medical technologies, increasing burden of chronic and non-communicable diseases, shortages of qualified medical personnel, and the need to implement digital technologies. Trends shaping the future of healthcare include:

- **Telemedicine** — remote consultation, diagnosis, and monitoring of patients using information technologies. The COVID-19 pandemic significantly accelerated the adoption of telemedicine worldwide.
- **Personalised medicine** — tailoring treatment to the individual characteristics of each patient, including genetic profiling.
- **Electronic health records (EHR)** — digitised patient records that improve continuity of care and reduce medical errors.
- **Preventive medicine** — shifting the focus from treatment to prevention, including screening programmes, health education, and lifestyle modification.
- **Artificial intelligence** — applications in diagnostics, drug development, and healthcare management.

Understanding the structure, strengths, and weaknesses of different healthcare systems allows professionals to critically evaluate their own national system and contribute to its improvement through the adoption of effective international practices.