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Main Directions of the Promotion of Healthy Lifestyles

Health is a necessary and essential condition for the full, active, creative human life in society. To preserve the health of becoming a public culture of health, which would not only reduced the likelihood of disease, but would encourage the strengthening of existing human vitality.

In accordance with the definition of the World Health Organization, contained in its Charter, health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [1].

Health is purely individual category, which depends on a significant number of risk factors, external processes and phenomena. According to the academician of the RAMS Y.P. Lisicyn (1987) with reference to the WHO, share of the health impact of lifestyles and socio-economic conditions is 49-53%, heredity - 18-22%, the quality of the environment and the natural conditions - 17-20%, health – 8-10% [2]. Social policy in health is based on the idea that health - is higher inalienable right of man, without which it loses the value of other assets.

According to the weekly polls "What is important in life?" (10-11 January 2009), safety, health, economic status and family relations are the most important parts of life for Russians (98% of respondents consider them such). Over the past three years, the hierarchy of the most important aspects of life has virtually unchanged. Attitude to health from February 2006 to January 2009 is for respondents consistently high significance (97, 96, and 98% respectively) [3].

Health is not only purely medical (based on physiological parameters) category, but also largely social category, depending on the value of health, lifestyle, the level of claims of different categories of the population. Not less important determinants of the health of the population, are: characteristics of the physical culture of the various sectors of society, the situation in the field of mass sport, alcoholism and drug addiction degree of population, the conditions and nature of the labour, socio-psychological characteristics (optimism/pessimism, expectations/frustration etc – i.e. social well-being) [4].

Healthy lifestyle - a way of life of the individual for the purpose of disease prevention and health promotion. It is the implementation of action in all areas of life: employment, social, family and household, hobby [5].

As a sociological concept, healthy lifestyle is characterized by:

a) the degree to realize the potential of a particular society (individuals, social groups) in providing health care;

b) the degree of social well-being as the unity of the level and quality of life;

c) the degree of efficiency of social organization in its assignment to the value of health.

In a broader sense, the idea of a healthy lifestyle is the concept of social policy, based on the recognition of high social importance of health, the

responsibility for its preservation by the State, individuals, social groups and society as a whole and asserts the need for concrete measures and actions aimed at creating safe and supportive environment.

It should be noted that the Concept of health system development in the Russian Federation until 2020 in order to achieve sustainable socio-economic development of the Russian Federation, one of the priorities of state policy declares the preservation and strengthening of health through healthy lifestyles and improve the availability and quality of care [6].

At the end of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases (28-29 April 2011, Moscow, a delegation from 167 countries UN officials, leading scientists and physicians - about 800 participants) was adopted The Moscow Declaration. The declaration stated that non-communicable diseases (NCDs) mainly cardiovascular diseases, diabetes, cancer and chronic respiratory disease - the main cause of death and disability - causes more than 60% of deaths in the world, of which 80% occur in developing countries. Experts estimate that by 2030, share of the NCD will contribute up to 75% of deaths worldwide. The declaration notes that prevention and control of NCD require regulation at all levels and implement a wide range of multilevel and cross-sectoral measures aimed at the full range of determinants of NCDs (from the individual to the structural level) in order to create the conditions necessary for a healthy lifestyle. This includes promoting and supporting healthy lifestyles, and select it. "Particular attention should be paid to promoting healthy eating (low intake of saturated fat, trans fat, salt and sugar, and a considerable consumption of fruits and vegetables) and physical activity in the primary and secondary prevention in all areas of life".

According to the Federal State Statistics Service, the main causes of mortality in Russia in 2009 were heart and cardiovascular diseases - 56% of deaths. Next comes cancer - 14.5% and death from external causes - 10.6%, ie from homicide, suicide, accidents, etc. Of the 100 thousand people from heart attacks in Russia die each year 330 men and 154 women, from stroke - 204 men and 151 women.At risk of cardio-vascular system consists of men over 40 and women over 50 with high blood pressure, having overweight, way of life involves stress, low physical activity, lack of exercise, sedentary work, as well as work associated with excessive mental or physical exertion. Thus, for heart disease prevention activities should be conducted before a critical age.

According to a public Internet poll of the Health Ministry of Russia for 75% of Russians healthy life is - giving up smoking. 64.9% believe that this is a balanced diet, 62% - sports, 61.8% - sufficient physical activity, 61.1% invested in this concept the rejection of drug use. 81.5% of respondents are convinced that television broadcasts on health are useful, but 43% pointed to the need to explain how to use the received information in real life. 11% of respondents were unable to answer the question, because they do not watch programs about health. Negate the usefulness of 7.5% of respondents: 6.4% of them do not trust, and 1.1% not all understand.

In April 2011 a study was conducted aimed at identifying the awareness of residents of the city of Novosibirsk on cardiovascular disease and attitudes towards a healthy lifestyle.

The object of study is the population of Novosibirsk in age from 18 to 25 years, since this is the age to start preventive action to prevent the development of cardiovascular disease, and in this age people are more socially active, more use information technology. The majority of respondents (42%) are working students.

The subject of this study is the degree of involvement of young people in Novosibirsk in the problem of early prevention of cardiovascular diseases.

The method of study is selected on-line survey, because according to regular surveys of the Public Opinion Foundation conducted during the season (winter 2010-2011), the level of Internet penetration in the audience age 18-24 years was 81% [7].

The study involved 57 men aged 18 to 25 years. Of these, 35 girls and 22 young people. They were given a questionnaire distributed through one of the social networks.

Surveys showed that 58% of respondents did not know about the high death rate from heart disease. It can be concluded that the younger generation is not informed about the high importance of early prevention of cardiovascular disease.

The leading causes of heart disease surveyed identified primarily harmful habits - 21% of responses, followed by stress and nervous tension - 19%. Third place among are overweight and congenital conditions - by 16%. The influence of heredity noted 14% respondents. 13% of respondents as reasons for the development of cardiovascular disease noted physical inactivity. Thus, knowledge about the causes of cardiovascular disease is reduced to a greater extent to give up bad habits; respondents were less aware that causes of heart disease are much greater.

The overwhelming majority of respondents believe that a healthy lifestyle can be called one of the factors preventing the development of heart disease - 84%. As in the previous question the main causes of cardiovascular disease was first identified bad habits, then the answer to the question "Do you consider a healthy lifestyle one of the factors preventing the development of heart disease?" can be considered natural.

The main components of a healthy lifestyle respondents named smoking cessation - 16%, abstinence from alcohol and regular exercise - 14% ,abstinence from alcohol - 12%,efficient power supply - 11%. Less commonly known as hardening of the respondents and adequate motor activity - by 4%. Just as in the case of the causes of heart disease, the main components of a healthy lifestyle respondents in the first place called the rejection of bad habits (avoiding alcohol and tobacco), but still one of the most popular options was playing sports.

81% of respondents said that already at a young age should think about heart health. At the same time more than half of respondents (68%) said that no trace information to the media about heart disease. Responses to the question

"Would you like to receive more information about heart disease, to prevent them from themselves?" divided exactly in half.

In the first place in importance among the sources of information about diseases of the heart respondents consider the recommendations of doctors in medical institutions - 42%, followed by specialized Internet portals - 15%, and the transfer of health programs on television.

The most authoritative opinion on health 68% of respondents consider the advice of experts in health, in second place - friends and relatives - 24%.

After analyzing the respondents' answers, you can create a picture of the perception of youth problems of cardiovascular disease. Mostly the young generation is not aware of the high mortality from heart disease, but consider that even at a fairly young age is necessary to think about the state of the cardiovascular system. There is no tracking information to the media about this issue, perhaps because of the lack of targeted messages to this audience.

The main source of information consider the recommendations of doctors at medical centers, relying on this source of most.

It can be argued that young people between the ages of 18 and 25 are not aware of the seriousness of heart disease, and present information on this issue is not aimed at young people for early prevention.

The study revealed two basic stereotypes:

1. The main components of a healthy lifestyle, which were named by respondents - not smoking, avoiding alcohol, regular exercise.
2. The leading causes of heart disease - bad habits, stress and nervous tension.

It can be concluded that the younger generation of Novosibirsk has a very narrow concept of healthy lifestyles, so the design of programs to promote healthy lifestyles should pay attention on this aspect.

The purpose of the program to promote healthy living should be increased activity of the population aged 18 to 25 years in the field of early prevention of cardiovascular disease.

The key areas of the program of promotion of healthy lifestyles are the following:

- Attract the attention of the target audience to the problem of early prevention of cardiovascular disease.
- Ensure there is sufficient awareness of the target audience about the problem.
- Motivate to action for the prevention of heart disease.

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The Dynamics of Status and Professional Values of Russian Doctors at the Time of Health Care Reforms

1. The social attitudes of professionals towards the reforms in health care

Attitudes towards the medical insurance system and privatisation of medicine

The pilot interview research with head doctors showed that the functioning of the medical insurance system was not transparent for medical practitioners. Some of them even did not realise the difference between the compulsory and private insurance system. Indeed, at the time of research, private medical insurance had been introduced only in Moscow; it did not function in Komi and Kirov regions. However, some rank-and-file medical practitioners (about 40% in Kirov and about 62% in Komi region) thought that it had functioned in their regions as well. In general, the money that came through the insurance system and through the state many rank-and-file medical practitioners considered to be institutional 'budget money'. The health insurance fund was 'inscribed' into the state system. So, the doctors thought that the fund of health insurance shared with the Ministry of Health the responsibility for the low wages, unsatisfying working conditions and life chances. In general medical practitioners had mixed views on whether the introduction of compulsory medical insurance had had an impact on the state of affairs in their medical institutions. In INTAS research, more than half said that compulsory medical insurance had either negatively affected or did not change at all the following things: the supply of technical equipment (64%); medical and routine supplies (67%); the level of doctors' wages (69%); and the quality of patient care (74%).

Despite the fact that more than a third of all the respondents said that they would prefer to work in the private sector, were they given a choice, there was a widespread sense that some characteristics of the system of state socialised medicine must be preserved. The majority (60%) of doctors said that they supported a partial privatisation; 23% of the respondents did not support privatisation at all and just 15% supported the privatisation without reserve, even if there was some element of payment for health care. Overall 83% of doctors said that some groups in the population must be exempt from payment for health care. They gave priority to a service free at the point of access to handicapped, children, low-income families and medical practitioners themselves. The INTAS questionnaire findings showed that the value of altruism was widespread among medical practitioners. The interviews in Komi region showed that there were private practitioners who gave 30-50% discounts for pensioners, medical workers and other low income groups.

The pilot interview research had also indicated that head doctors also thought that certain areas of practice, as well as certain groups in the population, should be exempt from payment. In the interviews, head doctors argued that some services should be free at the point of use for all the population. In the INTAS questionnaire survey there was an attempt to estimate which medical services might carry charges and which should stay within the free-of-charge state services. It was found that medical practitioners did not reject the idea of introduction of the fees-for-service within the state sector. However, their view was that fees for services should first be introduced for areas of health care not directly connected with the life and immediate well-being of the patient.

The attachment of professionals to the state sector and the notion of state socialised medicine

The interviews showed that many medical practitioners were not ready for the market and privatisation as they remained attached to the notion of socialised medicine, which guaranteed certain social benefits to medical practitioners themselves and to their patients. Most doctors interviewed did not give up their job at a state medical institution, as this might lead to the loss of their social and welfare benefits. Another reason was the importance of retaining registration as an employee in a state medical institution in order to maintain their work record and to qualify for a pension. In the past, registration also provided access to a further range of social benefits such as free or subsidised housing. Nowadays, although this benefit had largely gone as housing construction for medical institutions had been cut back, some medical practitioners said that there was still a chance that new apartments could be sold to medical practitioners at reduced prices.

Also important was the finding that the Soviet work ethic, particularly among older people, still persisted. The interviews with head doctors brought out a few important social attitudes and stereotypes that remained from the past: (1) a priority was to remain employed in a permanent place of work, in which the person worked for many years. There was a high degree of attachment to the labour collective; (2) the ideal of Soviet socialised medicine was maintained although there was also partial support of the privatisation process. This finding corresponds to other research findings (see, amongst others, Twigg 2002)

Soviet ethics involved not only a commitment to the profession, but also an attachment to the labour collective as what many workers referred to as their second home. This corresponds to Clark's (2002) research showing that in Russia, the Soviet sense of the labour collective, shorn of its Communist rhetoric, continued. In the INTAS questionnaire survey, it was found that doctors considered their colleagues to be the most significant reference group, whose opinion they valued. 81% of the respondents turned to their colleagues for help in the cases when the ethical dilemmas arose in their practice (see Table 1 below). Colleagues too came first (37%) in the list of those who provided protection for

doctors, leaving behind the medical association and trade unions. Moreover, 74% of doctors shared their dissatisfaction with the quality of medical care primarily with their colleagues. Medical practitioners did not attach the same degree of trust to medical administrators as well as other professional and justice bodies. Moreover, even in the case where a mistake by medical practitioners had resulted in a death, 40% of respondents said they would prefer to see their colleagues dealing with this.

Table 1

To whom medical practitioners refer

	Reference groups (%)				
	Colleagues	**Administration of medical institution**	**Family**	**Trade union**	**Medical association**
Discussions of ethical dilemmas	81	21	25	2	2
Dealing with medical mistakes	40	63	N/a	N/a	14
Dissatisfaction with the quality of medical care	74	31	18	2	1
Protection for doctors	37	36	N/a	10	6

*N/a – not applicable

Under economic and social conditions where the majority of the population, could not afford private medical services and medicaments, private practice did not fit well with professional ideals and values. In the pilot interviews, some head doctors shared with us their concern that their active involvement in private practice could also lead to a loss of respect among their colleagues. Private practitioners were sometimes treated by their former colleagues and patients as people who had sacrificed professional and social values for private gain. Most doctors referred to their private practice as 'earning on the side' or as 'earning a little extra', even though their income from private practice might become the main source of income.

To summarise, the majority of medical practitioners (83%) said that they supported a *partial* privatisation or did not support privatisation at all. Although medical practitioners were frustrated and apprehensive about market-oriented reforms in the abstract, they were willing to overcome those apprehensions in favour of opportunities to earn more money (about similar research results see Twigg 2002). Concerns expressed by these respondents about the privatisation of health care could indicate philosophical opposition to the notion of privatisation in general. Or it could simply reveal scepticism about how market reforms had

actually operated, or might operate in the future, in Russia. As Twigg rightly argues, concrete observations of Russian citizens about the unpleasant results of market forces in their daily lives could easily give them cause to hesitate in supporting a market for medical services in practice, even if in principle they might be inclined to back the concept of market-oriented reform (Twigg 2002).

2. Dynamics of the social standing of orthodox medical practitioners during the reforms

Before looking at the impact of health care reforms, it is first useful to reiterate that the system of health care that existed in the Soviet Union immediately prior the 1992 reforms was highly centralised. Until the end of the 1980s, health services were funded from taxation for service provided free at the point of use (see, amongst others, Allsop *et al.* 1999). The Ministry of Health at the centre dictated policy and determined resource allocation to the regions and districts in the Soviet Union (Davis 1989). This included setting prices for medicines and equipment and the salaries of health personnel. Capital expenditure was closely controlled, as was the training of health practitioners. Thus, in the former Soviet Union, medical practitioners could not operate as independent professionals. Soviet doctors differed from their Western colleagues in that they did not have an exclusive jurisdiction in a particular division of labour controlled by occupational negotiation. They did not either have a sheltered position in both external and internal labour markets based on qualifying credentials created by the professional association.

In 1991, organisational changes in health care and opportunities for private practice have possibly created the conditions for change in the social standing of Russian doctors. And in the INTAS questionnaire research, there was an attempt to analyse whether it might be that the medical profession had acquired greater autonomy and self-regulatory powers. The research investigated this by assessing the scope for participation for rank-and-file doctors, in or through medical administration; in, or through, trade union activity; and lastly through membership of medical associations. In the research, professionalisation was analysed from a neo-Weberian perspective. Thus, an attempt was made to estimate whether members of a professional group pushed for enhancement of the scope of power, and the gaining economic or cultural resources in the market place or for influence within the state sector, in order to achieve a legally underwritten professional monopoly. The extent of power, financial and cultural resources of medical practitioners was given a special attention in the INTAS questionnaire research, the findings of which are presented further below.

Power resources of medical practitioners

The power resources of doctors were central to the analysis. In the Anglo-American model, power resources derive from the exercise of professional autonomy in a number of spheres (Freidson 2001). The scope of power resources determines the opportunities of a professional group in different social dimensions such as income, prestige, and interesting work. The resources of power used to analyse the INTAS data are summarised as follows: (1) the relative autonomy in making professional decisions, particularly in the sphere of diagnostics and medical treatment; (2) the influence on the scope of a professional remuneration; (3) the professional control over group entry: social closure in the market and in the system of education; (4) the professional control over group exit via the sanction mechanism; (5) the existence of a strong professional organisation as in medical associations or trade unions[1]. Other aspects of power analysed were the ability to determine conditions of work such as work plans and the pace of work. Before considering these aspects of professional practice, legal health care regulations need to be explained.

According to official regulations, the medical management system in health care continues to endorse the central authority of the Minister of Health and this is legally underwritten (State Duma 1997). Officially, the state does not allow the medical profession to govern itself. Those who occupy positions at the top of the state bureaucratic hierarchy, whether medically qualified or not, determine the scope of regulation of those professionals who occupy lower level positions. Thus the medical administration in lower level institutions can do little without Ministry of Health approval, nor behave in a way contrary to instructions from above. In interview, the majority of head doctors agreed that the Ministry of Health governs the profession through a broad web of regulation. The central mechanism is through the allocation of funding that determines the institutional budget. However, regulation is very detailed and there is very little discretion at the lower level. Even the prices for fee-for-services in self-financing departments are controlled by the Ministry of Health.

Power resources of rank-and-file doctors, trade unions and medical administrators

In the INTAS questionnaire survey, an attempt was made to assess what decision-making powers doctors felt that they had within their institutions. Overall, about two thirds (63%) of doctors said that their inability to influence decision-

[1] The membership of Russian medical practitioners in trade unions is still larger than membership in medical associations. In our sample, more than half of all surveyed were members of trade unions, whereas only a fifth of them were members of medical associations.

making in medicine worried them. However, there were regional differences. Only just over half (55%) of Moscow medical practitioners were worried by their lack of influence on decision making in medicine, while over two-thirds of doctors within Komi region (70%) and Kirov (71%) were concerned about their lack of influence. Table 2 below shows the data on the degree of influence that different groups – medical administrators, trade unions and rank-and-file doctors – could exercise over different forms of activity[1].

Table 2

Medical administration, trade union and rank-and-file doctors' influence

	Medical Administrators	Trade Union	Rank-and-file doctors
Admittance of new doctors	4.4	1.3	1.5
Dismissal of doctors	4.1	1.4	1.4
Drawing up work plans	3.8	1.3	2.3
Work tempo	3.5	1.3	2.6
Wage levels	3.6	1.3	1.5
Bonuses/allowance payments	3.9	1.5	1.4
Medical institution funds: profit, credit, etc.	3.8	1.2	1.3
Control over doctors' work quality	4.0	1.3	1.9
Changes in working conditions	3.4	1.4	1.7

This Table is based on the following scale: 5 – very great influence, 4 – great, 3 – medium, 2 – little, 1 – no influence, centred on the mean scores from Moscow, Komi and Kirov regions

As Table 2 above shows, rank-and-file medical practitioners appear to have had almost no influence over (1) the admittance, and dismissal, of doctors and (2) remuneration, such as wage levels, bonuses/allowance payments and medical institution funds. And they could not change their working conditions and control the quality of work of their colleagues. Rank-and-file medical practitioners had from little to medium autonomy in drawing up work plans and setting work pace. Decision-making in the sphere of diagnostics and medical treatment was curbed particularly in primary care, which was reflected in the systems for payment there. Primary health doctors were paid by the number of patient attendances at a level determined by the guidelines of the Ministry of Health. As the interviews showed, many doctors were discontented with this form of piece-rate pay. The prescribed number of visits often did not correspond with the demand of patients for care or

[1] The pilot research showed that medical associations did not interfere with the state of affairs in medical institutions.

with the capacity of professionals to provide health care. Ministry of Health guidelines, however, were a form of rationing system and difficult to alter.

Rank-and-file doctors believed they had next to no influence on their wage level and bonus payments, although the majority of them said they were dissatisfied with their low wages (Moscow 70%; Komi 88%, Kirov 98%). It was expected that trade unions would feel that they had a greater influence on the financial issues, as these organisations were initially formed with the objective of improving salaries and working conditions. However, as Table 2 above indicates, trade unions were no longer able to exercise influence in this and other areas. According to the mean scores presented in Table 2, trade unions were even less influential than rank-and-file doctors. They had little to no influence on the issues of control over entry and exit into the profession: they did not influence the remuneration and had no impact on the changes of working conditions of doctors and the quality control.

Although, in the interviews, head doctors said that trade unions varied in their ability to exercise influence. Some remained quite strong. There had been a few cases where trade union leaders had brought an action against a medical institution for failing to pay back-wages. Other trade unions tried to influence the policy of the Ministry of Health. For example, in relation to issues affecting working conditions and life style, some trade unions made recommendations, lodged complaints, or demanded solutions. Some medical trade unions tried to improve the low standing of medical practitioners. However, the INTAS questionnaire results showed that influential trade unions were perceived to be an exception.

Overall, the INTAS questionnaire respondents said that the power of the medical administrators surpassed that of the medical associations and trade unions. However, many medical administrators did not see themselves as being 'very influential'. They said that budget constraints and tight Ministry of Health' regulations limited the scope of their decision-making powers. For example, many head doctors said that they were not permitted to lease excess physical space in their facilities. They were also clearly frustrated with the administrative limitations placed on their flexibility in spending the resources the government budget allocates to their facilities, a system that prohibited them from shifting money between specifically delineated line items: wages, medications, capital repair, utilities. They argued that they should enjoy more flexibility in spending budget money. The lack of strong power resources of head doctors was evident in raising medical institution funds, wage levels and changes in working conditions predetermined by the guidelines of the Ministry of Health and work tempo.

Power resources of medical associations

The research showed that medical practitioners did not consider professional medical associations to be strong either. As it is shown in Table 3 below, only 6% of

medical practitioners turned for support to medical associations. The majority of them turned to their colleagues (37%); medical administrators (36%) and trade unions (10%). Whereas 33% of medical practitioners said that there was no protection for doctors at all.

Table 3

Who doctors turned to for support and protection

Reference groups	Frequency	Percentage
Colleagues	218	37
Medical institution administration	213	36
There is no protection for doctors	192	33
Trade Union	59	10
Medical Association	37	6
Ministry of Health	28	5
Justice bodies	15	3
International organisations	7	1
Other	16	3
Total	785	–

In this Table more than one category could apply

The interview research indicated that medical associations most often acted as scientific societies where doctors of the same specialty shared their work experiences and discussed interesting medical cases. Some members of the medical associations participated in the state committees that certified private practitioners, and those that determined the ranking category of doctors. Russian doctors are given a category according to their professional level. For example, the category of 'outstanding merit' is awarded to a doctor with the length of service longer than 10 years and extensive experience within a particular specialty. The first category and the second category relates to doctors with the length of service equivalent to 5 years and 7 years with the corresponding experience in a specialty. Representatives of medical associations were often engaged in the certification of the ranking category. Moreover, medical associations might also offer financial or legal assistance to the association members in malpractice cases.

In pilot interviews, head doctors explained the absence of strong medical associations as a consequence of a lack of ambition on the part of rank-and-file doctors. They suggested that these doctors did not think in terms of upward social mobility for themselves or their group. When confronted with infringements on the rights of medical practitioners, most of them remained passive and did not try to defend their rights because they did not believe in the eventual success of their 'struggle for justice' or feared that this struggle would bring more losses than benefits. They were more likely to look to private practice and working extra hours to enhance income, rather than seeking advancement through professional channels or additional qualifications. Other head doctors stated that most Russian

doctors lacked the funding to finance the work of associations. As a result, many professional associations drew on contributions granted by the Ministry of Health. They had limited opportunities to hire personnel and, therefore, they survived due to the commitment of dedicated professionals.

Moreover, some specific features of the historical development of Russian medical profession restrained the development of medical professional associations. Most doctors have accepted the reality of a dominant state bureaucracy that did not only control access to medical posts, but also determined exit from them. It could apply sanctions and dismiss a doctor for poor practice. Therefore, tight state regulations still deprived medical professionals of the ability to control the quality of the work of their colleagues, their training and accreditation. Doctors were subordinated to state officials and academics in many respects. In summary, medical professional associations lacked influence on the life of rank-and-file doctors. However, as it will be discussed below some elite professionals and major professional associations attempted to cooperate with the state in different spheres from the management of the health care system to the creation of new professional ethical principles. And some professional associations even saw professionalisation as one of their primary goals.

Power resources of private practitioners

Those who undertook private practice did not see themselves as gaining a great deal in terms of increased autonomy either, as is seen in Table 4. Doctors in private practice still came under the supervision of the medical authorities in the Ministry of Health who controlled the standards of work and closely supervised the financial aspects of private practice.

Table 4

The influence of rank-and-file private and state medical practitioners on the professional matters

	State	State with fee-for-services	Private
Admittance of new doctors	1.5	1.4	1.6
Dismissal of doctors	1.4	1.4	1.4
Drawing up work plans	2.2	2.3	2.5
Work tempo	2.6	2.7	2.9
Wage levels	1.4	1.3	1.9
Bonuses/allowance payments	1.4	1.3	1.7
Medical institution funds: profit, credit, etc.	1.2	1.4	1.7
Control over doctors' work quality	1.9	2.0	2.0
Changes in working conditions	1.7	1.6	2.1

This Table is based on the following scale: 5 – very great influence, 4 – great, 3 – medium, 2 – little, 1 – no influence, centred on the mean scores from Moscow, Komi and Kirov regions.

Private practice still did not have a well-defined economic and political status. However, private practitioners had acquired greater control over the content of their work and their working conditions. They were also better placed to control the tempo of their work. In contrast to state employees, their income had increased.

Financial resources of medical practitioners

The majority of medical practitioners said that their income had dropped sharply since the beginning of the reforms. In 1999, for example, real disposable personal income of 60% of Russian medical practitioners was equal or lower the subsistence wage (Demoscope Weekly 2001). In 2003, the average income of medical practitioners was 3.707 roubles which was just half as much again as the subsistence wage. In the same year, the arrears of wages were more than 565 million roubles (Mustaphina 2004). It is a disturbing commentary on the reforms that 82% of medical practitioners in the INTAS research said that they were dissatisfied with their economic position and not confident about their future.

Even more important was the widespread sense that the system of remuneration was unfair – that it did not provide real opportunities and did not reward effort. In the Komi pilot interviews, head doctors said that the current system of physician remuneration, which paid salaries solely according to years in service and level of specialty, should be abolished in favour of a market-based payment system. Perhaps not surprisingly, they believed that the needs of doctors were still being ignored, and indeed, in certain respects that the social and financial benefits of medical work had decreased. Respondents estimated their own financial standing as 'quite low'. Table 5 below shows that although most respondents had enough money for food and clothes, there were insufficient funds for other necessities:

Table 5

Medical practitioners' estimate of the current financial situation of themselves and their families

	Regions (%)			Total (%)
	Moscow	Komi	Kirov	
We live from hand to mouth	1	9	14	6
We have enough money for food. We cannot afford new clothes	16	54	51	34
We have enough money for food and clothes. We cannot afford expensive household things (TV set, fridge, etc.)	48	29	31	39
We can buy most expensive household things, but we cannot afford a new car or a dacha	32	7	4	19
We do not deprive ourselves of anything	4	1	0	2
Total	100	100	100	100

The financial position of Moscow doctors was better than that of provincial doctors. However, there was no consensus about whether wage levels had fallen, risen or stayed the same since the health reforms. One third thought that their wages had risen since the reforms. Another third believed that they had fallen, the remainder thought that they had stayed the same. The reason for this lack of consensus among Moscow doctors may be that the range of potential income sources had increased. In the provinces in contrast the possibilities for private practice had not expanded greatly: only 12% of Kirov respondents and 19% of Komi medical practitioners mentioned a growth in income.

After the INTAS questionnaire research, we singled out the group of the respondents who said that they had improved their economic position since the beginning of the reforms to identify the characteristics of this group. It was found out that there was no correlation between the pattern of income growth and the personal variables of the respondents defined by skill, specialty, age and gender differences. Irrespective of their personal characteristics, those doctors who had improved their material situation were more market oriented: either had secondary employment or provided services privately in an official or unofficial way. As it is shown in Table 6 below, for many respondents extra earnings from professional practice were as important as their wages.

Table 6

Importance of income sources for state employed doctors

	Moscow	**Komi**	**Kirov**	**Total**
Doctor's wages	4.4	4.7	4.7	4.5
Other household wages	4.3	4.4	4.6	4.4
Doctor's extra earnings from professional practice	3.5	3.8	4.1	3.7
Doctors earnings from other sources	1.8	2.7	3.1	2.3
Social security benefits	2.5	3.0	2.9	2.7
Rent from housing	1.3	1.5	1.6	1.4
Interest from investments/ savings	1.6	2.0	1.7	1.7
Savings	2.0	2.5	2.2	2.1
Help from relatives and friends	1.8	2.8	3.2	2.2
Other	1.2	2.3	3.4	1.8

This Table is based on the following scale: 5 – very important, 4 – important, 3 – somewhat important, 2 – hardly ever important, 1 – unimportant, centred on the mean scores from Moscow, Komi and Kirov regions.

Overall, 55% of Muscovites, 52% of Komi doctors and 65% of Kirov doctors said that extra earnings from professional practice were important or very important for them. And the research showed that extra income from professional practice was equally important for both state employees and private practitioners.

55% respondents of the state sector, 59% respondents of the state with fees-for-service and 65% of the private sector stressed the importance of the extra income, which was earned as overtime work or in secondary employment. These findings show the existence of multi-faceted strategies for adaptation which doctors used to cope with the decline of the state financing of the health sector and unofficial payments was one of these. In the Russian press, estimates of the percentage of health care that is delivered illegally have varied widely, with Gerasimenko, then Chair of the State Duma's Committee on Health Protection, giving a figure as high as 40% (Shishkin 2003: 17).

Cultural resources of medical practitioners

The cultural resources of doctors were defined as those that derived from the specialist cognitive knowledge base of medicine (Bourdieu 1990). In the Anglo-American sociology of professions, 'professional expertise' and 'the professional ideology of altruism' are seen as important professional characteristics (Abbott 1988; Cant and Sharma 1996). Public acceptance of professional advice was also seen as crucial in determining whether an occupation can be called a profession. In the INTAS questionnaire, an attempt was made to find out whether Russian doctors believed that their knowledge was valued and whether it was a source of their respectability. The professional ideology of altruism that asserts a greater commitment to 'doing good work' than to economic gain, and to quality rather than efficiency was taken to be a significant professional characteristic (Freidson 2001). In the INTAS questionnaire, Russian doctors were asked about the issues of the value of professional expertise and professional altruism.

The value of professional expertise

An interesting finding of the INTAS questionnaire research was the fact that medical practitioners did not directly connect the issue of the level of professional expertise and the quality of patient care with the worsened economic position. The INTAS questionnaire research picked up the discrepancy between the sense of unparalleled material shortcomings of medical practitioners and their rather positive estimations of the professional side of things. In general, medical practitioners rated the quality of clinical work of their medical colleagues at a rather high level: 7.2 at the average on the scale from 1 to 10. The respondents also gave the quality of patient care high marks: 7.8 – on the same scale. The questions on the level of qualification, the quality of medical help and the opportunities to use professional knowledge and experience showed a widespread sense among INTAS questionnaire respondents that despite all the difficulties, progress had been made in terms of the growth of what could be termed 'professional expertise'.

As the INTAS questionnaire survey indicated, the subjective self-assessment of pride in clinical work, professional knowledge and its applicability were rated rather highly:

- 46% of respondents believed that the quality of patient care today was the same as it had used to be in the period prior the reforms. At the same time 32% thought that the quality of patient care had improved and just a minority (7%) said that it had worsened.
- Quite similar results were obtained to the question about the quality of clinical care. It had increased, from the point of view of the 41% of the doctors, had seen no changes for 38% and had worsened just for 5% of respondents.
- 56% of respondents argued that now they could use their knowledge and qualification as effectively as they had done before the reforms started. 28% said that the opportunities to get most of one's experience and knowledge had increased. And only 5% stated that they had lost all the opportunities for development in the professional sphere.

However, if the 'constituent' elements of 'professional expertise' are considered closely, such as the opportunity to take refresher courses, and the frequency of reading professional literature and periodicals, it may be that high marks given to the growing level of professional expertise referred to by doctors can be somewhat overstated. Thus, many respondents said that reforms have reduced the opportunities to retrain (see Table 7 below). As regards the professional retraining, the worst situation was shown in Komi region. In this region, the opportunities for training through attending courses had lessened for the 40% of medical practitioners: 22% had seen no changes and just 19% had had more chances to go through retraining. In Kirov, 23% of the respondents reported negatively about the possibilities for retraining. The reforms had not influenced the retraining opportunities for 28% practitioners and for 37% had improved them. The best opportunities for retraining were found in Moscow. For 42% of Muscovites reforms had not had any impact on the opportunity to retrain and for the third part (36%) the reforms had widened the scope of opportunities to take refresher courses.

Table 7

Opportunities to take refresher courses

	Regions (%)		
	Moscow	**Komi**	**Kirov**
Worsened	6	40	23
Remained the same	42	22	28
Improved	36	19	37
DK	16	19	12
Total	100	100	100

Another indicator of 'professional expertise' – reading of the professional monographs and press testifies to the above-mentioned idea that the optimism of respondents about the increased professional expertise was not well-grounded. Overall, one third of the respondents said they read the professional press seldom or did not read it at all. The data about the frequency and the scope of reading of the professional literature are presented in Tables 11 and 12 below:

Table 8

Frequency of reading of the professional literature

	Frequency (%)		
	Often	**Rarely**	**Never**
Monographs	30	40	7
Newsletters, information bulletins	47	34	3
Journals	58	29	3
Newspapers	44	34	8

In this Table more than one category could apply

Table 9

Scope of reading of the professional literature

	Regions (%)		
	Moscow	**Komi**	**Kirov**
Monographs	30	24	31
Newsletters, information bulletins	55	38	44
Journals	62	54	55
Medical newspapers	41	45	48

In this Table more than one category could apply

The frequency and scope of reading of the professional literature were often limited as a consequence of financial constrains of medical institutions and medical practitioners themselves. In the Soviet time, medical institutions subscribed to the professional literature and kept libraries. This tradition was largely broken after the reforms.

The unrealistic treatment of the level of professional expertise shown by many medical practitioners in the INTAS questionnaire can be explained by an intrinsic desire of a professional community to protect the positive image of medical profession. Despite low income and low professional discretion, medical practitioners in Russia were considered to be a part of a prestigious social layer of the intelligentsia. Similar to Western doctors, their work remained to be a 'status' profession to a certain degree. Weber argued that status communities are organised for the defence of their social privileges and entitlements. Status groups depend crucially upon the maintenance of a life style, and they seek to reproduce themselves through educational mechanisms, in order to prevent the social

mobility of outsiders. Russian doctors did not have the control over training procedures and the entry into medical professions. However, they presumed a special position in the labour force and professional ideology (Freidson 2001).

Professional ideology of altruism

Professional altruism, taken as a social good at which the professional expertise is directed, was seen as an important characteristic of professionals by social researchers writing from various theoretical perspectives. Functionalist and trait writers saw professions as ethically positive embodiments of the 'central values' of the society (Goode 1960; Parsons 1968). Critics felt that this approach reflected too closely the ideological image which professionals tried to convey of their own work. However, neo-Weberian critiques, for example, have not denied the importance of the professional ideology of altruism, arguing that some of their actions may be self-enhancement, but the reverse side of the coin is still a service for their patients or clients (Saks 1999; 2003a).

As the INTAS questionnaire research showed, the respondents were disappointed with the reforms of the state health care sector. However, they were not disappointed in their profession. Overall 69% of the respondents said that they were not disillusioned with medicine, despite the fact that 82% of them said that they were unhappy about their wage level. This proves that professionals try to produce a positive image of the medical profession taken as commitment to a value to doing good work instead of economic gain. As shown in Table 10 below, satisfaction with the profession of medicine was high:

Table 10

Disillusionment with the profession

		Regions (%)			Total (%)
		Moscow	**Komi**	**Kirov**	
Disillusionment	Do not worry	74	66	62	67
	Somewhat worry	11	7	16	11
	Worry	7	16	12	12
	DK	8	11	10	10
	Total	100	100	100	100

Questions on the feelings of respondents towards their work showed that the profession itself supported professional values. Most respondents, almost two thirds, stated that their work motivation did not depend on income. They were committed regardless of income (see Table 11 below). Of course, a proclaimed ideology should not be mistaken for reality. Nevertheless, it is worth noting that regardless of the reforms, doctors still wish to be seen as supporting a professional ideology of altruism.

Table 11

Work motivation

	Regions (%)			Total (%)
	Moscow	**Komi**	**Kirov**	
My work is a contract: the more I am paid for, the more I do	11	11	10	11
My work does not depend on the income I earn. I do all I can regardless of income	62	61	59	61
My work is a necessity. If I had money from other sources, I would not work	11	13	12	12
I like my job, but my family (household duties, hobbies) matter most to me	11	9	10	10
DK	5	6	9	6
Total	**100**	**100**	**100**	**100**

Following the functionalists and trait writers, professionals were supposed to see their work as a kind of mission or calling. Unlike people whose work was considered to be an occupation, and who were taken to lack the feeling of 'commitment' to their work-activity, professionals were assumed to remain committed to an area of work during their life span. Members of the profession were less willing to leave an occupation, and were more likely to assert that they would choose the same work if they were to begin again (Goode 1957). The status of medicine as a career choice was also still significant to the INTAS questionnaire respondents. About one third of them (less in Kirov, more in Moscow) were ready to advise their children or other close relatives to follow a career in medicine. Although in the provinces the proportion of those who would not give such advice to close people is larger, this reflects the greater opportunities that exist in Moscow, as can be see in Table 12 below.

Table 12

Advice to follow a career in medicine

	Regions (%)			Total (%)
	Moscow	**Komi**	**Kirov**	
Ready to advise	44	30	18	35
Would not advise	34	50	63	45
DK	22	20	19	21
Total	100	100	100	100

In summary, the research showed that most Russian doctors did not gain power in the economic and political dimensions. Rank-and-file doctors did not exercise the right to determine their remuneration and to make independent policy decisions as the legitimate experts on health matters. However, medical administrators (head doctors) reserved the right to set their own standards and control clinical performance, exercised, for example, through professional control over working conditions, allocations of money earned in self-financing departments and collegial control over discipline and malpractice. They also exercised some control over the organisation of medicine in their medical institutions. And private practitioners gained more freedom to determine terms of work under the rubric of clinical autonomy. What was also important, was that professional group identities had not been entirely 'wiped out': Russian doctors used their professional expertise and professional ideology of altruism to produce a positive image of the medical profession. And the profession itself and professional values, despite all the shortcomings of the reforms, still were important. Overall, medical practitioners were dissatisfied with their current social position and wanted to redefine it. Some possible strategies of professionalisation are considered in the next section.

3. Professionalisation of medical practitioners

As was discussed, most medical practitioners said that medical associations were not sufficiently strong and active in their regions. During the Soviet era, as was the case with many professional bodies, the few medical associations in existence were essentially coopted by the Soviet authorities (Schecter 1992; 2000). Since then, most professional associations of medical practitioners have not represented an autonomous political voice. However, it may be argued that some newly organised All-Russian professional associations have moved beyond the Soviet-era status. The content analysis of the medical press showed some professional associations proclaimed professionalisation among their goals.

There has been an evident trend of the resurgence of professional associations and the corporate work of doctors for the redefinition of their rights and obligations. For example, this is illustrated by the organisation of the Russian Medical Association (RMA) set up in 1992, which nowadays unites doctors and other health workers all over the country and has a well-developed regional infrastructure. In 1995, the Russian Medical Association initiated and organised the first (XVII) All-Russian Pirogov Congress of Physicians. This was the first meeting of the Congress for more than eighty years. The congress welcomed 600 delegates and more than 500 guests from all over the country. The number of participants at the subsequent second and third Pirogov congresses grew. More than 2000 delegates took part in the former in 1997. 1423 delegates and 600 guests took part in the third Pirogov congress in 1999 (Komarov 2001).

The content analysis of the *Doctor's Newspaper* highlighted the fact that the RMA strives for the status of a 'political' association, which aims at influencing a broad spectrum of the health sector problems. The main goals of the RMA, under which auspices the Pirogov congresses have been held, were proclaimed as the following (Doctor's Newspaper 2001. №21):

> 'Assistance [to the state] in the solving of the vital problems of the health sector, medical science and education, production and mastering of medical technical appliances, pharmaceutical industry, ecology, formation of the moral principles of the society, introduction of our country's and foreign medicine achievements, creation of the favourable conditions for the realisation of national humanitarian and charitable activities throughout Russia'.

Thus, the RMA suggests that assistance of the medical profession should be given to all spheres of health work from the supervision of the pharmaceutical industry and the introduction of new medical achievements to the advancement of moral principles within Russian society. This follows the views supported by earlier Russian and Soviet intellectuals. The status of the intelligentsia has always implied support for broader principles as well as just professional functions. It has meant a special cultural mission involving the dissemination of values and knowledge associated with the practice of a particular form of work (Mansurov and Semenova 2001). Before the October Revolution the physicians, especially the members of the Pirogov society, saw themselves as a critical and creative social force that, above all, developed and protected societal morals and values. They also acted as social critics. In the Soviet period, the physicians had not stopped generating what Bourdieu has termed 'cultural capital' (Bourdieu 1990), however, they could no longer criticise the political elite. The reforms of 1992 changed this situation, brining more scope for the development of a wider role of the medical profession, including the role of social critiques.

The content analysis of the medical press showed that heads of medical professional associations considered two options for the enhancement of the social standing of their professional group (Komarov 2001; Sarkisyan 2001). Some doctors, mostly state employees, hoped that the state would enhance the status of medical practitioners by increasing autonomy and decision making powers – representing 'professionalisation from above' (McClelland 1990: 107). Other doctors, mostly private practitioners, considered another option referred in social literature as 'professionalisation from within', namely the independent development of private medicine from the state, which would mean a legal monopoly in the market: passing over to the professional associations the power to determine training standards; requirements for certification and licensure; and the licensing procedures themselves (McClelland 1990: 107). This is similar to the classical model of professionalisation of the British medical profession. Differences and similarities of the goals of the two major All-Russian medical associations, namely – the Russian Medical Association which unites state employees and the Russian Association of Private Medical Practitioners – are illustrative of the two above-mentioned options for enhancing social standing, as the former association is more

oriented towards 'professionalisation from above', whereas the latter strives for 'professionalisation from within'.

Professionalization from above: Russian Medical Association

As the analysis of the resolutions and other documents of the Pirogov congresses showed, the Russian Medical Association had severely criticised the state, first, for weakening state control of the health sector, while the non-state mechanisms of the regulations of public health had not yet developed (Komarov 2001). Second, the RMA had blamed the state for the substitution of the system of the state financing of the health sector with the insufficient system of compulsory medical insurance. When the members of the RMA talked about their own rights they mainly aspired for participation either in federal or in local departments of the Fund of Compulsory Medical Insurance. The doctors insisted that the members of the RMA were included in these departments and were drawn into the central and local legislative political bodies for (1) drawing up and adopting of the main legislative documents as regards the health care sector (programmes, laws, concepts); (2) working out the professional standards of practice and the main principles of the licensing and accreditation of the medical institutions and certification of doctors. However, the RMA insisted that their participation in the legislature and licensing procedures should go hand in hand with the reinforcement of the state control of the health sector (Sarkisyan 2001).

The RMA had referred their suggestions to the various state organisations, among them the Ministry of Health of the Russian Federation, the President, the Parliament and the State Duma. These higher authorities to whom the participants of the Pirogov congresses had referred, however, did not respond to the concerns of the congress participants (Komarov 2001). This lack of mutual understanding between the state and the profession was mirrored in the resolutions of the three Pirogov Congresses which were not virtually changed from the first Congress to the last. In brief, the resolution of the delegates of the III Pirogov Congress is presented below (Sarkysian 2001):

- The worsening of the health of the Russian population can be considered a national catastrophe and requires immediate in-depth measures on the part of the state. The Congress advises that the Minster of Health should be a member of the National Security Council. Health protection must become a priority for the state and must be put under the control of the President of Russia.
- The state budget investments into the health sector must be increased up to 6% of the GDP. The allocations to the Fund of Compulsory Health Insurance should be raised from 3.6% up to 7.2%, which would bring Russia into line with other European countries.

- The Congress recommends the President and the Parliament to inform the population of the country about the measures taken to improve the general situation in the health sector.
- The Congress announces that the rights and economic conditions of the physicians, nurses, as well as medical scientists, scientific and medical personnel who work in the higher medical education institutions and their students do not correspond to their contribution to the development of the society. The vicious system of back wages should be eliminated. The socio-economic conditions of all health workers must be improved. The average salary in the health sector must be equal to the average salary in the industry.
- The Congress argues that there is a distinct need for the state organisation of the single countrywide medical information system which would provide an opportunity for close cooperation of physicians and their influence on the health promotion and prevention of ill-health. The information net should draw in professional periodicals, TV programmes, Internet sites and publishing houses.

As the above-mentioned resolutions of the Pirogov Congresses highlight, the RMA was mainly concerned with the issues of the health of Russian population in general, while their own professional corporate interests came second. Considerable attention was devoted to the facts of increased health problems of the population: decreased birth rates, growth of the infectious diseases, low life expectancy. Moreover, the members of the RMA have challenged state health policies, mainly those concerned with the introduction of the compulsory insurance system. Thus, it may be argued that the interaction of the RMA with the state is already very different from the strategy of trade unions, generally concerned with improvements in salary and working conditions. However, the members of the RMA have not yet attempted to introduce macro-changes such as an extension of private medicine or changes in health care funding through the insurance system. Rather, they have supported minor reforms which would improve the situation gradually, imposing the responsibility on the state.

Professionalisation from within: Russian Association of Private Medical Practitioners

Changes in the social attitudes of the private medical practitioners and the growth of their aspirations for increased autonomy could possibly lead to the development of a professional ideology, a collegiate culture and, in the long run, a transformation in their social standing. As the resolutions of the first Russian Association of Private Medical Practitioners formed in May 2001 showed, private practitioners, search for more radical changes in the health sector. The goals and purposes of this association are more proactive than the aims of the Russian Medical Association. The main goals of the association stated in its resolutions touch upon the following issues (Komarov 2001):

- The introduction of a single register of private practitioners. The local branches of the association should be opened and should keep registers of medical practitioners as well as the information about their successes and failures – as indicated for example by medical negligence cases. The register would help the association to recommend the best practitioners to the medical insurance associations and the Ministry of Health for the purpose of making contracts with the best private medical institutions and private practitioners.
- Participation in the accreditation procedure. The members of the Association must by all means participate in the procedures of licensing and accreditation of private practitioners to protect doctors form arbitrary and unjust decisions by bureaucrats.
- The regulation of prices on the medical market should be passed into shared regulation of the Ministry of Health and the association, for the purpose of the prevention of the dumping of prices as a consequence of the faulty economics of the Ministry of Health. The state gave an advantage to the state self-financing departments, which work under the privileged conditions compared to the private practitioners (e.g. qualified doctors state employees who render fee-for-services do not undergo accreditation procedures, as against qualified doctors who render independent private services). More than that, the prices on the services of the self-financing departments are still fixed on the 1991 base.
- Arbitration courts that would deal with cases of the medical negligence of private practitioners should be introduced.
- Adoption of laws on the private practice, as fee-for-service practice should become available to the population with the help of change in the system of financing of health care. The major sources of investments into the development of the private health sector are seen as the combination of compulsory and voluntary medical insurance and partial budget financing.

Thus, the Russian Association of Private Medical Practitioners called for more far-reaching changes than the association of their state employed counterparts. Following Burrage and colleagues (1990), professionalising Russian private medical practitioners can be defined as a 'regulatory association' that seek to regulate the members of the profession, to examine and certify them and negotiate on behalf of their members. Private practice still does not have a well-defined economic and political status. However, private medical practitioners have acquired greater control over the content of their work and their working conditions. They are also better placed to control the tempo of their work. In the future, it is possible that private practitioners will outstrip state practitioners in the realisation of the goals of their professional organisations.

Conclusion

This paper has demonstrated that health care reforms oriented to privatisation created a new dynamic and opened up new opportunities for doctors to improve their social standing. It was shown that the majority of orthodox medical practitioners who participated in the research, were discontented with the social standing of medical profession and sought to redefine it. The research revealed that doctors fell into two groups, one anxious to proceed along the Western-style, market-reform path, and the other determined to preserve what they saw as the positive elements of Soviet style health care. Most state orthodox medical practitioners aimed at sharing regulatory responsibilities with the state. In contrast, private orthodox medical practitioners were more willing to achieve relative autonomy from the state and pushed for self-regulation.

Historically in Russia the process of professionalisation of orthodox medical practitioners has been both encouraged, and hindered, by the state. It may be argued that today in the new Russian politics, the state is likely to have the most critical influence on the perspectives of professionalisation of Russian doctors. According to the latest Decree on health regulations, a new cabinet of the Ministry of Health and Social Development still has responsibility for all health care regulations, and the scope of professional discretion of state and private medical practitioners will remain low (Government 2004). Currently, state ministerial authorities plan to enhance the social standing of the medical profession by reducing the number of medical practitioners employed in the state health care sector by half by 2010. They presume that this will increase the efficiency of work and incidentally, the income of those doctors who retain their posts in the state sector. However, the influence of doctors on decision-making in medicine is likely to remain weak, as professional autonomy in clinical and social spheres may not necessarily increase.

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Inclusive Education in Moscow: Differentiation in Awareness of Participants as a Limiting Factor

Introduction

The success of implementing any reform or introducing any social innovation is predominantly shaped by the extent to which these reforms and innovations cater to the interests of the main stakeholders (parties involved) and by the extent to which these *interests* are in line with each other. In turn, alignment of interests begins with agreeing on *views* and *expectations* that the said parties have about the proposed changes.

The introduction of inclusive education (IE) into the practice of Moscow school facilities is a social innovation that affects interests and prospects of a number of social groups – participants of the process and supposed beneficiaries. These are, above all, special needs ***children*** (SNC), children without special needs, ***parents*** of both children's groups, ***teachers*** (of both general and special education schools), and finally, ***administrators*** – officials of the city government and educational supervision bodies. It would be logical to assume that the nature of the said groups' involvement into the inclusive education process (their contribution or opposition to the process) depends on the way inclusive education is viewed by all the stakeholders, the way they see their prospects during its implementation, and the extent to which their interests will be protected throughout the process.

As our colleagues correctly said at the outset of the problem's discussion, the inclusive education model "...throughout its implementation… faces not only the difficulties of creating the so-called "barrier-free environment" (wheelchair ramps, single-storey school design, introduction of on-staff sign language interpreters, upgrading of public facilities, etc.) but also the obstacles of social nature, which include widespread *stereotypes* and *prejudices*, in particular, readiness or refusal of teachers, school students and their parents to accept the discussed form of education" [1].

Managing expectations and attitudes is one of the most important elements of any reform, while building correct perceptions of inclusive education for all participants of the process is apparently one of the significant tasks in managing the process (unless, of course, the managing party is set to implement the innovation by force, which in turn leads to a higher risk of the reform's inefficiency).

It should be stated that worries of many teachers and parents about the large-scale introduction of IE are just as natural as any worries related to any innovation about the type and consequences of which its participants are poorly aware. As a

result, the problems of participants' **awareness** (or, to be more precise, lack of awareness) of the nature, targets, plans and supposed results of inclusive education, together with the problems of **misaligned views** that the main stakeholders have about the process become a high priority.

At the beginning of summer 2010, without waiting for Russia to ratify the UN Convention on the Rights of Persons with Disabilities, the Moscow Government passed the Law on Education for Persons with Special Needs [2]. The essence of implementing the inclusive education program in Moscow is certainly based on humanistic ideas, and addressing the problems, including the educational ones, of persons with special needs and disabilities, is undoubtedly important. Nevertheless, when engaging in any activity or implementing any ideas, even the most pressing and humane ones, one should consider the society's economic as well as social and psychological readiness for the reforms. Otherwise, when implemented incorrectly, even the most humane idea might bring quite the opposite to the expected results, all the way down to rejecting the idea as such.

Research Description

The information above has highlighted the main problem, objective and aims of "**Inclusive Education in Moscow: Social Environment, Problems and Limitations**", an applied research project implemented by the Laboratory for Monitoring Research of Various Children Groups of the Moscow State Universityof Psychology & Education in 2010 (see [2]).

The **research object** was representatives of the following target groups – stakeholders of the inclusive education introduction (see Figure 1):

- Teachers of general education schools;
- Teachers of inclusive schools;
- Teachers of special needs schools and resource centers;
- Parents of children with no developmental disabilities;
- Parents of special needs children and children with disabilities.

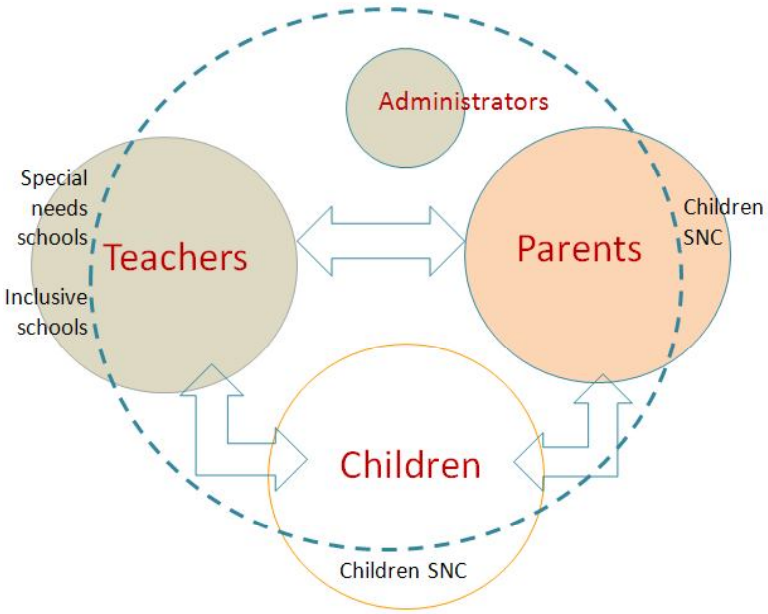


Figure 1. General scheme of the research object

The main **research method** was a selective questionnaire poll among the representatives of the abovementioned groups of respondents from different school groups.

The poll involved respondents from 40 schools that represent four types of educational facilities (ten schools of each type):

1) general education schools,
2) schools planning to open inclusive classes (pre-inclusive schools),
3) schools with the inclusive education model (inclusive schools),
4) special needs schools.

The **selection** included schools that represent all administrative districts of Moscow.

The research (polls) involved 450 respondents (both teachers and parents of school students). The selection structure is presented in Table 1.

Table 1

Selection structure

Respondent type	**Sample size (persons)**
Teachers	
Teachers of general education schools	50
Teachers of pre-inclusive schools	50
Teachers of inclusive schools	50
Teachers of special needs schools	54
TOTAL	**204**
Parents	

Parents of children with no special needs in general education schools	50
Parents of children with no special needs in pre-inclusive schools	53
Parents of children with no special needs in inclusive schools	48
Parents of SNC in inclusive schools	47
Parents of SNC in special need schools	48
TOTAL	**254**

Note: Due to the small subsample size, the research results should be regarded as qualitative.

The **research subject** was:

- **Awareness, perception, evaluation** (attitude) of a specific inclusive education model by target groups;
- **Potential behavior** of target groups' members while inclusive education is being implemented;
- **Factors** that affect awareness, perception and attitude to the inclusive education model and potential behavior of target groups' members during its implementation.

The timeframe of the polls: May to June 2010.

This article outlines some of the results of the completed research pertaining to the problem of awareness among the process participants and the influence that this factor has on their attitude to the IE introduction.

Inclusive education awareness of teachers and parents of school students

Considering the main objectives of the research, the development of the research program helped outline a number of hypotheses about the key factors that are limiting (hampering) the introduction of IE into the practice of Moscow school facilities. These hypotheses were tested during the project implementation.

In our opinion, the basic limitation in the promotion of the very idea of inclusive education as well as its actual introduction in schools of Moscow is insufficient awareness of the main stakeholders – parties that are involved in the introduction of inclusion. It is obvious that in any reform, poor awareness of its participants about the reform's nature, timeframes, mechanisms and supposed results of the project invariably gives rise to myths about both advantages and risks resulting from the upcoming changes, contributing to either a biased negative attitude or to groundless euphoria. In any case, the absence or controversy of information prevents the reform from properly and effectively meeting the targets that it is aimed at.

The poll questionnaires for teachers and parents included several questions that measured the **level of respondents' awareness of inclusive education.** To be more precise, the questionnaires measured mainly the declared awareness across

various aspects of implementing inclusive education (which, being basically a subjective self-estimate, can strongly differ from reality).

Figure 2 shows the shares of respondents who have stated their awareness of various aspects of IE introduction.

As seen from the presented data of the poll, the level of declared awareness on various aspects of implementing inclusive education varies greatly. While some general information related to IE was made available to quite a lot of the respondents (this is what is stated by a majority of teachers), the awareness of the city passing the Law on IE cannot be described as strong. Only approximately one quarter to one third of parents from various school types said that they heard about the passing of this Law, with this answer being the least common one in the categories that are supposedly most heavily involved in this issue (see parents of SNC).

The share of teachers who claim to be well familiar with an inclusive education experience is quite low. Of special note is the poor awareness of this experience among the teachers from special needs schools.

Teachers **Parents**

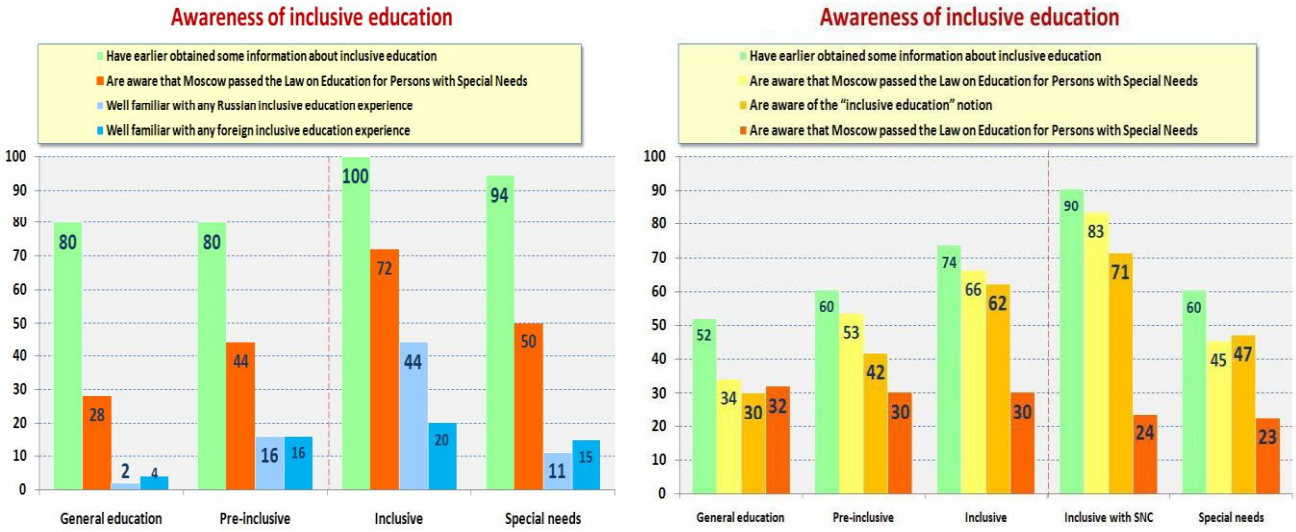


Figure 2. Level of inclusive education awareness across various respondent groups

According to the research data, only teachers from inclusive and pre-inclusive schools, as well as parents of SNC from inclusive schools, can be described as having a fairly large share of participants with strong awareness. These are precisely the groups of participants that are the most interested parties in the IE implementation process.

We should once again note that at the moment we are talking about declared awareness, which due to pressure from social norms is usually higher than real awareness. It is clear that the authors of the research would also like to obtain information about the real **awareness, at least that of the very notion of "inclusive education"**.

When asking the question the answers to which are presented in Figure 3, the authors of the research planned to obtain data on the extent to which teachers and

parents of children from various school types are aware of the established definition of inclusive education as *"education of SNC together with non-disabled children on the basis of general education schools"*. This data was supposed to show the alignment of views that the main stakeholders have about the specific inclusive education model being implemented across Moscow schools.

Above all, it should be noted that the most numerous groups of teachers and parents of children from general education schools basically have no more or less predominant view on what inclusive education is. At the same time the "correct" view, introduced by the city Law on Inclusive Education, fails to account for even half of the "votes" in these schools. The distribution of answers (which is close to even) tends to point at the real **unawareness of inclusive education aspects for most teachers and parents**.

Teachers **Parents**

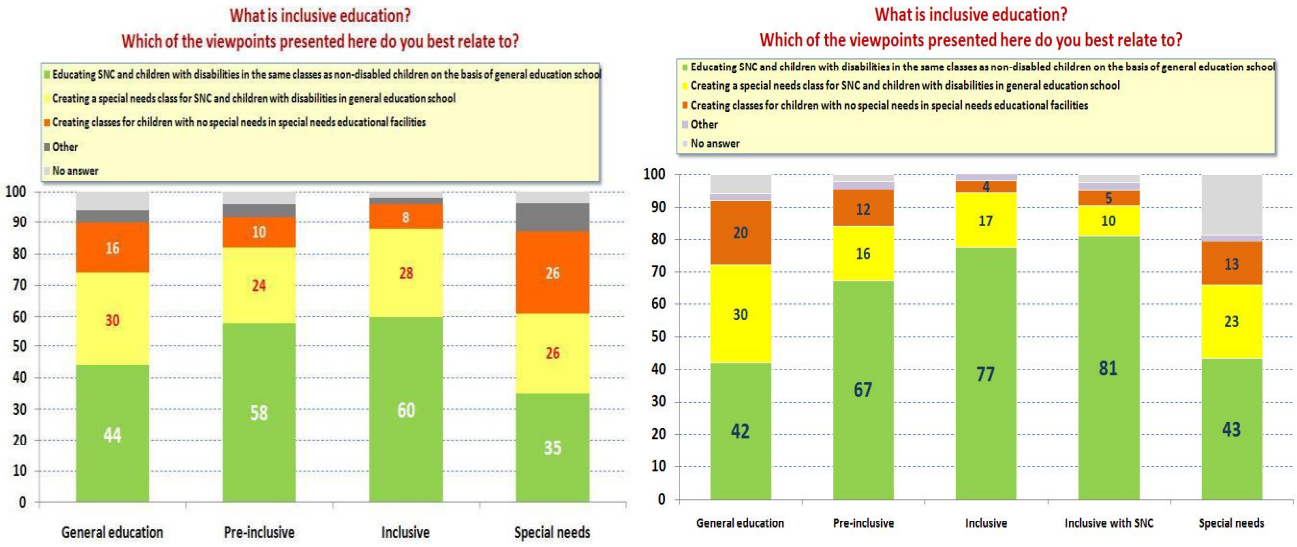


Figure 3. Various sources, including specialized literature, sometimes offer different understanding of inclusive education. Which of the viewpoints presented here do you best relate to?

In contrast to the respondents from ordinary schools, the teachers and especially parents of students from school facilities with an inclusive component, which are still rare in Moscow, obviously have better understanding of the nature of the IE model being implemented in the city. It seems logical considering that the introduction of inclusive education in these schools involved appropriate informational and professional preparation.

Curiously enough, the distribution of answers given by the teachers and parents from special needs schools, who we assumed would be well-informed, show the strongest differentiation in their viewpoints.

It should be noted that presented data not only shows the respondents' overall awareness of the inclusive education problem but also identifies their attitudes to various education models for SNC.

From one quarter to one third of teachers from various school categories believe that inclusive education is "*Creating a special needs class for SNC and children with disabilities in general education school*". And although this option, which we view

as a compromise, is not officially recognized, its frequent selection points at its viability and acceptability.

It is also well-known that creating *classes for non-disabled children in special needs schools* is not a widespread official practice today. However, in reality there are cases when non-disabled children attend special needs school as an experiment or in cases when parents want to educate their non-disabled child and their child with minor special needs in the same special needs school. As a result, it can be said that when choosing the third option in answering this question, the respondents were most probably guided not only by specific knowledge but also by their preferences across different variants of inclusive education. In this case, it is clear why this option was chosen by one quarter of teachers of special needs schools, in contrast to its majorly lower frequency of choice by teachers of the other groups studied (from 8% to 16%). In our opinion, *this choice is an indirect sign of the oppositional attitude to the implemented model of inclusive education that this group of teachers has.*

The data above (Picture 3) shows a quite predictable picture, i.e. it is teachers of inclusive and pre-inclusive schools that account for the largest share of the respondents who have the "correct" understanding of the inclusive education notion. At the same time, we believe that 60% is nevertheless a fairly low level for the facilities which are either already using an inclusive education model or are planning to introduce it soon.

To find out the quality of participants' awareness, they were directly asked about their **sources of information** about inclusive education (Figure 4). Analyzing the answers to this question showed that the majority of members from all the respondent groups have superficial publicly available information about inclusive education. Research participants from inclusive and special needs schools have a more thorough and profound awareness of the topic.

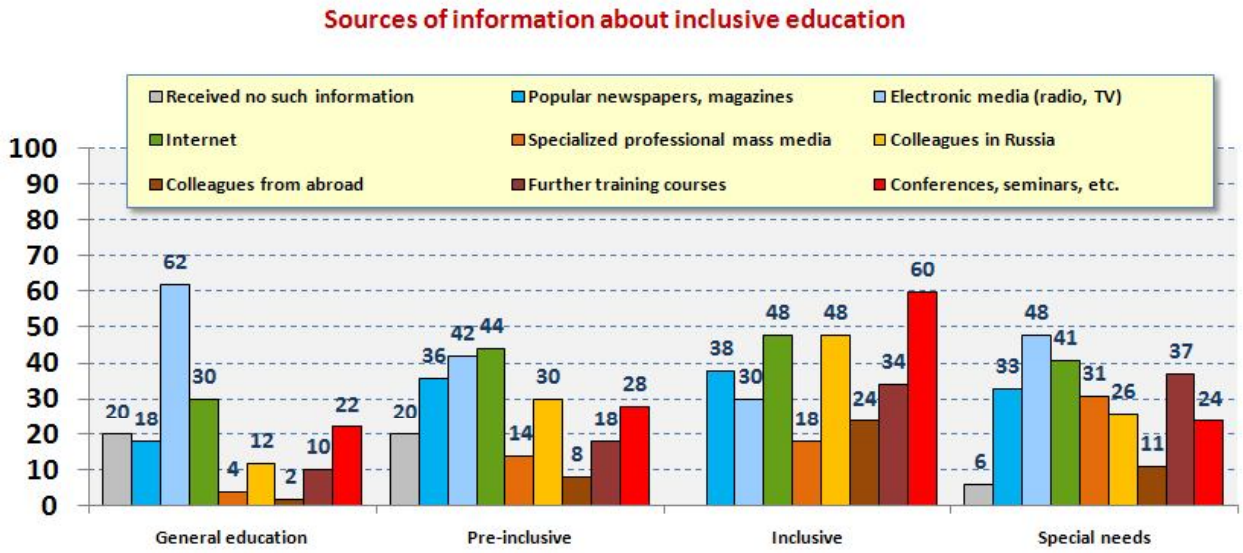
The chart above shows that most teachers involved in the research have in this or that way received information about inclusive education (at least this is what they claim). However, the majority of both teachers and parents mentioned popular mass media and not professional communications as a source of information about this topic, i.e. views of the main participants of the process today are often shaped by biased information which fails to provide an all-round comprehensive picture of all advantages and risks of inclusive education. Such information is often aimed solely at establishing a tolerant social attitude to persons with disabilities, while not quite appropriately reflecting the problems involved in activities aimed at creating a barrier-free environment, in particular, in implementing inclusive education.

Certainly our respondents also included those who obtained information from serious sources such as conferences and seminars, further training courses, colleagues in Russia and abroad, and representatives of other school types. There are notably more of them among the respondents from inclusive schools.

One fifth of teachers from general education and pre-inclusive schools have obtained absolutely no information about this issue. The share of parents who have

obtained absolutely no information about inclusive education problems is even larger across all school groups, with the exception of inclusive schools. As a general result, teachers and parents of children who attend general education schools today can be definitely described as one of the respondent groups with the lowest awareness.

Teachers



Parents

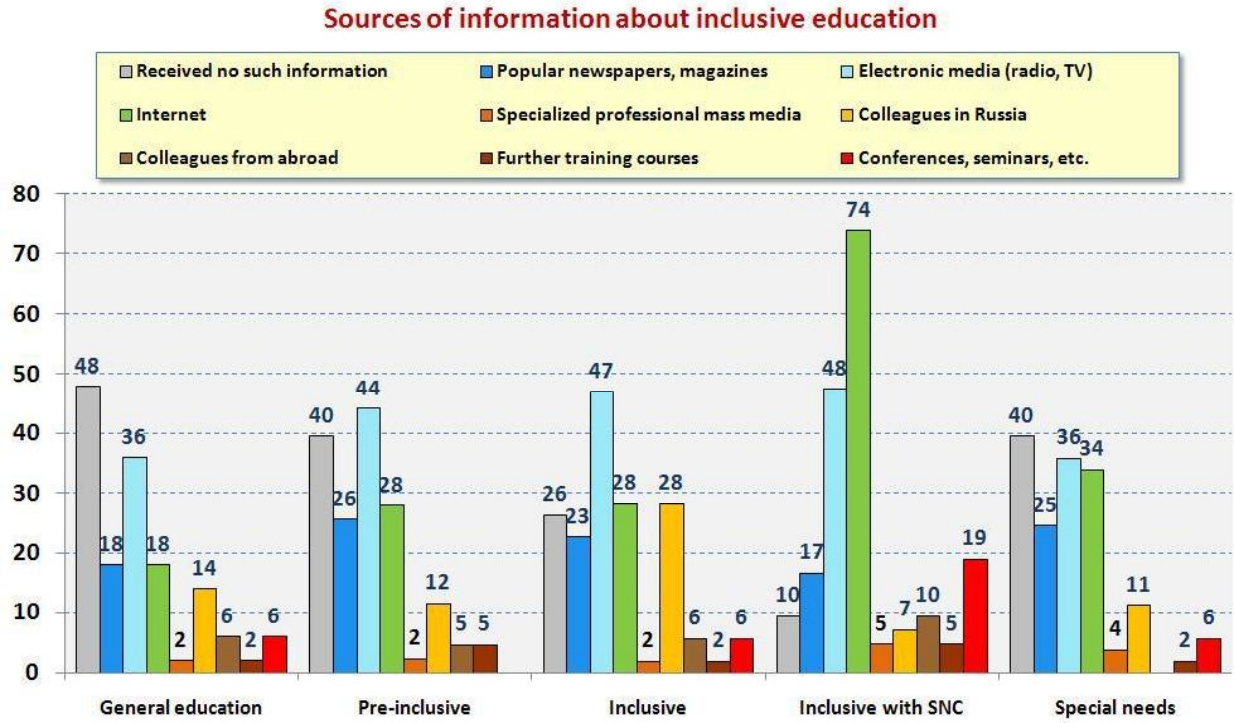


Figure 4. Have you ever received any information about inclusive education before? If yes, please specify the source

A stand-alone group in terms of awareness of inclusive education problems is parents of students attending inclusive schools and, to the largest extent, parents of SNC. This is quite explainable. Apparently this is the group of parents that have rather strong hopes for the inclusive form of education in terms of providing a successful life path for their children, including career and income prospects. There is another parameter, which we believe to be important, that makes this group of parents stand out: 74% of parents from this group have obtained information about inclusive education from the Internet. Other groups have a notably lower share of parents who have also obtained information from the Internet. This might mean that parents of SNC are actively involved in the Internet communities and in searching for related information on the Internet (with the Internet most probably as their best accessible source). Compared to parents from other groups, it is also the category of parents that most often obtains information about inclusive education problems by participating in various conferences and seminars. Parents who educate their SNC in inclusive schools are most likely pro-active people who are highly interested in and have strong confidence for developmental prospects of their children. This category of parents is also characterized by a higher level of education compared to other parent categories: 76% of the respondents from this group have a university degree (Figure 5).

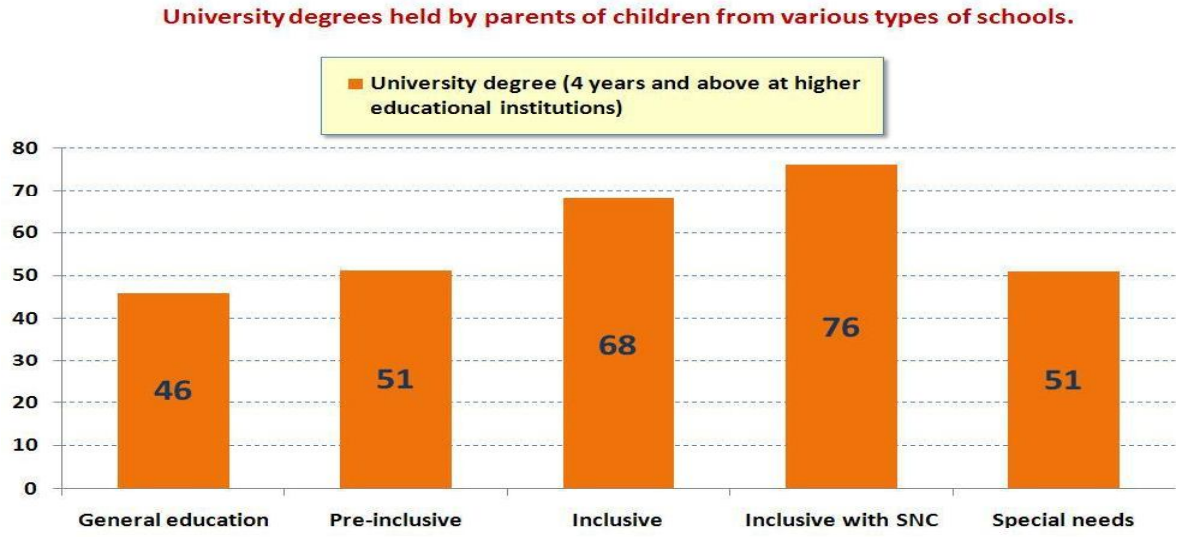


Figure 5.University degrees held by parents of children from various types of schools.

Perceptions of inclusive education and attitudes to its introduction

The level and nature of respondents' awareness of inclusive education issues largely shapes their attitude to this matter. To show existing perceptions of inclusive education and attitudes to its introduction, let us look at the data shown by Figure 6.

The data provided by Picture 6 shows that even the group of teachers from inclusive schools has less than 50% of supporters of the inclusive education model approved by the city (educating SNC and non-disabled children in the same classes

on the basis of general education schools). In the groups of teachers from general education schools and schools that plan to introduce inclusive education, the share of supporters stands between 18% and 30%, and in the group of special needs schools, it is only 2% (1 person).

Teachers from inclusive schools have a much greater share of supporters of integrated (same-class) education for non-disabled children and SNC on the basis of general education schools of Moscow. At the same time, however, just below one half of teachers from inclusive schools are supporters of other education models for SNC. As a result, even the community of inclusive school teachers does not have a commonly established positive attitude to educating SNC in the same classes with non-disabled children in general education schools.

The position held by parents of pre-inclusive school students is majorly different from that of teachers in these schools. This data demands further explanations. As a rule, teachers and parents from the same type of schools have a rather similar attitude to IE, which in turn points at intensive communications and two-way influence between teachers and parents from the same school.

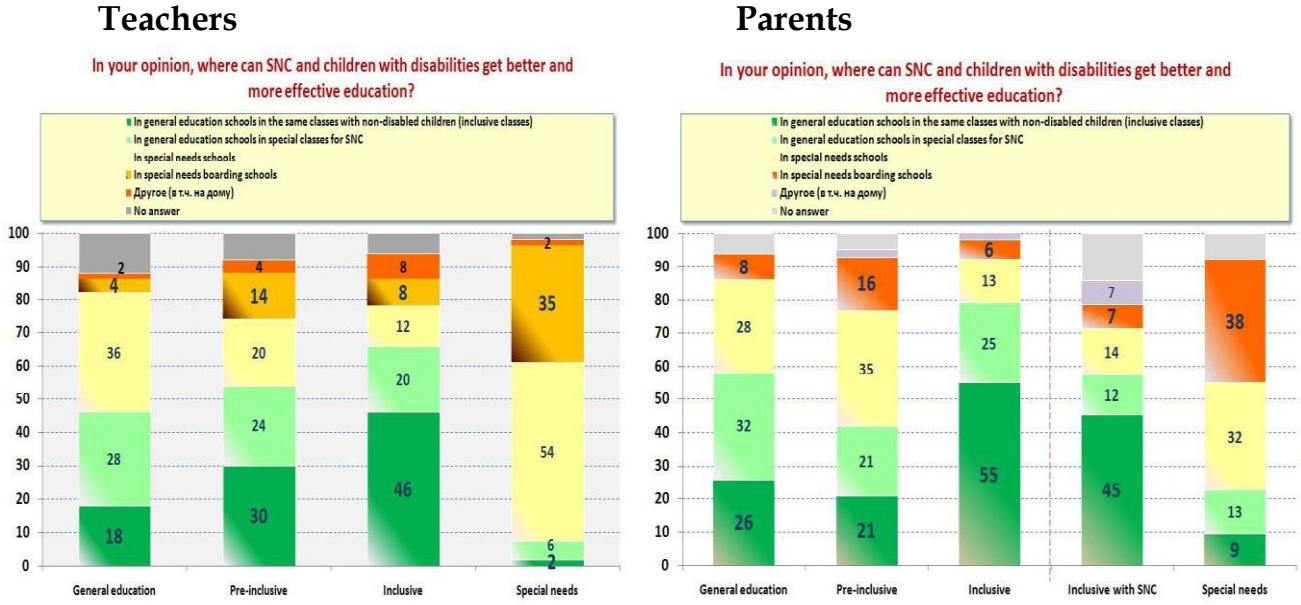


Figure 6. Today, the teachers' environment does not have any commonly established view on where SNC and children with disabilities can get better and more effective education. In your personal opinion, where can SNC be provided with better and more effective education?

In this relation, the shared position held by teachers and parents from special needs schools, who predominantly do not accept the introduction of the IE model, calls for attention. 90% of the polled teachers from this group of schools are opposed to the idea of educating SNC in the same class as non-disabled children on the basis of general education schools.

The analysis of answers to the question about the personal attitude of teachers from various groups to the general idea of inclusive education produced broadly the same results (see Figure 7).

As seen from Picture 7, more than a half of teachers and parents from different groups of schools, with the exception of special needs schools, are in this

or that way positive about the idea of introducing the inclusive education model. The most positive attitude to the idea of introducing inclusive education is shown by the teachers and parents from inclusive and pre-inclusive schools as the most highly aware persons with professional and psychological preparation and certain experience in dealing with SNC, i.e. in the first place basically accepting the idea of inclusive education. The most negative attitude to IE is shown by the teachers and parents of children attending special needs schools as they believe this form of education for SNC to be unnecessary provided that an effective streamlined system of special needs education is in place.

Teachers **Parents**

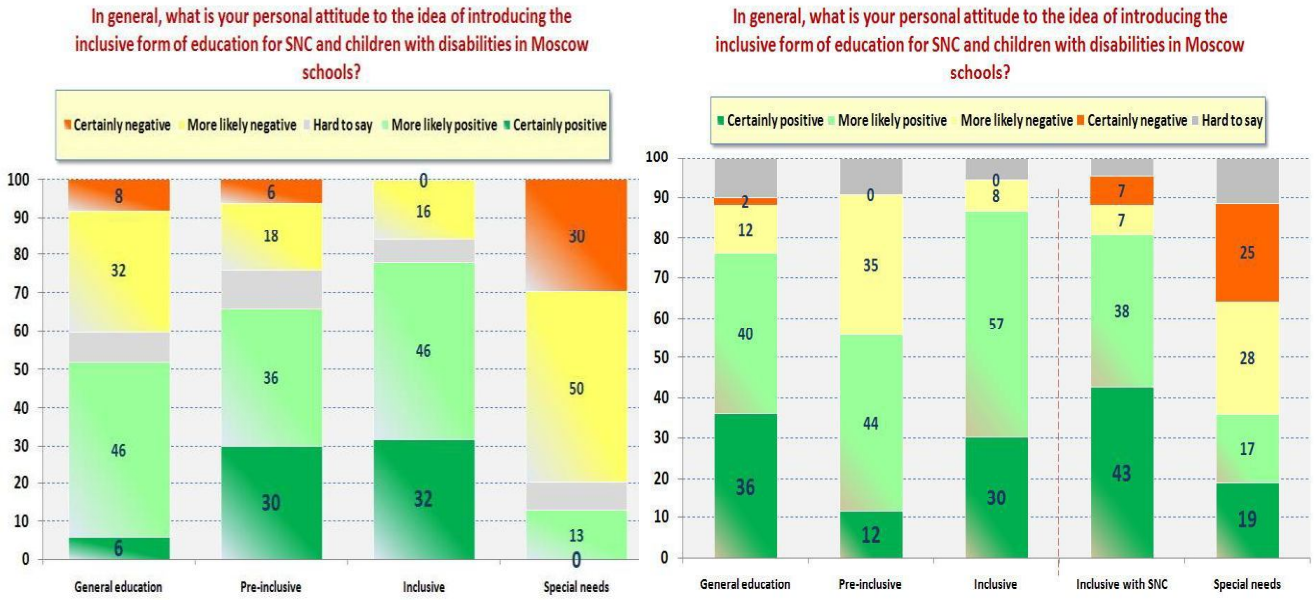


Figure 7. In general, what is your personal attitude to the idea of introducing the inclusive form of education for SNC and children with disabilities in school facilities of Moscow?

Of interest is the position held by parents of children attending general education schools. For members of this group, the declared level of positive attitude to the idea of introducing inclusive education is comparable to that of parents whose children attend inclusive schools. At the same time it is difficult to concede that this attitude was shaped by a thorough study of the issue or a specific first-hand experience. Most likely it is connected with the absence of extensive information about the advantages and risks associated with the introduction of inclusion, while at the same time pointing at the stereotype of a tolerant attitude to special needs persons already established in public consciousness. Nevertheless, teachers of general education schools have a certainly positive attitude to the idea of introducing inclusive education in school facilities of Moscow in only 6% of cases, with more than a half of them opting for a milder statement – "More likely positive".

The worst attitude to the idea of introducing inclusive education in school facilities of Moscow is displayed by the teachers and parents of children attending special needs schools. None of the teachers from this group have a certainly positive attitude to the given idea, and only 16% of teachers from this group opted

for the "More likely positive" variant. The remaining 80% of teachers from this group are in this or that way negative about the established IE model. Compared to the teachers, the parents who educate their children in special needs schools show a slightly more interested attitude to the idea of introducing inclusive education in Moscow schools, but the level of positive attitudes to IE in this group of respondents is significantly lower than that shown by the members of other parent groups.

In our opinion, an unambiguous answer to the question why it is teachers and parents of children who attend special needs schools that are opposed to the idea of the inclusive education model comes from analyzing answers to the question whether respondents agree or disagree with a number of statements related to the problems of introducing inclusive education, i.e. to the fact that the introduction of inclusive education will involve closing part of special needs educational facilities (see Figure 8).

The data analysis clearly shows that teachers of special needs schools have serious worries that a large-scale introduction of inclusive education will involve closing special needs facilities and result in a consequent reduction in funding for educating SNC. Other types of schools have a significantly smaller share of teachers sharing this position. Nevertheless, it is clear that the representatives of general education and inclusive schools also have an equal, and rather large, share of those who agree with this statement. It is teachers of pre-inclusive schools that have the smallest share of those who in this or that way agree with the statement above. It seems that the teams of teachers from special needs schools turned out to be virtually excluded from the introduction of inclusive education, which resulted in a definitely critical and worried nature of their perceptions of the process. It is possible that their opinion could become more grounded and open to compromise if they were more involved in the process.

8.1. **8.2.**

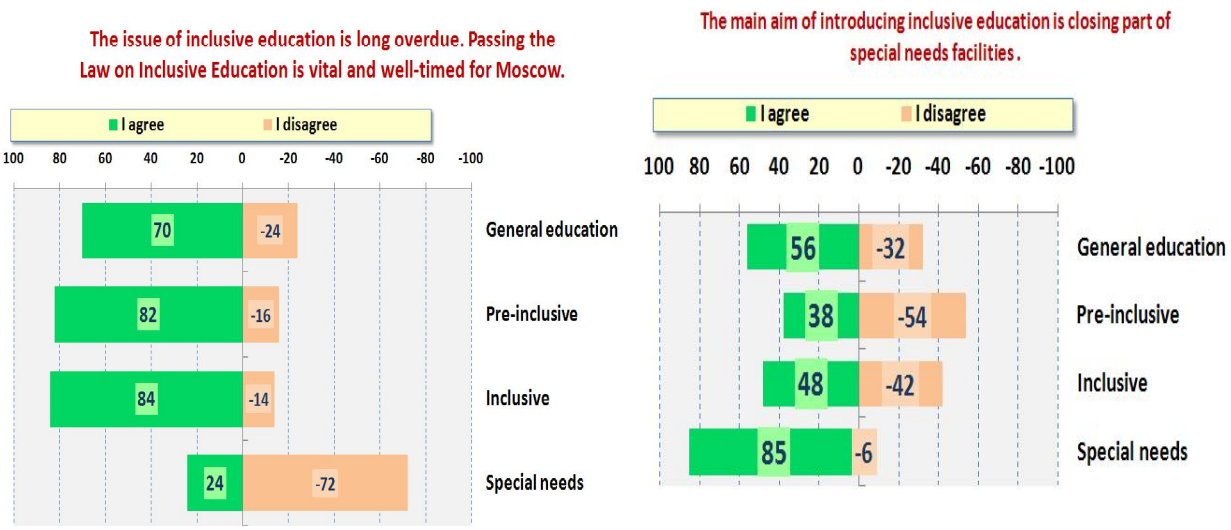


Figure 8. Extent of agreement with some statements on inclusive education introduction in Moscow among teachers from various schools

General conclusions

The data above gives grounds for the following conclusions:

1. The most positive and interested attitude towards the introduction of the inclusive education model in Moscow schools is displayed by the respondents from inclusive and pre-inclusive schools, i.e. those who due to the circumstances are already involved in the public discussion around creating a barrier-free environment for special needs persons and already receive the largest amount of proper extensive information about the problems and aims of inclusive education, those who are familiar with their colleagues' experience in this area

2. The lowest level of inclusive education awareness was shown by the respondents from general education schools – the biggest group which will soon become the main basis for the introduction of the inclusive educational model. At the same time the majority of the group's members obtain their information not from specialized sources but from mass media reports, which are mainly aimed at shaping a positive tolerant attitude to special needs persons in the society as part of creating a barrier-free environment. This might be the reason why the respondents from general education schools declare a positive attitude to the idea of introducing inclusive education in schools of Moscow. It seems that a positive attitude to the problem of creating a barrier-free environment and inclusive education is perceived by the community of parents and partly of teachers as a socially approved norm.

3. The group of teachers from special needs schools is a separate group in terms of their attitude to the idea and problems around the introduction of inclusive education in Moscow. While declaring an average level of awareness compared to other groups of teachers, the respondents of this category are often strongly opposed to the idea of implementing the inclusive education program. As shown by the research data, one of the reasons behind this attitude is the fact that there is no clear information about the future and place of special needs educational facilities in the process of establishing a new context of educational environment. Being excluded from the discussion and practice of introducing the inclusive education model, the respondents from special needs facilities have strong worries that the barrier-free environment, which inclusive education is an element of, will be created through reducing the number of special needs educational facilities.

As a result, the awareness factor certainly has an impact on the attitude to inclusive education shown by teachers and parents of school students from various categories of Moscow schools, with the low awareness level acting as a real barrier and a limiting factor in the process of introducing the inclusive educational model. The latter can result in both a quite high level of non-critical IE acceptance, often leading to a sudden disappointment (the case of respondents from general education schools, where teachers might not perceive the introduction of inclusive education as a possibility of close changes in their work), and probably ungrounded opposition (the case of teachers from special needs facilities). In any case, absence of proper awareness improvement for all participants involved in

inclusive education increases the risk of opposition to its introduction process from the community of teachers and parents.

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Zakirova, Venera M., Zakus David,
Larson, Charles P., Gataullin,Rinad

Quality Health Care in Russia Today: Is It Free and Accessible for Everyone?

Russia's constitution guarantees free, universal health care for all citizens. Is it true for today's Russia? The article attempts to provide an analytical answer to this vital question to each Russian inhabitant.

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 150 million in 1990 to about 142 million in 2006, caused by the duel 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 it's 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[1].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

[1] 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.DOC]

to doctors and nurses rather than through private insurance schemes[1]. As a consequence, a serious barrier to quality health care for low income persons, who make up 17-20% 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.

[1] See ibid

Zakirova, Venera M., Zakus David,
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Health Care Reform in Russia: The Gap in Access to Quality Health Care for All Remains Wide. A Comparison with Canada

Russia's constitution guarantees free, universal health care for all citizens.
Article 41, Russian Constitution

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to doctors and nurses rather than through private insurance schemes[1]. 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.

Background

In the Soviet era the health care system was based heavily on primary prevention, consisting of extensive 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[2]. 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[3].

Current State of Health in Russia

The best way to understand the current state of health in Russia is to listen to ordinary people. Freelance journalist Shaista Aziz, UK, spend a week in Russia in 2007 mapping out poverty in Tver and Tula oblasts and in St Petersburg gathering

[1] See ibid

[2] 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

[3] Jeni Klugman, et al. Health Reform in Russia and Central Asia. http://www.nap.edu/html/transform/ch12.htm

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[1]. Below is the extract of her report on the information gathered

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 only around 8,9,000 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 then 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

[1] 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.

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 curios 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 then 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 career 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. "

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[1] . 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[2]. 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

[1] http://www.nationmaster.com/country/rs-russia/peo-people

[2] See ibid

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[1]. 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[2]. 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[3]. 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)[4]. 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[5].

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

[1] 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

[2] http://www.who.int/chp/working_paper_growth%20model29may.pdf

[3] 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:

[4] http://www.nationmaster.com/encyclopedia/List-of-countries-by-Human-Development-Index

[5] 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

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[1]. 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[2]. 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[3]. In terms of access to primary health care, children are the most disadvantage 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[4]. Those children in large have limited or no access to quality health care.

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[1] 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 Genebra Nov. 2003. http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862003001100003#fig2

[2] See-ibid

[3] 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; W.Tompson. Healthcare Reform in Russia: Problems and Prospects. - Economics Department Working Papers No. 538. www.oecd.org/eco/working_papers

[4] 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

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[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[2]. 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[3]. 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[4]. 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.

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[1] http://www.nationmaster.com/red/country/rs-russia/hea-health&all=1

[2] *За семейным врачом стоит будущее здравоохранения.* http://medi.ru/DOC/7392301.htm

[3] 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

[4] Jeni Klugman, et al. *Health Reform in Russia and Central Asia.* http://www.nap.edu/html/transform/ch12.htm

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[1]. 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[2]. The Canada Health Act requires that all medically necessary services be covered by Medicare, without any "out of pocket" cost to the patient[3]. 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[4]. 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[5]. 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

[1] Health system in transition. HiT Summary Canada, 2005. http://www.euro.who.int/Document/E87954sum.pdf

[2] Armstrong P., Armstrong H. Health Care. About Canada Series. - Fernwood Publishing, Halifax and Winnipeg. 2008

[3] Barry Carin, David A. Good. Financing Russia's Budgetary Institutions In The Health Sector. - http://www.aucc.ca/_pdf/english/programs/cepra/HealthPaper.pdf

[4] Armstrong P., Armstrong H. Health Care. About Canada Series. - Fernwood Publishing, Halifax and Winnipeg. 2008

[5] See ibid.

direct provision of services through public financing[1]. 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[2].

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[3]. 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

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[1] Barry Carin, David A. Good. *Financing Russia's Budgetary Institutions In The Health Sector*. - http://www.aucc.ca/_pdf/english/programs/cepra/HealthPaper.pdf

[2] See ibid

[3] 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

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[1]. 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) [2]. 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

[1] See ibid.

[2] See-ibid.

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[1].

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[2]. 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

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[1] 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.

[2] See: www.nationmaster.com/country/rs-russia/eco-economy: Millions more Russians shunted into poverty.

http://www.guardian.co.uk/world/2009/aug/31/russia-economy-poverty-increase-putin, 31 August 2009.

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.

Shestakova, Natialia N., Krasavtseva, Eugenia I.

Lifelong learning as a factor of personal stability in turbulent times: a view of Russian secondary school students

The English term "turbulent times", which is part of the title of the conference, can be translated into Russian as "times of discontent, of disquiet". Or, of instability. It is apparent that during periods of turbulent historical development, each person will strive towards personal stability and continuity. This leads to a question: what could become the factor, which would give each person a sense of self belief? What could help each individual, even if partially, of external circumstances, which often cannot be changed, and which define one's way of life? It would seem that one's education could be such a factor. Moreover, taking into account the rapidly increasing pace of modern information sources one can access, this education cannot have a defined end point, or be given once and never updated after that. Education must become an integral part of one's life, of the very existence of each person, it must be continuous.

The authors have carried out a special survey, which was intended to investigate the views of Russian secondary school students on lifelong learning. The goal of the survey was three-fold: 1) to identify how aware secondary school students are of the principles of lifelong learning; 2) to assess their understanding of the very term lifelong learning, and 3) to identify, how important they consider the idea of lifelong learning in their future lives.

The survey was carried out as a questionnaire of 8th-9th grade students in one St. Petersburg school, which was filled in by 59 persons, including 55.2% girls and 44.8% boys (Feb 2011). It should be noted that these respondents were chosen on purpose, as these teenagers are at the first educational "crossroads" in their lives: they are about to complete their junior secondary education stage and make a decision whether to continue their education. It is obvious that such a decision can be made once (i.e. the person has made a definite decision what he or she intends to do in their life and clearly sees ways to reach the set goal), or undergo adjustments (in case the young person does not know or does not sufficiently understand what he or she strives towards, or just wants to try different things in life). It is obvious that in both cases reaching the goal requires obtaining the required education.

The survey has shown that 2/3 of the respondents (66.1%) understand that one should begin planning one's educational route in middle grades of secondary school. Middle/upper grades correspond to the current status of the respondents – 8th-9th grades of secondary school.

So what are the educational plans of teenagers? According to the data obtained through the survey, the vast majority (96.6%) are planning to obtain a full secondary education, after which 2/3 of the respondents intend to continue their

education in universities, institutes and academies. Furthermore, girls – as it was always the case historically – are more inclined towards professional higher education, than boys. These figures vary by almost a half: 61.5% girls compared to 38.5% boys. One in five students about to complete junior secondary education has not decided on his or her future educational trajectory – after completing junior secondary education, 11.9% of students intend to obtain professional secondary education on professional schools and colleges. Only 3.4% respondents – boys – do not intend to continue their education. In general, the obtained data quite correctly reflects the overall picture of educational goals among young people in large Russian cities.

These are the current general intentions of young people. However, up to this point we discussed education obtained in a single go. What are the longer-term plans of teenagers with respect to their educational trajectory? What is their understanding of the *objective need* to continuously maintain and develop one's knowledge, skills and qualifications in line with the idea of lifelong learning? The survey has shown that the majority of students have not developed the willingness to continue their education throughout their entire lives: only 4 in 10 respondents share this idea (39%). Girls are more inclined towards this – 78.3% (boys – 21.7%). A third of the respondents believe that the education they would get in their early lives would be sufficient "to the end of life". Such views share 30% girls and 70% boys. More than a quarter of teenagers could not give a definite answer to this question.

What causes the identified distribution of responses? The authors can offer as the explanation the suggestion that, perhaps, young people simply do not have the necessary information about the ideas and principles of lifelong learning. The questionnaire contained a number of questions, intended to confirm this hypothesis. Indeed, it turns out that the level of awareness among school students is not sufficiently high. One in five teenagers (20.7%) have never heard about the idea of "lifelong learning". They indicated the following sources of information (sorted with decreasing share): "parents and other relatives at home" – 24.1%; "teachers at school" – 24.1%; "informational TV and radio programs" – 20.1%; "newspapers and magazines" – 8.6%; "classmates, friends" – 6.9%; "the internet" – 3.4%. Furthermore, one in four girls has obtained information from TV and radio (for this group, this source significantly stands out), whereas boys were more likely to indicate parents and relatives (30.8%) and school teachers (26.9%).

Another question was directly related to the previous one and was intended to define the teenagers' understanding of the idea of "lifelong learning". Half or Russian (St. Petersburg) secondary school students (49.2%) identify lifelong learning with "constant studying in different educational institutions during the entire life, by choice". For one in five (18.6%) it's the "constant studying in different educational institutions during the entire life as a result of work needs/employer's requirements". A small share of respondents (6.8%) believes it's the "intermittent studying in educational institutions whenever such need arises".

Why do students consider such education necessary? When answering this questions, the responses divided as follows. Four in ten respondents (36.4%) believe that lifelong learning is required "in order to stay in line with leading developments in the chosen professional field"; two in ten (22.7%) – "in order to stay in touch with the quickly developing world, to be a modern person"; one in six (15.3%) want to be an interesting person to talk to. One in seven (13.6%) believe that lifelong learning helps develop active citizenship. Only 3% of the respondents could relate lifelong learning with the opportunity to keep in touch with professional news. The list of possible answers was extended with such answers as: "to be an educated and intellectual person", "to be developed, to know everything, in short – to be a 21st century person", "to be developed and get to know a lot of new things". In general, one can conclude that teenagers at the intuitive level quite correctly understand the term "lifelong learning".

It should be noted that the survey helped create an interest towards lifelong learning among the students, which can definitely be described as a positive result. In particular, this can be confirmed by the fact that half the respondents (47.5%) have sought additional information about lifelong learning, believing that such knowledge would help with the choice of future profession. Furthermore, one in three has indicated the usefulness of such knowledge.

In conclusion, it can be stated that the ideas and principles of lifelong learning are poorly distributed among young people in such a large city as St. Petersburg. As a result, there has to be a discussion on popularization of the idea of constant maintenance and development of the received basic education, including professional education. It is extremely important to inform young people that constant interest in one's own education is the very real stability factor, which can help preserve personal stability, at least to an extent, and compensate for the environmental effects, which are often beyond one's control. Such work can be especially productive in those periods of social and pre-employment development of teenagers, which precede the decision on one's future educational trajectory.

Yushkova, Svetlana A.

The Institutional Character of the System of Social Protection of Population

The institutional character of the system of social protection of population reveals itself in the fact that it is implemented by different specialized social institutions, which activity, essentially, defines the framework of the system of social protection. Such institutions are the state, different funds, agencies, services etc., depending on the national specific character of the system of social protection.

Each of these institutions is distinctive by its role, functions and status, but in order to analyze the institutional character of the system of social protection of population let us start with the definition of the term "social institution".

"A social institution is a social phenomenon, i.e. the result of people interaction on the one hand, a social process on the other hand, the element of social stucture, historical forms of organization and regulation of public life on the third. By means of social institutions social interactions between people and other elements of society are regulated, stability of public life is provided".

Every social institution, regardless of which sphere of social system it functions in, brings pressure to bear on its members to fulfil the norms which are in the competence of the given institution. Everyone who breaks the norms and directions is liable to a definite sanction, which often includes such a measure like expulsion of an individual from participation in the institution's activity. An institution has a definite structure. As developing, an institution, its structure can change, but always, at any stage of its evolution, an institution aspires to stabilize its structural elements. During structure stabilization diversified positions appear, which are related with the system of social roles, necessary for the given institution to function.

The structure of social institutions is rather varied, but, as a rule, it includes the basic elements as follows:

1) structures, i.e. financial resources, providing fulfilment of different kinds of activity, which are specific for the given institution;

2) competence and forms of activity, which define the methods of actions and behaviour of individuals working in the given institution;

3) persons, realizing the goals of the given institution by impersonal way.

The three named basic structural elements of social institutions – structures, competence or powers and persons, fulfilling functions, – depend on those types of social needs, which are to be met by the given social institution. It is these needs that define, ideally, the character of the elements and the method of their combination.

The evolution of society implies the evolution of needs, methods and forms of their satisfaction, as well as the emergence of new needs. These needs help

define the basic functions of social institutions as well, which are, in our opinion, as follows:

- Satisfaction of certain social needs.
- Cultivation and protection of social values.
- Support for the principles, according to which an institution functions and meets the needs.
- Definition of specific social roles and norms for individuals and groups, as well as other institutions, and control of their observance.
- Consolidation of the social systems of the given society, unification of individuals and their mobilization, reinforcement of social relations.

Spontaneous activity which is not yet structurized by the norms of the given institution becomes institutionalized, changes into actvity connected with a social function that manifests itself in a specific social position and a model of behaviour which is expected by society from the person having the given social role. In social systems an institution has the central place, that is why some sociologists consider a social institution to be a synonym of a social phenomenon. It appears that an institution is a system of social phenomena, which repeat, join together and form a social process. A social process constitutes a repeating model of social interaction, and in this sense a social institution is also one of such models.

The relation between an individual and an institution is often conflicting, in spite of the fact that an institution, ultimately, must meet his needs. On the one hand, the existence of an institution is a precondition for the stability of a social system, on the other hand, it appears as a process, limiting the person's needs and, in certain cases, hindering the evolution of personality.

The system of social protection in any country is an integral social institution, i.e. consists of the sum total of institutions, establishments, organizations, fulfilling both specific functions and a number of the system-forming ones. The basic components of the institution of social protection are, firstly, the presence of financial resources in the form of money, tangible and intangible assets in the one hand, special equipment, buildings, transport, communication facilities, computers etc, in the other hand, which are necessary for their normal functioning. Both types of structures are system-forming, i.e. without which the system cannot operate.

The second component of the system of social protection as a social institution is the methods of acting and behaviour of individuals forming selected (special) social groups which are called to fulfil specific institutional functions. It should be noted that the fulfilment of these functions is defined by competence or powers both on the state generally social and regional or territorial levels, and not arbitrarily, but in the form of law or by-laws. It is clear, that there are thousands of information units in these legal and standard acts, and they concern both the forms of realization of social protection and the forms of accountability of structural units and officials of the system of social protection as a social institution. Competence or powers stated by the law define, essentially, not only the legitimacy of a social institution itself, but also the form of its legitimate activity.

The third component in the structure of a social institution is individuals or persons, on whose shoulders the destiny and differentiation of labour met concern for the poor and needy, sick and aged fellow citizens, and which fulfil the social goals of a specific institution, in this case the institution of social protection. Requirements which must be met by these people are connected with education, experience, place of living etc.

Let us mark out the basic functions of the system of social protection as a social institution. The first function of any social institution is to meet certain social needs. It appears that the system of social protection meets a number of society's needs. They are as follows:

- prevention from destabilization of society by the support of certain standard of well-being of citizens, which can be defined by the proportion between the sum of money in the form of income and transfers and the sum of material wealth that can be bought for it corrected for inflation and tax policy. It is the degree of inequality in income distribution illustrated by the Lorenz curve that indicates the standard of well-being, particularly of poverty. The system of social protection is exactly to retain it within certain limits.
- accumulation of resources for the goals of social protection from different sources and by legitimately defined methods;
- distribution of resources according to the criteria, defined by law. The distributive function is to divide resources coming to funds or being there, between different categories of population, covered by the system of social protection and maintenance. Thanks to the system of payings from the funds of social maintenance the part of money earned by professionally active citizens is transferred to the group of citizens less professionally active or passive. On the other hand, money is transferred from the generation below retiring age to the generation of retiring age via the same system of payings. From men to women, from single citizens to those having families and children etc, i.e. what is called now a social state.
- the modern system of social maintenance in most countries fulfils the function of employment maintenance more and more, has an influence on the forming of its structure and is used as a tool providing employment. In every national economic organization economic changes both in structure and market have a distinctive influence on both the functioning and activity of the system of social maintenance, and vice versa.
- maintaining adequate living standards depending on concrete socio-economic conditions of society.
- the economic function of the system of social protection and maintenance is as if secondary with respect to the analyzed functions. In this case the funds of social maintenance or, at least, a part of them, are used as capital investment in high-performance branches of social production, in financial and other institutions. The purpose of such investment is to protect the means of funds of social maintenance from inflationary processes in society. In this case the means of funds don't devalue, moreover, they participate in the development of

economics and social sector in respect to employment and social protection, in the forming of workplaces, the development of scientific and technological advance, of service market.

- the principles of work: creation of the system of effective employment; training and re-training of personnel; creation of effective system to form population income; macroregulation of the process of differentiation of income and consumption, providing both professional and social mobility of population; official (legal) definition and maintenance of living standard according to international norms.

The system of social protection as a whole and social maintenance particularly are specific factors of economic development and being themselves social processes and institutes are connected tightly with economics. We'll show that such connection is not accidental, i.e. the system of social protection and maintenance is really socio-economic factors. Firstly, the system of social protection and maintenance accumulates financial resources; secondly, pays them; thirdly, it reallocates resources and income. Besides, payments through the system of social maintenance as the basic element of social protection are directed to satisfy the needs of citizens, which are in one or another situation stipulated by law. In the system of social maintenance resources are reallocated from some subjects to others, and their destination itself changes. Reallocation itself as interaction between different social subjects is an important social problem, which main point is efficiency of social maintenance financing. The problem solving gives rise to immediate socio-economic consequences. For example, persons receiving payments through the system of social maintenance spend them to satisfy their needs, i.e. pay for goods and services, creating demand for these goods in the market. Apparently, they can constitute and they do constitute a special segment of the market at least because the specified amount of payments through the system of social maintenance sets limits to effective customer demand of those who such payments receive. Naturally, some could oppose that it is not the main purpose of the system of social protection and social maintenance, but on the other hand it is the inalienable socio-economic consequence of such payments.

Forming effective customer demand, the system of social protection and social maintenance gives rise to consequences in economics, which have influence on market cycles to emerge, on employment situation and the course of iflationary processes. It is particularly important during the period of world economic crisis.

Thus, the system of social protection and maintenance is an important socio-economic institution, defining the basic socio-economic features of society and the prospect of its development. It reveals itself first of all in reallocation of income, in forming of effective demand, in reduction or increase of tax burden. Such peculiarities in their turn influence on employment and unemployment processes, determine such economic position as poverty, which is not only an indicator of inequality in income distribution, but also an important indicator of social and economic status of people in concrete society.

Tarasenko, Elena A.

Towards Patient Accessibility: The Quality and Characteristics of Leading Federal Medical Clinics' Websites in Russia

Russian federal medical clinics are famous hospitals which provide specialized high-tech medical care for Russian citizens and for foreign citizens too. Russian federal medical clinics are official substructures of The Russian Ministry of Health and Social Development. Its duty is to provide medical care for all population from different regions. However patients are often not well informed about the nature of their illness and how to treat it. In addition, consumers of medical services often have difficulty not only in the choice of treatment method and scope of medical care, but also in choosing a particular health clinic that provides adequate medical care. So patients feel that medical care market is characterized by a high degree of uncertainty and information asymmetry. Patients want to have additional arguments (health related information) in order to make right choice of medical clinic.

Due to the rapid development of Internet and online health communications in the last decade as the world in general and in Russia in particular, the growth of Internet literacy, the expansion of paid medical services in Russia, patients as consumers become more consciously involved in medical care choosing. The Internet and computers accessibility now allow patients and patients' relatives to tern to the World Wide Web in order to find and share health information as well as information about quality and price of medical care.

In this situation the problem of consumer assessment of medical care quality and consumer choice in medical clinics transforms into the problem of comparative assessment of the quality and information characteristics, as well as site usability medical clinics / hospitals.

Leading federal medical clinics websites[1] in Russia are increasingly used by the target audience – patients and their relatives, but research how consumers assess the quality of these websites in Russia is few and far between. However for a variety of reasons, the characteristics, content and quality of websites are different. For medical care managers and hospitals heads it is very important to know about patients' opinion and their assessment in order to improve the quality and characteristics of medical clinics websites.

Online information and communication technologies may help to reduce health disparities through their potential for promoting health, preventing disease,

[1] Medical clinics website is a internet site that provides users with online health and medical treatment related information such as information related services, search functions, hospitals commerce offerings. Medical clinic website is one of the most effective communication tool between doctors and patients.

and supporting clinical care for all. The role of the medical clinic / hospital website as a non-monetary factor of medical clinic choice is already significant and in the future will only increase[1]. Medical clinic' website allows medical clinics to establish effective communication with potential patients, to focus on patients, their needs and wishes, to persuade the consumer-patient service quality, to improve consumer-patient dialogue, to construct high reputation of medical institutions.

This article focuses on the evaluation of quality of 6 federal medical clinics websites in Russia from February to March 2011. Medical Clinics election is on the basis of experts' review of the best Russian hospitals which provide innovative high-tech medical care:

Table 1

Leading Russian federal first-class medical clinics

Medical Clinic/ Hospital Name	City	Establishment	Subject of duties	Website
Federal State Organization"Pirogov National Medical Surgical Center"	Moscow	1907	High- tech medical care	www.pirogov-center.ru
Burdenko Institute of Neurosurgery, Russian Academy of Medical Sciences	Moscow	1932	High- tech medical care	http://www.nsi.ru/
Bakulev Scientific Center of Cardiovascular Surgery them. RAMS	Moscow	1956	High- tech medical care	http://www.bakulev.ru/
Research Institute of Eye Illness. RAMS	Moscow	1973	High- tech medical care	http://www.niigb.ru/
Federal State Organization "Ilizarov Russian Scientific Center for Restorative Traumatology and Orthopaedics"	Kurgan	1974	High- tech medical care	http://www.ilizarov.ru/
Federal State Organization "Russian Children's Clinical Hospital"	Moscow	1985	High- tech medical care	www.rdkb.ru

A user-friendly and well structured medical clinic' website has greater communication accessibility and completeness of the information than websites of similar clinics. So management of medical clinics with such website has the opportunity to influence the amount of medical care due to the fact that user-friendly site affects customer's choice.

[1] The Quality and Characteristics of Leading General Hospitals' Websites in China. Xiaolei Liu, Zhen Bao, Haitao Liu, Zhenghong Wang. Journal of Medical System. N 2. 2010.

However there is some underestimation of Russian health care professionals the importance of quality of medical clinics and hospitals websites as an effective tool of communication with patients. The quality and characteristics of health clinics websites are different from each other.

There are no clear standards what information should be on the site. There is no official medical professionals' opinion about best hospital website model for needs of the target audience. In Russia there are also no any ratings of medical clinics and hospitals websites, showing the extent of a medical clinic on the internet.

I have made the analysis of content and basic usability characteristics of the 5 best sites of health clinics in the world according 2011 World medical clinics websites' "Ranking Web of World Hospitals", defined by the international research agency Cybermetrics Lab[1].

I have identified 55 key characteristics of the content information of the following world's best hospital websites:

a) NYU Langone Medical Center New York (USA)
b) University of Michigan Health System (U.S.)
c) University of Kansas Medical Center (USA)
d) Buddhist Tzu Chi General Hospital (China)
e) University of Texas Medical Branch at Galveston (USA).

Table 2

Information/content characteristics of medical clinics websites

N	Information Characteristics of Medical Clinics' Websites
1	Name of the Clinic/Hospital and Ownership
2	Governmental Licenses for Medical Care
3	The Presence of the Clinic's Logo on the Website
4	Low Normative Acts
5	Medical Clinic' Mission
6	Basic medical specialty offices, clinics Profile
7	History of establishment
8	Contact: address, phone, mail, travel information
9	Medical Care Schedules
10	Paid Services
11	List of Insurance Companies
12	Terms of Fee-based Medical Care
13	Price List for Paid Medical Care
14	The contract for Paid Medical Care
15	Health/Disease Specific Information
16	Medical Personnel Information: Specialty, Full name, Qualification, Degree, Date

[1] Website of Cybermetrics Lab: http://hospitals.webometrics.info/top2000.asp (Date of access - 25/04/2011)

	of Last Training
17	Information about Medical Clinic' participation in scientific research, research activities, including International
18	Rules for entry into primary consultation / hospitalization
19	Rules of hospitalization: dates, documents
20	Information about patients' living conditions at hospital
21	Information about the living conditions of patients' families (hotel/hostel availability, etc)
22	Information about Medical Clinic' plan for patients traffic
23	Opportunity for complaints on the medical care quality
24	Opportunity to take chief physician clinics / offices' consultation
25	Information about Medical Clinic' accessibility for wheelchair's users with disabilities (universal design - whether ramps, spacious closets, etc.)
26	Contacts with the press office
27	Admission rules for foreign patients
28	Information for sponsors and charities
29	Information about blood/ organ donation
30	Information about the Patient Organizations
31	Patients Forum
32	Patients Recommendations about Medical Treatment/ Patients Successful Stories
33	Media Information about the Medical Clinic
34	The presence of formally independent medical clinic corporate blog (team blog, or blog the head physician)
35	Medical News
36	Popular Information about diseases and its treatment
37	Non-fiction materials on healthy lifestyles and health-behavior
38	Information on availability of municipal services for patients and their relatives (shops, bank branches, post office, flower / newsstand at the clinic, etc.)
39	relevance / "freshness" of information
40	opportunity to file a complaint online
41	make an appointment - electronic registry
42	opportunity to get on-line-consultation
43	Opportunity to monitor the application for admission
45	Print results on the service
46	availability of search tools on the site
47	The presence of FAQ section (Frequently Asked Questions)
48	The site map availability
49	Navigation
50	Front size, accessibility for the visually impaired patients
51	Foreign languages Sites version (English, etc.)
52	Links to other medical online resources
53	Using the web 2,0 technologies in communication with the audience: teleconferencing, online events, webinars
55	Opportunity to take a virtual video tour of Medical Clinic

These selected 55 information characteristics are used as important content standard for medical clinic websites. The purpose of the article is to make comparative analysis and to assess the quality and describe the characteristics of 6 leading Russian federal medical clinics' websites in terms of content, structure, function, usability, design. The main research questions are the following: Do medical clinics that are considered to provide high quality medical care also have websites with high quality? What are the characteristics of the websites of these leading general medical hospitals? Is it possible to find in the Russian best hospitals' websites the majority of the best world hospitals' websites information characteristics?

It is important to mention that the majority of ordinary Russian clinics are not currently available on the Internet. Thus, at present some federal state medical centers and clinics, providing high-tech medical care to the population, do not have their own websites. For example, there are no websites at the following hospitals:

a) The Federal State Institution "Republican Clinical Hospital of Infectious Diseases (Moscow);

b) Federal State Budget Institution "Federal Centre for Neurosurgery" (Tyumen);

c) The federal state budget organization "Federal Center for Cardiovascular Surgery (Chelyabinsk);

d) The federal state budget organization "Federal Center for Cardiovascular Surgery. (Khabarovsk).

The results of my research[1] show that the websites of most federal clinics demonstrate sufficient good quality of content, functionality and design. However, due to the growth of Internet users, same websites are in need of higher standards and requirements for consumers.

Respondents say that the main advantages of health clinics websites are the availability of the site interface for inexperienced users, a clear structure of the site, and detailed information on opportunities for treatment, the procedure for admission, possibilities for online consultations.

Russian federal medical clinics/ hospitals are very important for illness prevention because federal medical clinics give qualified high-tech medical care for Russian citizens from all regions and for citizens of foreign countries. It is very important for patients to know all list of medical treatment, information about doctor's educational and professional background, information about health insurance companies cooperating with medical clinics. Also there are very useful

[1] In this article I conducted a comparative descriptive qualitative research study to assess the quality and characteristics of 6 Russian nationally prominent leading federal first-class medical clinics by target audience – patients with chronic illness or disability. Research design:

a) 18 deep interviews with potential patients (people with chronic illness or disability). Gender - 50/50 (female and male). Age – 18-24, 25-39, 40-55. All respondent are Internet users.

b) 3 expert interviews. Experts – health care managers and editors of health care portals/websites.

for respondents the information and photography about extra comfort hospital living conditions availability. Price for one day to stay in such comfort living conditions will be welcomed too.

Also very important for respondents all official documents about medical clinics licenses for all types of medical treatment. It is a pity but no website has information about official licenses for treatment as well as the official documents about death and cure statistic.

Most respondents indicate the following federal medical clinics as the most professional, comprehensive, modern and friendly to patients:

- Bakulev Scientific Center of Cardiovascular Surgery them. RAMS
- Federal State Organization "Russian Children's Clinical Hospital"

The website of the Research Institute of Eye Illness, RAMN needs to be distinguished. Only this hospital website has a section with a list of health insurance companies which cooperate with this medical clinic. In addition, in terms of medical marketing there is a unique selling proposition of the Research Institute of Eye Illness, RAMS in the section, which attracts the attention of the respondents with the name "Our unique capabilities."

It is very interesting for respondents the website of Federal State Organization " Ilizarov Russian Scientific Center for Restorative Traumatology and Orthopaedics", because it has a quite unique information blocks "Sponsors", "Forum of patients," "Guest." In the "Patients" block respondents like the following options: "Approximate dates of treatment", "Foreign patients". "*However, this site has very small print, so it is difficult to use this website for people with vision problems. It is also difficult to call this website as professional and stylish*".

Most often on the sites of medical clinics there are information on the following topics:

1) Activities of the Clinic.
2) Documents required for admission.
3) Contacts.
4) News.
5) History of clinical, scientific achievements of its founder/leader.
6) The medical science and various medical research conferences in which hospital representatives have taken part.

Analysis of the world's best medical clinics' websites shows that the structural units of website content are based on two main areas:

1) who (doctors, their educational and professional backgrounds, professional achievements and awards)

2) what (picture "before" and "after" good medical treatment / surgery at the clinic, video clips and patients' successful stories about their treatment; full, comprehensive and adequate description of high-tech medical care, additional social services for patients and their relatives; the transparency of the medical care' receiving) . If the user finds the website information on these key areas and this

information convinces him - he will go to the contact information and will become a potential buyer of medical services of the clinic.

The patients are not always fully satisfied with the information and usability characteristics of medical clinic' websites. For example, respondent, male, 20 years old evaluates website of Burdenko Institute of Neurosurgery, Russian Academy of Medical Sciences: "*As I note there is absence of any information about the paid services, lack of personnel information. I do not understand the level of qualification of doctors. There is no information about the quality of living conditions. The site has almost all the rules of writing (reception, consultation, research, hospital), but no online-registration system. Registry contact is able only by phone, at the present internet access time it is a significant disadvantage ... The site is made on plain old engine, no counters, no maps of the site, no patient forum, and, most importantly, no search tools. This website is made on plain old engine, no counters, no maps of the site, no forum. It is also very important to say about the absence of the search tools on the site* ".

From the patients' point of view the main disadvantages of site health clinics are the follows:

1. Website does not fully inform about the clinic's certificates
2. Lack information about medical insurance system and opportunities. A list of medical insurance companies is usually absent at medical clinic's website.
3. Lack of information about the cost of paid medical services, how to contract for paid medical services.
4. Lack of information about education, qualifications and achievements of ordinary medical staff at the departments of the medical clinic.
5. The website does not describe the living conditions at hospital for patient, and his relatives.
6. There is no information about the physical accessibility of clinics for people with disabilities, there is no option how to increase the font site for visually impaired patients.
7. There is no information about a clinic's patients plan.
8. Often there is not possible to send patients' feedback about the quality of medical care.
9. It is not possible to read patient's "happy stories" and information about medical clinic in the media, other information sources on the clinic website directly.
10. Often there is no English version of the federal clinic's website
11. As a rule, no such online features

Consultation:

- Complaint
- E-IR
- Forum FAQ (answers to frequently asked questions)
- Patients Forum
- A corporate blog.

In addition, respondents mentioned that the majority of federal clinics' websites have no very modern design. Sometimes federal clinics have rather outdated website design.

Conclusion. This is the first sociological research study to examine the websites of leading medical clinics in Russia. These websites are potentially useful for the public.

However the study indicates that the current websites of leading general medical clinics have several limitations. In order to make improvements in the above mentioned aspects a defining positioning shall be made for the medical clinics' websites: hospitals websites are in purpose of serving the public and patients; so great efforts shall be made for service and management.

The main recommendation of the heads of health facilities and management stuff are as follows. Pre-define the target audience of your site and competently carry out its segmentation. Determine what information about the clinic, its history, science, its medical services, qualifications and achievements of the doctors will be important for the medical clinic's target audience.

Clinic websites' design and content must be functional. The medical clinic website's content must be based primarily on the needs and interests of key segments of the target audience - the patients and their relatives.

It is very important for medical clinic's managers to pay attention for the following modern tools for target audience attractions:

1) Virtual Tour / Tour of the Clinic and its branches. Such virtual tour allows potential patients and their families receive the audiovisual information about the clinic and its medical equipment, the degree of luxury of living conditions and services.

2) Formally, an independent corporate medical clinic blog. Such blog is a tool for daily communication with patients and for medical clinic propaganda tool. Typically, a corporate blog used relatively long time and works in the long-term strategy for health-care setting.

So the sociological study demonstrates a variability of quality with respect to the leading federal medical clinics in Russia. These websites could be potential sources of additional information and patient education when they meet the above quality criteria. As patients increasingly look to medical clinics websites for information and services, leading federal medical clinics in Russia need to keep up with increasingly high standards and demands of health-care consumers.

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Salo, Elena P.

Problems of Legitimation of Healers' Activities in Russia

Theme of healing is as varied, diverse and unique as life itself. At the dawn of the 21th century both scientists and practitioners observe the development of scientific parapsychology, bio-energy, etc. with great interest. But not all members of the scientific world and the official medicine (allopathy) clearly recognize the right of healers to treat people. Till now, basic science isn't in a hurry to explore this social phenomenon seriously. Although as the field of scientific knowledge, the problem of existing healing in modern society is beginning to be studied within the anthropology of professions [1].

Relevance of the topic of the article confirms a radical transformation of Russian society, which led to structural changes in the health care system. Today this sphere is in crisis due to the lack of material security of budget medicine, reducing the quality of medical education and as a consequence, health care and lack of incentives to work in the official medicine. Reform of the latter has helped to broaden the range of "alternative" medical services. People's interest in the methods of national medicine (healing) is not dried up. According to the Public Opinion Foundation, about 25% of Russians are turning to healers.

This study was aimed at identifying factors influencing the occurrence of problems related to the legitimation of the healers in Russia, and the formulation of conceptual fundamentals for resolving the problems of legitimation of healers' activities.

For these purposes we have used such methods as deep interviews, analysis of documents and content-analysis of the press.

Analysis of existing law and socio-economic norms and relations in sphere of healing

1. Legal and socio-economic regulation of healing in Russia

In Russia, the main founding document for the healing activities is the "Fundamentals of Legislation on Health Care of Citizens." Article 57 of the document asserts the right to engage in national medicine (healing) on the basis of a healer diploma. The same article also defines national medicine as: "...methods of healing, prevention, diagnosis and treatment based on the experiences of many generations of people, entrenched in the folk traditions but not registered in accordance with the legislation of the Russian Federation" [2;3] . However, the "Fundamentals of Legislation..." are allowed to carry out medical activities only to persons with medical education, and a diploma of healer is not provided it. Thus, one article of the "Fundamentals of Legislation..." regulates the use in medical practice only techniques authorized for use in the manner prescribed by law; and

the other article refers to national medicine practices that are not registered in the manner prescribed by law.

These inconsistencies and contradictions have led to the situation that healing activities have dropped out of sight of medical and legislative oversight bodies. National medicine (healing) as the type of activity was not included in the List of Types of Medical Activities Subject to Licensing, although from 1993 to 1998 it was subject to licensing in accordance with the Order of the Ministry of Health of the RF in the section "Power Information Science".

So far, in practice health authorities in the Russian Federation do not regulate the activities of national medicine (healing) and do not give diploma of a healer, although all spheres of human activity should be governed by the laws in our country. It is very difficult to develop a law for the bio-sensor actions and other methods used by the healers. Nevertheless, a legitimate base for healing activities is existing. Unfortunately, not all know about it. The regulation rules about healing and national medicine are written in the "Law on Health Care of Citizens". Permit for healer work is the diploma. Healers work must be coordinated by self-regulating public organizations – professional associations in the field of healing.

Thus, the legislative base is existing, a form of work permit is provided, the procedure for obtaining a permit is registered. Professional associations are better than anyone else could determine the degree of skill and quality of the healer work and decide whether to grant him permission. But somehow the system is not working.

As a result, since the enactment of the law in 1993, almost in no regions diploma of a healer has been issued, or they have been issued in violation of the meaning of the law. But under existing legislation only healer diploma gives the right to practice national medicine.

In such a situation, the healers are not able to make arrangements for training, retraining and development of their communities; and this inevitably affects the level of provision of healing services. They remain isolated and alone cannot overcome the difficulties. Some are forced into healing without permits at their own risk, while others conceal their activities under other forms of business: consulting, massages, etc.

For over ten years, the citizens are not protected from low-quality services of persons providing services in the field of national medicine and from fraudsters posing as specialists in this field.

At the same time, some talented practices of national medicine with special health-restoring ability were unable to officially confirm their abilities and efficiency of services, which prevented the execution of legal practice.

All the mentioned above demonstrate the inadequacy of state regulation system of this sphere of services and lead to the discrediting of national medicine in the eyes of citizens.

2. Attitude of state and society to activities of healers

Today, interest in methods of national medicine is growing, despite the major public education programs and a large number of researchers working in the field of official medicine throughout the world.

First of all, it should be noted the tolerant relation of the World Health Organization to the activities of healers. The World Health Organization has repeatedly appealed to the States – members of the WHO with proposals and programs for the development of national medicine under the conditions of the creation of national systems of regulation and certification of such activities.

In our country, the attitude of the state and society to the activities of healers is ambiguous: from the total rejection of healing as a whole to recognition of the activities of individual healers.

On October 27, 2004 deputies of the Moscow City Duma appealed to M. Fradkov and B. Gryzlov with a proposal to adopt a law on healers. The author of the appeal B. Prisyazhnyuk believes that "the activities of magicians, sorcerers and quacks must be under government control" [4].

Moscow City Duma deputies expressed their concern about "the increasing number of people affected by unskilled medical care provided by healers." For this reason, V. Prisyazhnyuk said: "Diplomas giving them [magicians and extra-senses] right to engage in healing should be issued only to confirm their training" [5]. The deputy also added that the initiator to adopt such a law was the Legislative Assembly of the Vladimir region.

In January of 2005, the deputy L. Stebenkova offered to introduce a bill in the concept of "occult services". "This is not about banning national medicine and healing (they are stated in the law), and about the prohibition of such specific services, such as the removal of spoiling and the crown of celibacy, love spell a loved one and other services of the occult-and-mystical and religious nature", – said L. Stebenkova in an interview to the correspondent of newspaper "Kommersant" [6].

The deputy estimated the Moscow market of occult services of 8-10 million dollars a year. For violating the ban, it was proposed to impose a fine ranging from 20 to 25 minimum wages [7].

On February 17, 2005 the Moscow City Duma began to develop amendments to the federal law "On Health Care of Citizens", providing a complete ban on the provision of occult services in Russia [8; 9].

On January 26, 2006 portal "Interfax-Religion" referring to the head of the Duma Committee on Health Care and Public Health L. Stebenkova said that the project, in particular, provides for a ban on the use of religious paraphernalia by healers [10; 11]. According to L. Stebenkova, these initiatives may be considered by deputies of Moscow City Duma in the coming months.

On January 27, 2006 the Federal Service for Supervision of Health and Social Development (Roszdravnadzor) appealed to the Federal Research Center of the traditional methods of diagnosis and treatment of the Ministry of Health and Social

Development to establish criteria for the voluntary certification of citizens engaged in healing. The criteria were the following:

1) Voluntary registration as private entrepreneurs.
2) Charged studying the base course of medicine with subsequent exams.
3) Adding into the State Register by the Ministry of Health.
4) The activities of other healers will be considered illegal [12; 13].

Till now, the activities of healers are regulated by Art. 57 of the Law "On Health Care of Citizens" according to which the right to engage in national medicine is available to citizens with a healer diploma. The executive authorities of subjects of the Russian Federation must issue diplomas. However, the law does not contain exact wording which defines who can be qualified as a healer.

Previously, the Moscow City Duma offered to take the law on healers [14].

The scientific community recognizing the experience of national medicine and the unique healing capabilities of individuals calls for serious scientific studies of such capabilities and to more stringent procedures for admission to the practice of such specialists.

The leaders of the Ministry of Health of Russia has repeatedly advocated the need for use of national healing methods, cooperation with reputable healers, while pointing to the need for further research and implementation of the certification.

So, on the basis of the above, we can conclude that the attitude in society to healers is ambiguous. Unfortunately, the law regulating the activities of this social group has not been adopted. In our view, this should be done before the end of 2011.

Conceptual fundamentals for resolving legitimation problems of healers' activities

1. Directions for improving legislative law base of healing activities

Inconsistencies and contradictions in the law "Fundamentals of Legislation on Health Care of Citizens" has led to the fact that after 1998 a large number of extra-senses, magicians and all sorts of charlatans appeared in the market of wellness services. The primary objective is to adopt a law that would separate the healers from charlatans [13].

In recent years, from 2004 onwards, the media has been widely discussed problem of improving the activities of healers. There were a lot of ideas, suggestions and opinions. Moscow City Duma tried to develop amendments to the federal law "On Health Care of Citizens"; then Duma tried to pass a new law regulating the activities of healers in Russia. However, this law has never been passed.

Let us consider two ways of improving the legislative base in the field of healing.

1.1. System of Voluntary Certification

In 2006, on the initiative of Roszdravnadzor there has been developed "System of Voluntary Certification" of services in the field of national medicine for the formation of a civilized market of healers services: the security of services and the ability of objective assessment of the quality of such services by consumers.

Federal Research Center of the traditional methods of diagnosis and treatment of the Ministry of Health and Social Development has developed criteria for the voluntary certification of citizens engaged in healing: voluntary registration as private entrepreneurs; charged studying the base course of medicine with subsequent exams; adding into State Register by the Ministry of Health; other healers activities will be considered illegal.

Problems of certification system:

- Assessment of the security of services for health and life.
- Confirmation of the declared parameters of quality (effectiveness) of services.
- Provide consumers with reliable information about the service and its performer.
- Drafting of the Uniform Register of specialists, whose services have been tested.
- Providing tax services.
- Promoting scientific research.
- Creation of additional legal field for specialists in the field of national medicine.
- Avoiding unnecessary administrative actions with respect to certified specialists.

1.2. Scheme of legitimation of healers work in legal field

In 2010, the question about the activities of healers in the territory of the Russian Federation arose particularly sharply. The work of Roszdravnadzor on the regulation of the healers' activities was found to be unsatisfactory; and Roszdravnadzor was broken up.

Taking into account the suggestions of the World Health Organization, the heads of the Ministry of Health and Social Development of the RF, the scientific community and representatives of the healing community, the State Duma and the Moscow City Government found a way out of this situation – use the experience of foreign countries in this sphere of activity. In the U.S. and some European countries the activities of healers are regulated by the government and professional associations. After a marketing study,t here was selected the Association, whose work was initially focused on the interaction with the State (by definition of M. Burrage) [15] – "The World Association of Psychologists, Doctors, Spiritual and

National Healers". On its base, there was created the "Guild of Practitioners of National Medicine, Healers and Applied Psychologists" in the end of 2010.

It was developed a multistage scheme of work of healers in the legal field, for which a number of actions must be taken:

- Retrain in the State Educational Institution "Institute of Developing Additional Professional Education" by program "Entrepreneurship in the Sphere of psychocorrectional Services and Healing."
- Become an entrepreneur – starting a business.
- Join the "Guild of Practitioners of National Medicine, Healers and Applied Psychologists", which together with the Government will regulate and supervise the activities of healers in the territory of the Russian Federation.

Thus, we can conclude that the second direction for improving the legislative law base of healing activities is the logically built scheme, which can be taken as the basis for the new law.

2. *Legitimacy problems of integration of healers in system of legal and economic relations*

To identify problems of integration of healers in the system of legal and economic relations, first of all it is necessary to note that the healers are a great social group in the social structure of a society. A study conducted in 2005–2007 in the Institute of Sociology of RAS found that not all practitioners of the national medicine are in professional associations, many of them are not members of any association [16]. Currently, the healers have not been formed as a new professional group, and they are only in its infancy [17]. In other words, not all healers seek to professionalize its activities. This is the *first problem* of the integration of healers in the system of legal and economic relations.

Classic Western professional groups are Weber's status groups in the sphere of division of labor. As tendency to focus own style, prestige and moral standards is in the nature of any status group, the education is brought to the forefront, namely, it becomes the most important criterion [18, c. 206].

In 2005–2007, the study was conducted (resource approach) in three major regions of Russia (Moscow, Saratov and Balashov, Syktyvkar and Vylgort), which revealed the opinions of national medicine practitioners about the role of education in the process of professionalization.

In accordance with the neo-Weberian approach, we analyzed such a component of the *cultural resource* of professional groups as the possession of expert knowledge. On the question of what is generally necessary to become a professional in their chosen field, the majority of respondents indicated systematic professional knowledge in unity with the practice and continuous learning. Most informants compare the development stopping with the symbolic death of a professional.

Increment of knowledge and skills according to opinions of most respondents is carried out by a variety of sources of improving professional skills:

self-education, internet, meetings with colleagues, the passage of the certification courses, participation in seminars, conferences, congresses, training sessions, etc. It is noted that financial problems are connected with departures to other cities.

The vast majority of respondents agreed that the training courses are not enough: to become a professional in your field, you need to get an education and to engage in self-improvement and self-learning.

In the process of professionalization, a great importance is attached to membership of national medicine practitioners in professional associations, where there is a constant increment of knowledge. Participation in congresses, symposia, conferences allows practitioners to meet colleagues and share experiences, receive information on the latest developments in the practice of healers in Russia and other countries – members of the association, as well as to keep informed on all changes in the legislative law base of the Ministry of Health and Social Development of the RF. Seminars and workshops on various directions of national medicine give practitioners an opportunity to acquire new knowledge: it is so necessary to combine different methods to obtain the best results when rehabilitating the clients. Works on probation of practitioners of national medicine in China, India and Tibet allow them to gain not only the unique theoretical knowledge, practical skills, but also to obtain legitimate documents entitling them to use these methods and techniques in practice in Russia and the European Union.

Thus, we see that education for practitioners of national medicine is a continuous process that turns good practitioners in their field into true professionals. However, we might wonder: "Why do healers spend so much time and money to attend the various schools, seminars, conferences, congresses and symposia, but they do not want to be retrained in the state Institute and get a state diploma giving entitlement to a legitimate business"? The *second problem* of the integration of healers in the system of legal and economic relations lies in this contradiction.

Motivation of healers of Russia to open their business is associated with the complex interlacing of "push" and "pull" factors.

Voluntary entrepreneurship is characteristic to a small number of practitioners of the national medicine of Russia. While necessary entrepreneurship is typical to the vast majority because they have no choice: if you want to work legally in the market of healing services, become an entrepreneur. However, healers are not in a hurry to register the organizations and take a waiting position, which creates a *third problem* of the integration of healers in the system of legal and economic relations.

Reluctance of healers to be retrained in state educational institution "Institute of Development of Additional Professional Education" by program "Entrepreneurship in the Sphere of Psychocorrectional Services and Healing" does not allow them to become members of the "Guild of Practitioners of National Medicine, Healers and Applied Psychologists." This is the *fourth problem* of the integration of healers in the system of legal and economic relations.

Taking into consideration the above-mentioned, we can conclude that in order to resolve the problem of legitimation of the healers' activities in Russia, they should take only three steps:

1. Retrain in the state educational institution.

2. Become entrepreneurs.

3. Join the "Guild of Practitioners of National Medicine, Healers and Applied Psychologists."

Thus, we believe that once the united group of healers makes the first step towards the State, i.e. they will fulfill the requirements for improving the healing activities; the State will react immediately – it will pass a law allowing healers legitimately carry out their activities in the legal field.

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