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Review

Access to quality health care in Russia for all still remains questionable. A comparison with Canada

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Since the collapse of the Soviet Union the health of the Russian population has declined considerably as a result of social, economic and lifestyle changes. Similarly, its population has been in decline too: from 148 million in 1990 to about 142 million in 2006, caused by the dual effects of high death and low birth rates, the latter greatly influenced by high rates of abortion. Russia's health care system is based on the old Soviet one and thus possesses its merits and problems. The major achievements of the Soviet's system were establishing comprehensive health care services available to the entire population and its influence on the development of the Alma Ata approach to primary health care. However, simultaneously Soviet medical science was isolated from developments in the West. As a consequence, many ineffective treatments remained routine and innovations developed in the West were not adopted. The Soviet health care system was based heavily on basic prevention, consisting of extensive screening measures and check-ups, which generally made the healthcare system inefficient and relatively expensive. Recent economic growth has had minimal impact on key indicators of health and human welfare. Currently, Russia possesses adequate numbers of highly qualified doctors and healthcare professionals, though most of them are poorly paid and unmotivated. Medical equipment in the majority of clinics and hospitals is archaic and hygienic conditions do not even meet domestic let alone established international standards (See L.Maksimova. Healthcare Reforms in Russia: Current Status. 2006. [http://commercecan.ic.gc.ca/scdt/bizmap/interface2.nsf/vDownload/ISA_5214/\\$file/X_6362899.DO](http://commercecan.ic.gc.ca/scdt/bizmap/interface2.nsf/vDownload/ISA_5214/$file/X_6362899.DO)). Since 1991 the government of the Russian Federation has initiated health care reforms based on the health systems of the United Kingdom and Nordic countries. Yet, compulsory health care insurance and public programs cover only a small portion of drug purchases and a very limited number of medical procedures or operations. Despite the declared right of citizens to have access to free drugs at in-patient clinics, the majority of essential medicines and supplies must be paid for by patients out of pocket. It is estimated that patient out of pocket expenses comprise up to 60% of total healthcare expenditures, with most of this being direct payments to doctors and nurses rather than through private insurance schemes (See *ibid*). In a result, a serious barrier to quality health care for low income persons, who make up 15-20% of the population, has appeared. This article describes the current health care situation and raises questions about whether Russia's health reform process is able to ensure the constitutional guarantee for free universal health care for all citizens.

Keywords: Quality Health Care, Russia and Canada

INTRODUCTION

Background

In the Soviet era the health care system was based heavily on primary prevention, consisting of extensive

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screening measures or check-ups and on hospitals. The main policy orientation throughout this period was to increase the number of hospital beds and medical personnel. This system of prevention and hospital-based clinical care, with its primarily medical orientation, did not evolve into one of population-based health promotion. Moreover, the health care system was under the centralized control of the state, with the Ministry of Health under strict regulation by the Communist Party. The military demands of the Cold War, in particular the race to build missiles, took precedence over all social issues. One result was that Soviet medical science did not keep pace with developments in the West, including modern epidemiologic methods and the emerging evidence-based medicine movement. In addition, the USSR failed to develop a modern pharmaceutical industry and was dependent on imports from Eastern Europe and South Asia. Considerable resistance to adopt innovations that threaten the status quo and existing expert opinion continues to be found. For example, in pediatric asthma a reluctance to use steroids and excessively long periods of hospitalization reaches 3 weeks on average. The Soviet system did have some very real achievements. It succeeded in controlling communicable diseases, and it made comprehensive health care services available to the entire population. It provided a basis for community health activities including mandatory immunization and periodic health checks. In the 1950s the Soviet system was emulated in Eastern Europe and in several new states in Africa, Asia, the Middle East and Latin America (Tragakes, E. and Lessof, S. In: Tragakes E., ed. *Health care systems in transition: Russian Federation*. Copenhagen, European Observatory on Health Systems and Policies, 2003). On the other hand, the systems tended to be underfunded by Western standards (as social sectors were given low priority in the planning process), were inefficient, provided low-quality care, allowed little consumer choice, and were prone to informal payments for preferential treatment (Jeni Klugman, et al. *Health Reform in Russia and Central Asia*. <http://www.nap.edu/html/transform/ch12.htm>).

Current State of Health of Russia

The best way to understand the current state of health of Russia is to listen to ordinary people. Under the Oxfam GB in Russia, freelance journalist Shaista Aziz, spend a week in Russia in 2007 mapping out poverty in Tver and Tula oblasts and in St Petersburg gathering interviews from people who are most vulnerable to poverty. She met single mothers, women with larger than average sized families, older people and homeless people. She also visited a women's prison. These stories together illustrate the hidden and visible poverty in parts of Russia (This information became available for V.Zakirova as at that time she worked for Oxfam GB Moscow on poverty

reduction program in the regions where the journalist's visit took place). Below is the extract of her report on the information gathered specific to health care.

Natalia, born in 1971. "I'm a widow, my husband died seven years ago and I am responsible for my children. Our house is ok; it's not in bad shape when compared to other people's homes in this town. I work full time and also receive my husband's pension to take care of the family. We live a modest life. Its not like the old days where children would go hungry but it's a struggle to be able to afford to buy butter and meat. In theory I could try and find a better paid job but because I'm single mother and one of my children is sick I need to work flexible hours to be able to take care of my family. My son has been diagnosed with epilepsy, its very hard as the doctors keep telling me that there is no treatment for him. I keep taking him to the doctor who is expensive but keep being told there is nothing they can do. He was diagnosed when he was seven years old and he's now twelve. It's very stressful when the kids are sick even if it's a common cold as medication is so expensive. Its costs around 100 rubbles to pay for basic medication to treat a simple cold, I have only around 9,000 rubbles a month. This is a good salary for this area but I have to raise three children on this salary and its very hard. I have a University education and these days around here even if you want to do a low skilled job employers look for people with qualifications. As a single mother I feel that I put more effort into trying to improve my family's life."

Gennady, born in 1949."... My last job was in 2004 and I haven't worked since. I have a problem with my eyes and I find it hard to see clearly, my vision has deteriorated because of the work I've been doing. I had eye surgery a few years ago, it was free and it helped but my eyes are far from perfect and I have to find a job during daylight hours as I can't move easily when it gets dark. The roads and pavements here are in a very bad condition and because of my eyes I could fall and hurt myself. My wife is a pensioner and she is supporting me. Our daughter also helps out when she can, she lives in Tver with our granddaughter. I am looking for work but there is nothing out there, I was offered a job to be a security guard but I can't do that kind of job because I would have to do it late at night and I can't see well enough."

Irena, NGO for Women in prison. "Many women when they leave prison find themselves to be

more vulnerable than when they were before they ended up in prison. One woman was diagnosed with cancer when she was released, she realised that on the outside she had no network of support so she re-offended and ended up in prison again where she managed to get some treatment. Everyday I meet women with harrowing stories and it makes me angry that they continue to be so vulnerable. Many of the women are heroin addicts and many are also HIV positive because of addiction to heroin, they use dirty needles to inject themselves. I think heroin addiction is one of the main reasons that a woman ends up in prison."

Dr. Galina, Medical unit in prison. "The major health problem in the prison is HIV which then triggers a whole number of other health problems. The main need in terms of healthcare in the prison is dental care. Many of the women in here are heroin addicts and so they have very bad teeth. They come to me complaining about toothache as often their teeth are rotten and there is no treatment for them as we don't have the money. It's sad because often the dentist who visits the prison ends up pulling the rotten tooth out and there are many women, young women who have lost most of their teeth. All the heroin addicts are virtually toothless, the youngest addict is 18 years old and the eldest is 54. Heroin makes teeth rot, and combined with the hard water here it makes matters worse. Many women became addicts due to peer pressure, or of they had a dramatic event in their lives that made them turn to drugs, some are curious and try it out.

All women are screened for HIV before they enter the prison, the majority know they have the virus but on occasion they don't know and so we have to break the news to them that they are HIV positive when they arrive here. It's a dangerous environment to work in and of course as a doctor I have to take precautions to safeguard my own health too. Around thirty of the inmates receive anti viral treatment; they wouldn't get this on the outside so you have a situation where if you have HIV you are healthier in prison than out there in the real world. The problem is that by stopping and starting treatment the virus becomes resistance to drugs and the nature of the virus changes.

Recently 19 inmates received some training on HIV awareness from a western NGO and it was great. It helped the women to understand more about the condition. Some of the women once they were released put this training into practice and now work in a hospice to care for people with HIV. They are contributing to their society

and for me this is wonderful. One inmate has been in and out of this prison four times and in total has been to prison 14 times, she is a heroin addict."

Similar stories one can hear in most of the remain parts of Russia as the situation with health care challenges are true to the whole of the country, with most disadvantages for those living in peripheral small towns and villages. Recent economic growth in Russia seems to have had little impact on key indicators of human welfare. The country's population has been declining by 500,000 annually in the past decade: from 148 million in 1990 to about 140 million today (<http://www.nationmaster.com/country/rs-russia/people>). Russian men live 15-19 years less than men in other leading European countries, the USA or Japan (59 vs. 74-79). For Russian women the difference in life expectancy is 7-13 years (73 vs. 80-83). Forty years ago, the difference was only 2-3 years. Russia experiences great regional variations in life expectancy and varies by as much as 16 years. The highest life expectancy (72.5 years) is found in the Northern Caucasus in the Republic of Ingushetia. The lowest (56.4 years) is found in Eastern Siberia in the Republic of Tuva (See *ibid*). Such regional disparities are closely associated with differences in economic development, where some regions enjoy a strong industrial base and others suffer from severe unemployment and local government budget deficits. Such disparities are continually growing. In the process of the overall decline in health care quality and access since 1990, those who have good education use their knowledge and connections to gain access to better care. Even with similar levels of material well-being, people with less education receive poorer health care (N.Rusinova, J.Brown. *Social Inequality and Strategies for Getting Medical Care in Post-Soviet Russia*. - SAGE publication 2003.

<http://hea.sagepub.com/cgi/content/abstract/7/1/51>). A long-standing, culturally based predisposition is to delay treatment until health problems become more difficult and costly to manage.

It is estimated that Russia is losing over 6% of its GDP from premature deaths due to heart disease, stroke and diabetes

(http://www.who.int/chp/working_paper_growth%20model29may.pdf). The major factors contributing to low life expectancy in Russia for working age males are preventable and include alcoholism, stress, smoking, motor vehicle accidents, and violence. The leading cause of death for men in the Russia Federation is cardiovascular disease. These deaths often occur at younger ages than in western countries and are much more likely to be sudden. Much of cardiovascular disease is attributable to traditional risk factors, such as poor diets, smoking, and heavy alcohol consumption.

These deaths peaked in 1994. Additional important causes of death include homicide, suicide and alcohol poisonings. These are responsible for over 65% of the fall in life expectancy and are 4.4 times greater in men than in women (Tragakos, E. and Lessof, S. In: Tragakes E., ed. *Health care systems in transition: Russian Federation*. - Copenhagen, European Observatory on Health Systems and Policies, 2003). There is considerable evidence to link these external causes to alcohol abuse. The role of alcohol and specifically the tradition of drinking vodka (heavy consumption, binge drinking) as a way for men to cope with stress helps to explain the very wide differences between female and male mortality. The situation worsened to such a degree that in 2005 Russia ranked 62nd out of 177 countries on the Human Development Index (HDI) (<http://www.nationmaster.com/encyclopedia/List-of-countries-by-Human-Development-Index>). This measure takes into account a population health, education and gender equity. This low ranking can be linked, to low GDP spending on health care that amounted about 3.5%. In comparison, EU countries and Canada spend 9 to 11% of GDP and 15% in the U.S. on health. Furthermore, Russia's GDP health expenditures are lower than in China (5.1%), India (5.1%), Poland (6.3%), or the Czech Republic (7.3%). Instead, Russia's percent of GDP spending on healthcare in 2005 is similar to underdeveloped, sub-Saharan countries, such as Nigeria and Uganda (L.Maksimova. *Healthcare Reforms in Russia: Current Status*. - 2006. [http://commercecan.ic.gc.ca/scdt/bizmap/interface2.nsf/vDownload/ISA_5214/\\$file/X_6362899.DOC](http://commercecan.ic.gc.ca/scdt/bizmap/interface2.nsf/vDownload/ISA_5214/$file/X_6362899.DOC)).

High levels of mortality and morbidity also reflect such factors as environmental degradation, a sharp rise in murders, suicides and unemployment. This has become worse since the dismantling of the Soviet system. The paternalistic Soviet philosophy did not encourage the development of individual responsibility with respect to lifestyle issues that have a major bearing on health (alcohol use, smoking, diet).

Gender disparities

In the Russian Federation health begins to decline at about the age of 50 for males and 40 for females with a more rapid trend at older ages. Under present conditions, only 54% of 16-year-old males today will survive to age 60. Among women, their average life expectancy at any given age is higher than that of Russian men, but they also tend to spend much more of their lives in ill health (*Health expectancy in the Russian Federation: a new perspective on the health divide in Europe*. - Bulletin of the World Health Organization. Print ISSN 0042-9686. vol.81 no.11 Geneva Nov. 2003. http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862003001100003#fig2). Although the idea of

equality of the sexes was promoted, Soviet imagery encouraged a strict demarcation, with men as leaders and women as home-makers, supporting the men who were building socialism. In reality, women faced a double burden, as they were expected to work outside the home and bring up children. In the workforce there was (and still is) a clear hierarchy with a high proportion of women working in the least attractive jobs. Russian women continue to be especially disadvantaged in old age. Older women are three times as likely as men of the same age to live alone and are more likely to live in poverty. In 1994, over a quarter of women aged over 65 had never completed primary education compared with 9% of men of the same age (See-ibid). Maternal mortality (39.7 per 100 000 live births in 2000) is one of the highest in Europe. More than two abortions occur for every live birth that places Russia at the highest level in the European Region. Abortion still remains a common form of birth control. The incidence of sexually transmitted diseases is reaching epidemic proportions, with syphilis being particularly worrisome: its incidence in 2001 has increased by 77 times since 1990. In Moscow over 200 cases of indigenous malaria were reported in 2001. The share of deaths induced by poverty-related illnesses such as infectious diseases, and incidence of tuberculosis, remains high (Tragakos, E. and Lessof, S. In: Tragakes E., ed. *Health care systems in transition: Russian Federation*. - Copenhagen, European Observatory on Health Systems and Policies, 2003; W.Tompson. *Healthcare Reform in Russia: Problems and Prospects*. - Economics Department Working Papers No. 538. www.oecd.org/eco/working_papers). In terms of access to primary health care, children are the most disadvantaged group of population. The problem, in large measure, is related to the high proportion of children living under disadvantaged social and economic conditions. 12 million children live in families with incomes below the subsistence minimum. 20 million live in poor families. 2 million have dropped out of school, between 2 and 4 million are homeless beggars and 600 000 children are not under the care of either of their parents (Tragakos, E. and Lessof, S. In: Tragakes E., ed. *Health care systems in transition: Russian Federation*. - Copenhagen, European Observatory on Health Systems and Policies, 2003). Those children in large have limited or no access to quality health care.

Health System

Russia does possess significant numbers of highly qualified doctors and healthcare professionals and has more physicians, hospitals and health care workers per capita than almost any other country in the world. In 2003 4.25 physicians per 1000 people ranked the country 2nd among 148 countries (<http://www.nationmaster.com/red/country/rs-russia/hea->

health&all=1). Nevertheless, today, as under the Soviet system, Russian healthcare relies excessively on hospitalization: 15-20 percent of patients under care at any given time are in hospital (compared with 8-10 percent in most Western countries), most of the doctors (73%) work in hospitals and only 17% in primary level out-patient clinics. Therefore average stay is about three times longer than in Western Europe or the US. The problem stems from the inability of health care system to respond to new challenges and implement a family medicine approach to primary care (*За семейным врачом стоит будущее здравоохранения*. <http://medi.ru/DOC/7392301.htm>). Currently there is a severe lack in primary health care professionals who have the training and skills to deliver modern medical practices. The majority of primary health care personnel will require re-education and personal motivation to change their approach and practices. This will require significant private and public sector funding commitments (И.М. Шейман. С.В. Шишкин. *Российское Здравоохранение Новые Вызовы И Новые Задачи*. – Москва. 2009 <http://www.hse.ru/data/165/185/1241/zdravoohr.Pdf>). Is the Russian health care system ready to pursue this?

Human Resources are maldistributed in favor of specialty treatment rather than preventive and primary health care. The health researchers identified a broad range of problems in the health-care financing and delivery systems (Jeni Klugman, et al. *Health Reform in Russia and Central Asia*. <http://www.nap.edu/html/transform/ch12.htm>). They singled out the following problems such as: 1) poorly structured or nonexistent public health programs for health promotion, disease prevention, family planning, adult health, occupational health, and environmental health, 2) chronic underfunding (as an "unproductive" service sector) relative to the systems in Western countries, with low wages for health-care workers, 3) a rigid budgeting system encouraging inpatient over outpatient treatment, as well as care at the highest, most expensive levels of the system, 4) lack of professionalism among physicians, poorly trained primary-care physicians, resulting from the state-enforced breakup of professional associations, 5) limited inpatient and outpatient diagnostic capacity, and the poor condition of the capital stocks, and 6) a lack of modern quality assurance systems . These problems are fundamental and affect almost every aspect of health care at all levels. Nonetheless, the system retains substantial elements of success. First of all, access to care for all as a right, and secondly, an extensive and well-integrated hierarchical system of rural nursing, health stations, polyclinics, and local, regional, and national hospitals.

Canadian health system comparison

In Canada, life expectancy among women was 82.2 years, compared to 77.7 years for men in 2001. At the end of the 20th century, Canada ranked 5th among all OECD countries (*Health system in transition. HiT Summary Canada*, 2005. <http://www.euro.who.int/Document/E87954sum.pdf>). High life expectancy reflects the high quality and accessibility for all within the health care system. The constitutional right for universal health care for all is realized through provincially based health insurance systems. Canada Health Act (1983) is probably the most famous piece of legislation that later became a symbol of Canada defining health care as a right and providing universal equitable services for everyone. This means that you cannot have some hospitals and doctors for the poor and others for the rich. The government health insurance programs pay for all doctor and hospital services and prohibits from extra billing and charges on patients that in addition to fees the doctors received from their insurance plan (Armstrong P., Armstrong H. *Health Care. About Canada Series*. - Fernwood Publishing, Halifax and Winnipeg. 2008). The Canada Health Act requires that all medically necessary services be covered by Medicare, without any "out of pocket" cost to the patient (Barry Carin, David A. Good. *Financing Russia's Budgetary Institutions In The Health Sector*. - http://www.aucc.ca/_pdf/english/programs/cepra/HealthPaper.pdf). Almost all doctors' clinics in Canada are private and almost all hospitals are privately owned, but they operate on a non-profit base with almost all of their funding from the government. Likewise with doctors, most work in their own private practice, but get paid by the government according to a fee schedule negotiated between the government and their provincial medical associations (eg..Ontario Medical Association for the doctors in Ontario). The 13 provinces and territories vary considerably in terms of the financing administration, delivery modes and range of public health care services. In spite of the differences access has become significantly equitable not only for rich and poor but also among the provinces as extra federal funds support care in jurisdictions that lack the resources to provide reasonable access on their own (Armstrong P., Armstrong H. *Health Care. About Canada Series*. - Fernwood Publishing, Halifax and Winnipeg. 2008). The federal government is responsible for collecting and providing health data, research and regulatory infrastructure, in addition to directly financing and administering a number of health service for selected population groups. While the health care system has been successful in maintaining a high level of

population health and has undergone a series of reforms, many challenges are emerging. These include the ageing population, increasing health care expenditure, particularly for pharmaceuticals lengthy waiting times, and shortages of health human resources (See *ibid*). In Canada, autonomous non-profit organizations bear the major part of health care expenditures. The health researchers argue the current controversy in Canada on whether these organizations are adequately financed, and whether, in contrast to non-profit organizations, should "for profit" institutions be more centrally engaged in the direct provision of services through public financing (Barry Carin, David A. Good. *Financing Russia's Budgetary Institutions In The Health Sector*. - http://www.aucc.ca/_pdf/english/programs/cepra/HealthPaper.pdf). At the same time health experts note that Canada provides an example of the benefits of a federation in terms of its favorable setting for experiments. When the federal government wishes to investigate innovative ideas for payment, capital financing or delivery of health care, it is always prudent to confirm effectiveness and fine-tune the idea with experiments. A federal state is an advantage - cost effective experiments can be devised with selected sub federal units, thereby minimizing political difficulties and the risk of system-wide errors (See *ibid*).

Along with high quality health care practices, it is worthwhile to look at curricula in public health education, that is a discipline that encompasses several sciences including epidemiology, biostatistics, health economics, health psychology and education. A School of Public Health delivers courses that combine epidemiological studies, biomedical surveillance, health promotion and the delineation of roles and function of governmental bodies through political and legal procedures, and thus trains professionals to deal with social, health, governance, political and behavioral issues that determine a population's health. "Introduction to Public Health" course is firmly based on the traditions, beliefs and norms of the society, while using modern concepts and approaches in ways that best suit needs and the epidemiological situation of the society. Thus public health as an educational discipline has the ability to critically situate health, illness and health care in a wider socio-economic and historical context, through the lens of the role of health for the welfare and well-being individuals as well as for society as a whole.

In comparison to Canada, if one look at Russian health policies, they read very much like what they have here in Canada. The key difference lays in lacking people with the skills to implement and monitor Russian health reform policies. What is missing is a trained public health workforce in Russia with the capacity to implement programs that will help prevent HIV, tuberculosis, tobacco-related diseases, alcohol-related diseases and other causes of high morbidity and premature mortality in the country. Not only does public health education lacks

inclusion of modern western achievements but medical equipment in the majority of clinics and hospitals is archaic and hygienic conditions do not even meet domestic standards, let alone established Western ones. As many as one hospital in five still lacks effective hot water and waste management facilities in Russia (L.Maksimova. *Healthcare Reforms in Russia: Current Status*. - 2006. [http://commercecan.ic.gc.ca/scdt/bizmap/interface2.nsf/vDownload/ISA_5214/\\$file/X_6362899.DOC](http://commercecan.ic.gc.ca/scdt/bizmap/interface2.nsf/vDownload/ISA_5214/$file/X_6362899.DOC)). Studies argue, and it is already well-known fact, that despite the declared right of citizens to have access to free drugs in in-patient clinics (hospitals), in reality, the majority of medicines and supplies necessary for in-patient treatment must be paid for by patients out of their pockets. In many cases patients still pay for them unofficially, with the proceeds going directly to the doctors. According to different estimates, patients' out of pocket expenses fund up to 60% of total healthcare expenditures, and most of it is through direct payments to doctors and nurses rather than through private insurance schemes (See *ibid*). Informal practice with expectations that patients offer gifts or pay cash to get care is strongly embedded in to the system.

Since the communist time, healthcare has been low on the government's priority list. Preventive care has never been an objective, which generally makes the Russian healthcare system inefficient and very expensive. Since 1991, the centre piece of healthcare reform in Russia has been the transition from a centralized model of healthcare provision to a more decentralized and insurance-based system of public health care. That transition is still unfinished. In 1994 the government introduced Mandatory medical health insurance based of that of the UK and Nordic countries' systems. The reform brought compulsory medical care insurance and public programs that in fact cover only a small portion of drug purchases and a very limited number of medical procedures and operations. As for high-tech treatments, only a small percentage of the population gets them for free. In the majority of cases, patients have to pay for medical devices used in operations and surgeries based on prices set up by each hospital. Private insurance policies are still rare. Nonetheless, the new system has brought some positive developments such as development of new administrative and information management skills, computerized information systems for patients, providers, insurers and services and standards. Elements of external quality control are beginning to appear. There is also an increased awareness of patients' rights along with the possibility of seeking legal recourse with the support of insurance companies.

Based on its Constitutional declaration the federal government is dedicated to improving health care spending throughout the country at the federal, regional and municipal levels. But so far, the impact of decentralization has been to exacerbate inequalities

between regions and to undermine attempts to plan capital expenditures or human resources rationally. Health care in different regions and provinces of the country is very uneven and unpredictable. Each region has its own system of healthcare provision which is highly dependent on local financing opportunities. In fact, many experts argue that the majority of funding rarely reaches municipal clinics and, instead, continues to be diverted to federal medical centers (Moscow) (See *ibid*). Consequently the question of can the health care reforms succeed has been raised.

CONCLUSIONS

The government of the Russian Federation clearly recognizes the urgency of the health and demographic crises. In September 2005, President Putin emphasized health care reform as one of four national projects that would receive significant public spending increases including a national health care project. This new national health care project, launched by the government on January 1, 2006 represents a significant boost for the country's healthcare system. The two major priorities of the Healthcare National Project are: 1) developing primary medical care (including disease prevention measures) and strengthening the primary care establishments to provide up to 80 percent of the total healthcare services in the country; and 2) providing high-tech medical care to the population and the construction of 15 new federal medical centers and clinics to provide state-of-the art medical treatment. Under the health care reform, in an effort to stem Russia's demographic crisis, the government is implementing a program designed to increase the birth rate and attract more migrants to alleviate the problem of declining population, with immigration being increasingly seen as necessary to sustain the country's population. More money is to also be invested in new prenatal centres in Russia in 2008–2009 and the government has doubled monthly child support payments and offered a one-time payment of 250,000 Rubles (around US\$10,000) to women who had a second child since 2007. In the first six months of 2007 Russia has seen the highest birth rate since the collapse of the USSR. The number of childbirths increased 6.5 percent in the first half of 2007, while the number of deaths fell the same 6.5 percent (Tragakos, E. and Lessof, S. In: Tragakes E., ed. *Health care systems in transition: Russian Federation*. - Copenhagen, European Observatory on Health Systems and Policies, 2003).

The healthcare reforms are strongly supported by the majority of the population. They demonstrate the government's concern for well-being of the least socially protected categories of citizens who have been and continue to suffer significantly from poverty and low income. On the other hand, experts believe that an

increase in public health care spending in general will not result in significant improvement of the system's efficiency. They call for more targeted investments into specific healthcare segments, for example, life essential cardiovascular surgery, cancer treatment, etc. The public health system is now recognized as a significant factor in the national security of the nation. But a gap persists between the priority attached to health improvement on an official level and the actual political commitment to such improvements. Patient out of pocket expenses through payments directly to doctors and nurses remain a wide spread practice that forms a serious barrier to quality health care for people living in poverty, who by different estimates account for about 15-20% of the total population (See: www.nationmaster.com/country/russia/eco-economy: *Millions more Russians shunted into poverty* -www.guardian.co.uk/world/2009/aug/31/russia-economy-poverty-increase-putin, 31 August 2009). Russian societal values and accepted practices, such as high alcohol and cigarette consumption in particular, reflect the move from a highly paternalistic/passive system to a period of rapid and catastrophic deterioration of the health system. And now the current situation of system reform, gradual strengthening and the obvious need for a new set of competencies among health educators, management professionals and related decision makers that can effectively address evidence based clinical practice, equity, population health and health financing is being tested. Good lessons brought from overseas, from Canada for example, could significantly assist the health care reforms. Persuasive actions based on political will and government commitment to halve depopulation and ensure constitutional rights to health care for all are required.

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