

## Social inequality and strategies for getting medical care in post-Soviet Russia

By: Nina L. Rusinova and Julie V. Brown

N. L. Rusinova, [J. Brown](#), (2003). "Social Inequality and Strategies for Getting Medical Care in Post-Soviet Russia," *Health: An Interdisciplinary Journal for the Social Study of Health, Illness, and Medicine* 7 (1): 51-71. DOI: 10.1177/1363459303007001618

Made available courtesy of SAGE Publications: <http://dx.doi.org/10.1177/1363459303007001618>

**\*\*\*Reprinted with permission. No further reproduction is authorized without written permission from SAGE Publications. This version of the document is not the version of record. Figures and/or pictures may be missing from this format of the document.\*\*\***

### **Abstract:**

This article examines the relationship between social status and medical help-seeking strategies in St. Petersburg, Russia. Analysis of in-depth interviews with a cross-section of the population revealed that access to and use of medical care varied greatly across the urban social structure. Those in the highest social strata used their knowledge and connections to gain access to the best care. Their social position and understanding of the system also privileged them in interactions with physicians, enabling them to take greater advantage of 'free' services. Even with similar levels of material well-being, people with less education received poorer health care. Lacking confidence in their ability to assess quality and reluctant to consider options outside the impoverished, inefficient state medical system, they bore the brunt of its inadequacies. This reinforced a long-standing, culturally based predisposition to delay treatment until health problems had become more difficult and costly to manage.

**Keywords:** medical care; medical help-seeking; Russia; social inequality

### **Article:**

#### **Introduction**

This article analyzes inequalities in access to and use of medical services in present-day St. Petersburg, Russia. The findings presented here are part of a much larger study of health inequalities in post-Soviet Russia. In this analysis we focus on the strategies that people in different social strata utilize in the quest for medical care and discuss their implications for the quality of care received.

In the early 1990s the post-Soviet Russian Federation inherited the institutions of the national medical care system established shortly after the Bolshevik Revolution of 1917. Controlled and funded by the central government, the Soviet medical system was designed to provide cradle to grave care for all citizens. In theory everyone had equal access to medical care, because medical facilities were geographically dispersed and all care was free at the point of delivery. While anecdotal evidence suggested that reality diverged from theory, no systematic empirical research on possible differential patterns of access to medical care was published prior to the demise of the USSR in late 1991 (Field, 1957; Hyde, 1974; Knaus, 1981).

Our research on medical utilization patterns in the early 1990s confirmed that there was great diversity in the ways that people from different levels of the urban social structure had used the 'free' Soviet medical system (Brown and Rusinova, 1993; 1997a). Those in higher social strata were more aggressive in the search for care, and they had much greater informal access to highly skilled professionals and elite institutions. While many people made 'under the table' payments to health care providers, in the Soviet system money was not the primary determinant of access. The pervasive and important 'economy of personal connections' rested largely upon mutual obligation and informal exchanges of services and goods (Ledeneva, 1998).

During the 1990s the Russian medical system changed from a rigidly centralized system into a more pluralistic insurance-based one. While reform was supposed to increase efficiency, its most visible effects have been reduced funding for medical institutions, culminating in the near 'collapse of universal access and free provision of basic health services' (Twigg, 2000: 44). Although in theory the state guarantees basic medical care to the population, the poverty of medical institutions means that patients sometimes must pay for even basic care (Boikov, Fili, Sheiman, and Shishkin, 1998; Grigor'eva, 1998; Korchagin, 1997; Shishkin, 1998). Given the high rates of morbidity and mortality in post-Soviet Russia (Field, 2000; Shkolnikov et al., 2000) and the limited financial resources available to many Russian citizens, this has been a matter of great concern to scholars, publicists, and policy makers alike.

Discussions of the crisis facing Russian medical care have focused almost exclusively on its economic difficulties. While this is certainly not unexpected, the implicit assumption seems to be that merely putting more resources into the system would solve all its problems, including eliminating unequal access. Neither scholars nor policy makers appear to have seriously considered the possibility that access to medical care might be influenced by factors other than ability to pay, although research from other societies suggests strongly that medical utilization strategies cannot be explained by economic considerations alone (Blaxter, 1990; Kronenfeld, 2000).

With its paternalistic approach that coordinated everything from prophylactic care to the monitoring of chronic diseases through central social institutions (schools, the military, workplaces), the Soviet medical system fostered consumer passivity (Field, 2000; Ryan, 1978). Privatization and lack of funding since 1991 have rendered that old system ineffective. In post-Soviet Russia patients are expected to take more initiative in dealing with the medical system, and those who fail to do so are at a definite disadvantage. In this article we examine the behavior of a cross-section of the users of medical care in St. Petersburg, Russia. While poverty certainly limits the opportunities available to many people, other factors also influence people's interactions with the medical system.

### **The data**

The data used in this analysis were collected by the authors between 1992 and 1999. In 1992, we surveyed a representative sample (N = 1,500) of the adult population of St. Petersburg. Analysis of these data led to the identification of six social strata with distinctive lifestyles, values, and levels of material well-being. The classification was based upon educational attainment of both respondents and their parents. Our use of educational attainment as the primary indicator of social status reflects the growing consensus of its utility in the study of health inequalities. Using a two-generation approach in the analysis of this population is particularly revealing because of the high rates of rural-urban migration and dramatic upward mobility (e.g. peasant to intelligentsia in one generation) that were fairly common in the USSR. Given the importance of access to the informal economy for individual 'life chances,' inter-generational social mobility emerged as a significant predictor of individual attitudes and behavior as well as economic and physical well-being (Brown and Rusinova, 1997b). Using the two-generation criterion enabled us to account for more of the diversity in our survey sample, and it facilitated assessment of the impact of social mobility, childhood socialization, lifestyles, and material well-being on health status and health-related behaviors and attitudes in adult life. The six social strata were (1) 'Established Intelligentsia,' people with higher education and at least one parent with higher education; (2) 'New Intelligentsia,' people with higher education whose parents have less education; (3) 'Downwardly Mobile,' people who have only a complete secondary education but at least one parent with higher education; (4) 'Stable Skilled,' people who have secondary educations and whose parents have similar levels of educational attainment; (5) 'Newly Skilled,' people who have completed a secondary education but whose parents have less; and (6) 'Unskilled,' people who like their parents have less than a secondary education.<sup>1</sup> Analyses of these data established that people in these various strata differ not only in health status but also in attitudes toward health and in health-related behaviors.

In 1994 we conducted in-depth follow-up interviews with middle-aged individuals (N = 44) who were randomly chosen from the 1992 sample population based on age, gender and social stratum.<sup>2</sup> We used these interviews to

probe in greater depth attitudes about health, illness, and medical care as well as childhood experiences and adult lifestyles. The data confirmed the extent of differentiation within the population and demonstrated the degree to which early 1990s reforms were increasing economic disparities.

A second survey in 1998 (N = 1,200) focused on predictors of health status. These data pointed to the importance of material well-being as a predictor of health status; however, they also offered evidence that consumption patterns continued to differ from one social stratum to another even when levels of material well-being were held constant. For example, with the exception of the very wealthiest members of the population (whose medical care consumption patterns do not differ significantly), people from the highest social strata were significantly ( $p < 0.000$ ) more likely than lower status *Peterburgtsy* with similar levels of material well-being to indicate that they utilized 'pay' medical services.<sup>3</sup>

To help us understand the patterns revealed by those data, in 1999 we conducted another series (N = 32) of in-depth follow-up interviews that focused on health-related lifestyles and use of the medical care system. To select our sample we first identified those individuals in each social stratum who fell into the appropriate age range (in this case people aged 35–50 years of age). As a second step we eliminated all those who did not report 'moderate' levels of material well-being in 1998.<sup>4</sup> By eliminating the poorest and the most affluent, we sought to analyze how medical help-seeking strategies might be influenced by socio-cultural factors rather than by access to material resources alone. We then randomly selected four men and four women from all but two of the six social strata we had identified in 1992. We excluded two strata from this analysis: the Downwardly Mobile and the Unskilled. We had hoped to include the Unskilled but were unable to locate sufficient numbers of them for follow-up interviews.<sup>5</sup> We excluded the Downwardly Mobile because their growing heterogeneity under post-Soviet conditions renders them the most difficult to describe adequately while focusing on 'moderate' levels of well-being.

The findings reported here are based primarily upon computer-assisted analyses of the in-depth interviews. Interviews were coded separately by each researcher, and the codes were subsequently analyzed for comparability. The few discrepancies that occurred were resolved in face-to-face discussions between the researchers.

### **Discussion of findings**

The data we collected throughout the 1990s documented the existence of several distinct strategies utilized by people in St. Petersburg in inter-actions with the medical care system. These strategies were not randomly distributed across the population but were closely linked to social stratum. While personal finances played a role, help-seeking behavior was even more strongly influenced by socio-cultural factors, including attitudes toward health, illness, and the medical system and social norms governing both illness behavior and hierarchical social interactions.

A consistent finding was that the greatest differences in medical utilization strategies existed between those people with higher educations (intelligentsia) and less educated *Peterburgtsy*. The approaches of the former were grounded in notions of individual responsibility for health and health-related decision making (Brown and Rusinova, 1999). This fostered a commitment to early identification and treatment of illness and aggressive efforts to locate good medical care.

Analysis of intensive interviews revealed that one of the most distinctive features of intelligentsia strategies was the early recognition of emerging health problems. People with more education tended to apply strict standards in assessing personal health and to have greater medical knowledge. As a result, they were more likely to attribute meaning to feelings of malaise or physical discomfort and to new symptoms. Like their peers in other societies, our respondents were attentive to these states and quick to seek expert medical help (Blaxter, 1990; Evans et al., 1994; Lahelma and Rahkonen, 1997).

### **Entering the medical care system: intelligentsia strategies**

Among our interview respondents, differences in behavior were already evident when people first decided to seek medical care. The most comprehensive strategies were utilized by the Established Intelligentsia, whose parents also had higher educations and who therefore grew up with material and cultural advantages. Rather than assuming that one must begin with neighborhood polyclinics, the official point of entry into the state medical care system, people in this stratum typically embarked upon the quest for expert help aware of a broader range of possibilities. Knowledgeable about the urban medical system, most also had networks of personal connections that could provide them informal access not only to information, but to a broad spectrum of qualified medical help.

With very minor or routine matters everyone (including the Established Intelligentsia), typically turned to state institutions. *Peterburgtsy* used polyclinics to get sick leave certification, have routine laboratory tests or medical procedures, receive prescriptions for medications, and get referrals to specialized diagnostic or treatment centers. Virtually everyone had dealings with polyclinic doctors, and dissatisfaction with them was widespread. Established Intelligentsia expressed less frustration than others with these practitioners but not because they were less critical. Rather, they made less use of polyclinics and felt less dependent upon them.

Established Intelligentsia aversion to polyclinic medical care developed during the Soviet era (Brown and Rusinova, 1997a). Long before the system was overwhelmed by its current economic difficulties, people in this stratum used it selectively. This approach is typified by a woman with a bedridden mother: 'The polyclinic doctor comes to see mama regularly. She's just like all polyclinic doctors. She comes to write prescriptions for free medications.... Mama tells her what she needs.' Few expect these physicians to offer useful advice. As another woman observed, 'What could the polyclinic doctor tell me? What can she say in general? ... I never go to her.'

When confronted with any but the most routine health matters, most of our Established Intelligentsia interview respondents adeptly assembled the means at their disposal to search for the best available medical help. A central role in these efforts was played by the extensive networks of informal connections – both lay and professional – characteristic of this privileged social stratum. As necessary, these networks were expanded to include new acquaintances.

Informal connections to the medical world were, in fact, widespread among *Peterburgtsy*. Two out of five (40% in 1998; 45% in 1992) of our survey respondents indicated that they knew someone in the medical care system who could help them solve medical problems. Nonetheless, higher status individuals clearly had better connections. As was true of their consumption in general, the extent to which people could count on informal medical connections to help solve problems depended upon how extensive their networks were and the status of the professionals who comprised them. Many in the Established Intelligentsia reported that they were able to access a wide array of medical services – from consultations with specialists to direct access to specialized medical institutes and expensive medical technology (Brown and Rusinova, 1997a).

The extent to which our Established Intelligentsia interview respondents utilized acquaintances to search for primary care reflects the importance most attributed to precise diagnosis. This is illustrated by one mother's account of her efforts on behalf of her son, a student athlete and 'completely healthy young man' who suddenly developed serious back pain:

I tried all my acquaintances, neighbors. I consulted a neuropathologist.... [My son] was told what he could do and what he couldn't do. They prescribed some kind of treatment: injections, massage. We did this at home. I arranged and paid for everything.... We had a CAT scan.... We searched for a long time to find out the best place to do it ....We asked doctors where to get the scans, where the best equipment was. We sought advice until we found what we needed.

These search strategies tended to be dominated by a single criterion: quality of care. In intensive interviews most people in this stratum indicated that they were prepared to pay for care. However, most assumed that quality was determined by the professionalism of the individual practitioner rather than the form of payment. Cost considerations were thus secondary, arising only after specialists or technologies had been located. This was generally a cost-effective strategy – to the extent that they were able to avoid incompetence they were more likely to circumvent medical mistakes that could lead to far greater expenditures of time and money.

Once they had a diagnosis and recommended treatment, some of these skilled consumers reported going to state polyclinics and demanding ‘free’ services, i.e. paid for by obligatory state-mandated medical insurance. The effectiveness of this strategy is illustrated by the woman with the injured son:

Once I had gathered all the documents, test results, etc. of course, I went to the polyclinic and asked, ‘... Why did I have to do this myself? I don’t have any more money or time.’ What could they do? I had a CAT scan, x-rays, doctors’ conclusions! ... They gave me a referral – for free treatment. He went every day. The facility had massages, a swimming pool, therapeutic exercises, injections, physiotherapy, everything.... That was possible only after I brought them everything. The moral: ‘The drowning must help themselves.’

Their successful use of this strategy is evidence of mastery of medical and legal institutions and of their privileged position in the urban social structure. The former armed them with knowledge of the entitlement system; the latter gained the acquiescence of polyclinic administrators.

Both survey and interview data indicated that overt commitment to health was even more pronounced among the upwardly mobile New Intelligentsia than among the Established Intelligentsia. Our New Intelligentsia interview respondents eagerly discussed their health maintenance strategies, which tended to be more complex and elaborate than those of any other *Peterburgtsy*. Nonetheless, most found it more difficult to manipulate the medical care system. Even with serious illnesses, their initial steps were frequently toward state polyclinics, for which they tended to have higher expectations than did people who grew up in intelligentsia families.

These expectations were often disappointed. Frustration and irritation were recurring themes in New Intelligentsia accounts of experiences with state polyclinics. The following is typical:

I asked the doctor, ‘When I get a shot for influenza and encephalitis, do I need one for diphtheria too?’ Her response was, ‘You ask a lot of questions!’ What the devil! Just what exactly did I go there for? If I were to go there every day and she had to spend five minutes with me each time, is she going to be worse off for that? She looked as if I had come to beg her for bread!

While negative experiences eventually led many of our New Intelligentsia respondents to doubt polyclinic physicians, they differed from the Established Intelligentsia in that they did not base their initial search for care on the assumption that those doctors were inferior. They were most upset by the ‘negligence,’ ‘inattentiveness,’ ‘indifference,’ and ‘callousness’ of doctors in the state’s primary care system. They typically attributed this behavior to post-Soviet developments of which they perceived themselves to be as much victims as were the doctors: ‘They’re also people. Naturally they don’t only think about the patient but about how to survive, what they’re going to eat tomorrow.’ The 1990s impoverished physicians employed by the state, they observed and encouraged the ‘best’ to move to greener pastures:

In the ‘free’ medical system there are now only people who don’t have anywhere else to go. They are not accomplished scientists. No clinic that needs specialists is going to take them. And at some level they understand this.... They’d like to go somewhere but they’re trapped. Their attitude toward their work and their patients reflects it.

The emotional reactions of people in this stratum and the fact that they sometimes attributed their experiences to 'chance' or 'bad luck' both suggested a greater dependence upon polyclinics.

Nonetheless, our New Intelligentsia interview respondents were strongly committed to individual health. Having achieved inter-generational social mobility, they tended to regard good health as yet another status they could achieve by their own efforts (Brown and Rusinova, 1997b). Rather than settling for what the state provided, many eventually took matters into their own hands and began to search beyond polyclinics.

The task was complicated, because their networks of medical connections tended to be less developed, i.e. they included fewer high status specialists and more circumscribed routes to help sources. Asked whether he had any connections, one New Intelligentsia man boasted: 'Of course, I have friends! My cousin worked for about ten years as a nurse. Now my daughter has friends who are nurses, so whenever we need something we can ask them, for example, to give an injection.' Another cited his nephew, 'a fifth year medical student. Of course he's not really a doctor yet, but he's already sufficiently qualified for me to be able to count on him.' Needless to say, the assistance that such connections could provide was necessarily limited.

Several of our New Intelligentsia respondents indicated that they relied on the experience of acquaintances without medical training: 'I don't use connections,' insisted one woman. 'But I understand how that system operates. If somebody in my family gets sick, I call friends to ask who's had a similar problem. Then I start to act, to search...' Sometimes these lay referral networks sent them to alternative healers: 'My back started to hurt and my sister (who's not a doctor but always dreamed about it and has friends ...) gave me a pile of telephone numbers and advice about psychics, acupuncturists, masseurs, etc.' Although they claimed to be knowledgeable about alternative medicine, few of our Established Intelligentsia respondents reported utilizing healers who were not physicians.<sup>6</sup>

New Intelligentsia strategies for managing relationships with physicians also suggested a different perspective on the relationship between quality of care, personal relationships and payment:

When I developed a hernia, I was in shock. After I calmed down I called a doctor I know, a manual therapist. I consider him a specialist in all illnesses. In complex situations I turn to him and he helps me.... I also have an excellent acupuncturist whom I've known for about ten years. At first I didn't know anybody in the medical system but I made acquaintances in connection with my illnesses. Then they became friends.

Rather than searching aggressively for the 'best' specialist, some people in this stratum indicated that they tried to cultivate friendships with doctors they already knew or offered them money in hopes of ensuring better treatment. As one man observed, 'When a relationship is built on the basis of friendship, the doctor understands that you are not a regular patient, for whom he receives nothing ... it is impossible to be uncaring.'

### **Intelligentsia strategies for negotiating the hospital labyrinth**

St. Petersburg's medical system includes a range of in-patient facilities. Some have highly trained medical experts; others suffer from constant shortages of qualified and motivated personnel. There are also great differences in the ability of these diverse institutions to meet the needs of their patients: medications, intravenous solutions, syringes, sanitary facilities, clean linens, and even food are often in short supply. Given the many possibilities, knowledge about alternatives and the ability to control one's destination can make an enormous difference. It can even mean the difference between life and death. Our interviews with people from different social strata offered abundant evidence that of all *Peterburgtsy* those in the Established Intelligentsia were generally best equipped to negotiate this labyrinth.

As in their quests for primary care, Established Intelligentsia typically attempted to gather information well in advance of hospitalization. These search strategies focused on finding the best medical professionals, as that was the resource they were least able to provide for themselves. Everything else (living conditions, ancillary

personnel, availability of medications) was less important, as they tended to assume that they could make up for deficits. Many indicated that they were also willing to accept some physical discomfort and inconvenience in order to have the ‘best’ experts supervise their treatment:

Sometimes a hospital is beautiful and new but the treatment is bad. [At one institution] the toilets are at the end of the corridor and there are horrible wards with 20 patients. But the doctors are excellent. Diagnosis and treatment are both good. Or there’s Institute P. Conditions are terrible: it’s old with ramshackle furniture. The beds are so close together you couldn’t even get a night table between them. It’s horrid. After major operations patients don’t have nurses’ aids or housekeepers.... But of course the aids don’t do the operations! What can you do if that’s the only place in the city with excellent neurosurgery?

Anticipating hospitalization, our Established Intelligentsia respondents indicated that they activated their informal networks to prepare the groundwork for a satisfactory experience: locating good specialists and gaining access to facilities where they could expect to get good care.

I was treated in the Hospital S. It’s a very good hospital. I didn’t end up there by chance ... I found a surgeon who did the surgery for me.

When one respondent’s mother was hospitalized:

We didn’t have to bring medication, linens or anything. It was a planned admission. We know a doctor there. We don’t turn to her all the time [but the doctors] had advised mama to get rechecked.... Her friend is a department head. She arranged for mama’s admission to another department. She talked with the doctors who directed mama’s treatment.

The accounts of our New Intelligentsia respondents suggested that most had far less control over hospital experiences. They were more likely to enter the hospital via ‘official’ channels, i.e. referral by a polyclinic physician and/or ambulance transport. In such cases the patient has little choice – the destination is whichever hospital happens to be ‘on call’ for the day.

In life-threatening emergencies everyone’s medical care options are limited. An ambulance trip to the ‘on call’ hospital may be the only viable alternative – even for the most aggressive medical consumer. Nonetheless, the Established Intelligentsia individuals whom we interviewed appeared to be more adept than other *Peterburgtsy* at anticipating needs for hospitalization early enough to retain some control over the process. New Intelligentsia often lacked personal connections to help them make an informed decision or else they waited to take action until rapid intervention was unavoidable. Since they also tended to have high expectations for hospital care, the realities they confronted left them disillusioned and harshly critical:

I was so naive. I decided that it would be easier in the hospital. I spent three hours in admitting before anybody paid me any attention. Then they gave me a bed and pain medication but didn’t do anything else. Later I called somebody I know and he brought me something better.... I stuffed myself with medications to the point where I was totally out of it.... What a hospital!

A woman told a similar story. As in the preceding example, the hospitalization was unanticipated and the experience distressing:

My husband had double pneumonia. They took him by ambulance ... to an ordinary hospital. It didn’t have anything. We had to buy everything they prescribed and bring it to the hospital – even food. He was there for two weeks. Relatives cleaned the room. We never saw an attendant. The only thing they would do was give you a shot – provided you brought the syringe and medication.

Our interviews with St. Petersburg's intelligentsia were replete with richly detailed accounts of experiences with the urban medical care system. The few examples just cited illustrate patterns of behavior that were *remarkably* consistent within strata and strikingly different across them. People in these two social strata clearly brought differing assumptions and unequal amounts of social and cultural capital to the quest for medical care. Still, the differences between these two intelligentsia groups paled by comparison with differences between *Peterburgtsy* with higher educations and the rest of the population. Certain traits that intelligentsia groups had in common (e.g. a sense of personal responsibility for health; knowledge about health matters; high social status) apparently equipped them to take the initiative and be persistent in dealing with the medical care system (Brown and Rusinova, 1999). This enhanced their ability to receive good quality medical care – even without great expenditures of money.

### **Polyclinic experiences of lower status *Peterburgtsy*: 'they treat you like a football'**

Both survey responses and the interview narratives indicated that the approach of lower status *Peterburgtsy* to the utilization of medical services was very different, a product of attitudes toward individual health as well as position in the social hierarchy. As is characteristic of working class people elsewhere, our respondents associated health with functional capacity (Blaxter and Patterson, 1982; Brown and Rusinova, 1997b; Pierret, 1993). Being healthy meant being able to meet one's normal role expectations, a notion markedly different from that of 'positive' health as a vehicle for personal fulfilment common among the intelligentsia. Viewing health as functional capacity meant that people could suffer from painful sensations, negative feelings, or even serious illnesses and still regard themselves as 'healthy' – so long as those conditions did not interfere with daily obligations.

In interviews these *Peterburgtsy* indicated that they sought medical attention less often, and when they did so they relied primarily on the state medical system. One reason for this was certainly the heritage of paternalism fostered by the Soviet system, however, international research has demonstrated that people at the bottom of social hierarchies often perceive that they have little control over and hence less responsibility for health (Crawford, 1984; Freund and McGuire, 1999). Many of our respondents not only denied that learning about health was the individual's responsibility; some actually argued that it could be harmful: 'The less you know the better.'

Lack of knowledge makes people less able to understand health problems and assess alternatives. This, in combination with a dearth of informal connections to the broader medical system, sent most of these *Peterburgtsy* to polyclinics, where they often found themselves at the mercies of deteriorated state institutions and their underpaid, overworked practitioners. While the attitudes and behaviors of Stable and Newly Skilled people differed in many other respects, they shared similar medical utilization strategies. It was in their accounts that the Russian medical care crisis was most graphically described.

One recurring theme was unresolved diagnoses. Typical was the case of a woman who recently experienced a 'mysterious' illness. Despite her serious condition (extreme fatigue, weakness, rapid heart beat, dizziness, elevated blood pressure – all confirmed by ambulance crews) she indicated that she was sent from office to office and told repeatedly: 'that's not my [kind of illness]' or 'I don't see any serious abnormalities.'

It cost me my nerves. I described my problems to each doctor, beginning with a therapist, who [sent me elsewhere]. I told it again. That one said, 'You need to go to another doctor.' I made an appointment with him and again told everything from the beginning. I went around in circles. I felt so bad they had to carry me to the polyclinic. And for what? Nothing! I saw almost everybody and never got a diagnosis.

Another woman, exhausted by back pain, described a similar experience:



First I went to the therapist. Naturally she sent me to another doctor, who said, ‘You need to see a women’s doctor.’ The ‘women’s doctor’ sent me to a neuropathologist [who] sent me someplace else. They treat you like a football.... Three hours here; three hours there.... You go and they tell you everything is normal. You get upset and just feel worse.

Our respondents’ accounts suggested that the diagnostic process in state polyclinics was often cursory, based solely on visual examinations and elementary laboratory analyses. Patients were rarely referred for more sophisticated diagnostic procedures unless they insisted – uncharacteristic of lower status individuals who typically deferred to medical experts. Few of our Stable and Newly Skilled respondents were even informed about the existence of such options – either as an entitlement or a service for which they might choose to pay.

People who did make inquiries were frequently rebuffed. A diabetic complained about a recurring leg infection:

They need to determine whether it’s a streptococcal or staphylococcal infection. I even tried to find a lab where I could pay. I know there is one in Leningrad, but I couldn’t find it, and the doctors won’t give me a referral.... The polyclinic surgeon says they don’t know ... I’m willing to be hospitalized for tests but nobody ever suggested it – even when I had open sores.

This case is particularly revealing, as the individual involved clearly tried to understand her problem and asked for assistance. The physicians were unresponsive, and she, in turn, was reluctant to confront the higher status professionals. *Intelligentsia* patients were not similarly disadvantaged in social interactions with polyclinic physicians. Perceiving themselves to be the doctors’ social equals (or their ‘betters’), they were less hesitant to make demands and usually more successful in getting what they wanted.

Virtually everyone who had experienced an ambiguous ailment told a similar story. Unlike the *intelligentsia*, these *Peterburgtsy* rarely presumed to judge the technical competence of polyclinic personnel. They tended to locate the cause of their unsatisfying experiences in doctors’ lack of interest in their work. Most perceived a negative trend over time which they explained in terms of the worsening financial situation of doctors:

‘We have this polyclinic doctor! She just shoves you out the door. Maybe it’s because they don’t get paid so they don’t want to work. You get the impression they don’t care about anything!’

‘It takes so long and they’re so callous! Whatever specialist you go to, the attitude is that you’re a burden.... We do have an endocrinologist who’s very nice. I can’t say anything about her but you have to get in to see her, and it’s simply impossible to get an appointment.’

Having been badly treated by polyclinic personnel, many people were reluctant to return. Structural obstacles that patients confronted when using the state medical system reinforced those negative sentiments. These road-blocks they describe were so massive as to make one wonder whether they were designed to test patients’ seriousness and determination. The following illustrate:

The polyclinic opens at 8:00am. You have to be in line by 5:00 or 6:00 to get an [appointment] coupon. You have to stand on the street whether it’s raining or snowing or freezing.

I know that when I go to the polyclinic I will waste a whole day.

They give out [appointment] coupons on Wednesday, and not at our polyclinic. You have to go to a different one that’s not even in our region.... If I get there by 7:00, I generally succeed. You can’t telephone. You have to ask for time off from work.

As the official portal into the state medical system, polyclinics see patients with all types of illnesses and, given the propensity of Skilled *Peterburgtsy* to delay treatment, some of our respondents presented with potentially life-threatening conditions. The institutions' triage responsibilities notwithstanding, even seriously ill individuals confronted these same obstacles. One woman told of discovering a lump in her breast:

Later, my breast started to bleed but it didn't hurt. I didn't go until the fifth day. It was horrible.... I went to the gynaecologist. She said, 'Why did you come to me? You need to see the surgeon.' I went to the surgeon. He was in surgery all day. Again I didn't get seen.... Yesterday I called. They said that they only give out seven coupons. I have to go on Friday at 6:00am and wait.

Many people with chronic illnesses joined everyone else standing in line at neighborhood polyclinics, as this was their only means of access to the specialists who monitor their conditions. The more intensive the monitoring, the more burdensome was the process. When patients fail to maintain contact with them, physicians typically attribute it to lack of concern about health (Curtis et al., 1995). This 'blame the victim' mentality does not sit well with our respondents who complained that their efforts to get care were unrewarded and, as the following suggests, were sometimes aware that things could be different:

I haven't been to the doctor in a long time.... I thought summer would be easier, but the doctor was on vacation. It's very hard to get seen. I need to be checked constantly. If only the doctor would give me a coupon for the next time.... Once, when I hadn't been in for a while, they called me. I said that I hadn't been able to get a coupon and they made me an appointment. I came and got seen. So, I suppose it could be done that way.

Chronic patients in post-Soviet Russia are legally entitled to receive many free medications. These can be difficult to find in pharmacies; however, people cannot even begin to search without a physician's prescription. Having a physician friend, as did many of our intelligentsia respondents, simplifies the process, but most *Peterburgtsy* in lower social strata had to make appointments with polyclinic doctors. Patients who needed regular lab tests or therapeutic procedures confronted yet another set of obstacles:

It's difficult now to get lab work done. [They] used to give me a referral for a day that was convenient.... Now I have to go to a pre-medical office to get a coupon. They only give them for a certain day so you can come and not even get one.

Some experts have argued that it would be possible to rationalize this system without adding significantly to overall costs.<sup>7</sup> Doing so might help to ameliorate some of the difficulties faced by our respondents; however, factors external to the system also deterred them from seeking medical care. Prominent among these deterrents was a growing reluctance to take time off from work for illness. Many non-state employers in the post-Soviet economy do not offer paid sick leave. In contrast with the Soviet past, even people who worked in state enterprises told us that they avoided taking sick leave because of fears that supervisors might lower their pay or fire them:

You try not to take it because you lose money or something else bad happens. ... Now you work – even if you're falling down. Bosses don't care.

I drag myself into work. There are times when I would be better off at home but I'm afraid they'll fire me. I could take sick leave but I might lose my job. It's better to go to work with a temperature of 39C [102F].

They wanted to put me in the hospital. But I was called in to work so I refused. You have to choose – get laid off or get treated.

Polyclinic visits for sick leave certification increase the likelihood that developing problems will be detected at an earlier stage. (e.g. individuals who present with flu can be screened for cardiovascular and pulmonary functioning.) Many of the *Peterburgtsy* we interviewed had difficulty remembering the last time they took sick leave. Since regular work-related physical examinations are also mostly a thing of the past, all too often it was only serious and/or long-standing ailments that sent people to the medical system.

### **Hospital experiences of skilled *Peterburgtsy*: ‘the luck of the draw’**

When people avoid doctors, initial contacts with the system often entail emergency hospitalizations. The extent to which this was true of lower status *Peterburgtsy* is evident from answers to our questions about where they go first for medical help. Intelligentsia typically discussed an array of formal and informal sources they could consult depending upon the nature of the problem. Stable and Newly Skilled people tended to offer another kind of answer: ‘If it’s urgent, I call an ambulance – for everybody. We adults don’t do anything until legs collapse under us. We call the doctor for children on the second day.’

Since patients admitted via the emergency care system are taken to an ‘on call’ hospital, they have little control over their destination. Occasionally, ‘by uncommon good luck,’ our respondents and their families had found themselves in well-equipped facilities. Far more common were stories of hospitals with poorly qualified, inattentive personnel, medication shortages, and inadequate care. The range of possibilities is suggested by the account of a woman whose daughter recently gave birth to premature twins. Early in the pregnancy she was threatened with miscarriage and sent by ambulance to an ordinary hospital:

The doctors were not careful.... Every room had a radio, but if she didn’t go for her shots nobody came to get her. She didn’t even know which shots she was supposed to get. The doctor told her something but she didn’t understand.

As our respondent continued her story, there was a distinct change in tone. The birth experience had been quite different:

They took her by ambulance to [an institute]. It was the ‘on call’ facility. We were so lucky! A [staff member] telephoned the doctor on call.... I could talk on the phone! That was so unusual for me after other medical institutions. The doctor calmed me down. She said she had seen our babies. Everything was okay. She asked me not to worry. Specialists checked [my daughter]. An endocrinologist came ... just because of a note in her chart. Can you imagine? All kinds of specialists examined the babies.... I am so grateful!

Remembering the emergency hospitalization of his mother, another individual described a far gloomier scenario:

I had to create a scandal.... There was a problem with medications and the attitude was terrible. I had to yell at the assistants because they didn’t do anything for her after the operation. The nurse refused to change her IV. We had to find her when it ran out and buy medications ourselves. It was hard to find the doctors. I dropped everything and spent an entire week sitting there all day.... I fed the whole ward. I brought food from home. There were elderly single women there. It was a nightmare!

Even with planned admissions, lower status people typically assumed that they could not control the process and accepted without question the decisions of medical personnel regarding the locus of treatment. The ‘luck of the draw’ seemed to be the primary factor determining the outcome, one result of which was great variation in their assessments of the quality of hospital care.

The positive experiences of the few people in these social strata who did assert themselves offered evidence of that strategy’s effectiveness – regardless of social status. A neighborhood polyclinic failed to diagnose one woman’s problem, which continued to deteriorate causing ‘hellish pain.’ Her desperate mother finally

complained to the local health authorities (*raizdravotdel*) who insisted that the polyclinic refer her to a specialized institute which quickly diagnosed the condition and corrected it surgically.

This woman was required to pay for her treatment. Like several others in similar situations, she admitted to being surprised that the additional cost was not only reasonable but affordable. Her astonishment suggests the extent to which people in these social strata have remained out of touch with and confused by the changes that have swept through the post-Soviet medical care system. Their often flawed assumptions about the way the system works could seriously limit their help-seeking strategies.

Unlike the intelligentsia, they tended to see two stark alternatives: 'free' state-guaranteed medical care covered by compulsory medical insurance and 'everything else,' which they assumed to be unaffordable. So wedded were many to this perspective that they rarely attempted to determine what any medical service might cost. Their perceived inability to control the quality of care they received from the state system made them doubt that paying would produce good results. One woman described her failed efforts to get a diagnosis at her neighborhood polyclinic. She consulted every doctor on the staff but had not sought help outside the polyclinic:

There are better specialists, but it's completely unaffordable. Besides, if I go to a pay polyclinic it would be on my own initiative. I would have to pay for it and I am not at all sure that I would get any result.

Such misgivings were widespread:

I don't have money to go to a good specialist. Maybe it would be worthwhile to see a professor or some narrow specialist ... but I have to use free medical care.

I feel complete helplessness. You need money everywhere ... it's better to die and not suffer or make others suffer.

I don't trust pay medicine. Maybe I would if I had money. Maybe I would at least try, but money is so hard to come by and it's not clear what you'd get for it. Maybe it would be something negative.

Despite the fact that none of these individuals described themselves as 'poor,' the fear of 'pay' medicine and indeed of taking any autonomous steps out into the broader medical care system was so deeply ingrained as to be immobilizing. One respondent's husband was treated five years ago at a specialized facility for a complicated leg fracture requiring the insertion of a metal pin. He was told at the time that the pin should be removed after one year. At the time of the interview it was still in place. The woman explained: 'He can't go there for another operation for financial reasons.' As we probed we learned that they never asked about the cost. They simply assumed, 'you have to pay for everything! ... We don't have that kind of money – to pay for an operation.'

The result was that most of these *Peterburgtsy* said that they ignored symptoms or self-treated with traditional remedies and newer patent medications. Their sources of authority tended to be family and friends who had experienced similar ailments or traditional healers. While few of these consultants had any formal medical training, their assistance was, at least, perceived to be affordable and familiar.

For some people in these social strata the decision to avoid medical care had become an a priori one: 'I don't go no matter what.' In part, this reflects normative pressures to remain stoic and not abandon obligations. Our respondents' narratives suggested that becoming ill, entailing as it does the lifting of normal role responsibilities, potentially subjected one to suspicions of physical or moral weakness. The reluctance of others to seek care developed in response to repeated unsatisfying encounters. In either case the outcome was the same – unless some extraordinary situation (e.g. a traumatic injury) propelled these *Peterburgtsy* through the door, they could go for extended periods without contacting the medical care system:

Until pain gets really bad we don't go anywhere.

I go less often.... It's more crowded. You wait and they tell you everything is normal. Why should I go when I don't have to? I just take a pill.

I don't believe in doctors.... Even when I have severe pain I handle it myself.

## Conclusions

Economic inequality has increased significantly in Russia since 1991. No one would dispute the assertion that many ordinary people now find it extremely difficult to pay very much for medical care. Nonetheless, financial considerations are not the only factor influencing medical care utilization. As Max Weber long ago pointed out, a key feature of 'status groups' is 'a peculiar style of life' – as evidenced by shared patterns of consumption (Bendix, 1960: 86; Weber, 1947: 429). Depending upon the social stratum from which they come, the *Peterburgtsy* we studied approached the problem of getting health care very differently – even when levels of material well-being did not differ dramatically.

In general, people in the highest social strata tended to be proactive. Most were knowledgeable about the system and their informal social networks helped them find and gain access to the best medical care available. While not averse to spending money for medical care, their approach helped them to control expenditures. They tended to seek treatment early when the cost was lower. In addition, their high social status and understanding of the system privileged them in interactions with medical providers and helped them to take greater advantage of services available through 'free' compulsory medical insurance.

Like their counterparts in other societies, our data indicated that less educated (lower status) *Peterburgtsy* did less to stay healthy and tended to ignore troublesome symptoms (Feinstein, 1993; Lynch, Kaplan and Salonen, 1997). When they did seek medical attention, it was usually within the confines of the old state medical system. Most assumed that other alternatives were expensive and doubted their ability to find 'good' care that would justify the expense. Rather than galvanizing them into action, the diagnostic failures, personal indignities, and enormous inconveniences they encountered reinforced their predisposition to avoid seeking any medical care at all. Thus, health problems were too often identified only after they had reached an advanced stage at which time they were more difficult and more costly to treat.

Scholars disagree about how much medical care contributes to the health of populations. Nonetheless, to the extent that medical care is important to the well-being of our respondents, the strategies employed by those of higher social status (particularly Established Intelligentsia) clearly resulted in more and better care – without significantly greater costs. It was individuals lower in the urban social structure who bore the brunt of the state medical system's inadequacies. In the long run their avoidance of care and passivity in dealing with medical institutions will almost certainly increase not only medical costs but also the risk of permanent disability and premature death (Pappas et al., 1997).

Given the high levels of morbidity and mortality in post-Soviet Russia and the limited resources available for medical care, understanding noneconomic influences on health-related behaviors is particularly important. On the one hand, they suggest ways the system could be made more effective without adding significantly to costs. (Simplifying the process of making appointments with polyclinic physicians is only one obvious example.) Conversely, our findings indicate that merely putting more resources into the medical system is unlikely to guarantee everyone better care. As our respondents' narratives make abundantly clear, strategies for dealing with the medical system reflect differing levels of knowledge as well as actual experiences with the system. These in turn are mediated by culturally based attitudes toward health and illness and long-standing social norms regarding interactions between people of unequal status. Until they take into account the importance of social and cultural forces as well as economic ones, efforts to equalize access to medical care are likely to meet with limited success.

## Notes

1. The term 'intelligentsia' has been used in many different ways. In electing to use it, our intention has not been to take a position in the on-going scholarly debate on the nature of the Russian intelligentsia. Rather, we have utilized this terminology because of its long-standing association with the most educated segment of the population. Similarly, despite the fact that the majority of people we categorize as 'skilled' or 'unskilled' actually do the type of work suggested by those terms, our categorization is based upon level of educational attainment, not occupation.
2. Individuals in this cohort were born after World War II. They are old enough to experience health problems that emerge in middle age yet are often still dealing with health problems of children. Many are also helping with the medical care needs of aging parents. Thus, they interact broadly with the medical care system. Furthermore, current statistics indicate that the risk of dying is particularly high for Russians aged 50–60. Understanding the behavior of people moving into this decade of life is particularly important (Vishnevskii and Shkol'nikov, 199T)
3. Among those who describe their level of material well-being as 'poor,' almost two-thirds (65%) of those in the Established Intelligentsia reported using 'pay' medical services at least on occasion. At the other end of the social spectrum 35 percent of the Newly Skilled and only 16 percent of the Unskilled did so.
4. With the exception of controlling for material well-being, this is the same sampling strategy that we used in the 1994 interviews. In 1999 we assessed material well-being on the basis of per capita income and self-reported deprivation of goods and services relevant to health (e.g. diet, household goods and services, social contacts, opportunities for rest and relaxation).
5. These are the most marginal of *Peterburgtsy*. In 1994 we were unable to locate Unskilled men for follow-up interviews; in 1999 both men and women proved elusive. Some of those we had surveyed a year earlier had moved or died. The whereabouts of others could not be determined.
6. A number of licensed physicians in post-Soviet St. Petersburg have expanded their activities to include alternative medical therapies. (See Brown and Rusinova, 2002.)
7. Many well-equipped workplace facilities and specialized research and teaching clinics are greatly under-utilized. Critics argue that they should participate more fully in the compulsory medical insurance system. (See 'The Patient pays twice,' *Sankt-Peterburgskie Vedomosti*. December 3, 1999, p.5.)

## References

- Bendix, R. (1960). *Max Weber: An intellectual portrait*. Garden City, NY: Doubleday & Co.
- Blaxter, M. (1990). *Health and lifestyles*. London: Tavistock/Routledge.
- Blaxter, M. and Patterson, L. (1982). *Mothers and daughters: A three generation study of health attitudes and behaviors*. London: Heinemann Educational Books.
- Boikov, V., Fili, F., Sheiman, I. and Shishkin, S. (1998). Raskhody naseleniia na meditsinskyi pomoshch' i lekarstvennye sredstva. *Voprosy ekonomiki*, 10, 101–11T.
- Brown, J.V. and Rusinova, N.L. (1993). Personal contacts in the health care system and illness careers. *Sotsiologicheskie Issledovaniia*, 3, 30–36.
- Brown, J.V. and Rusinova, N.L. (199Ta). Russian medical care: A user's perspective. *Social Science and Medicine*, 45, 1265–T6.
- Brown, J.V. and Rusinova, N.L. (199Tb). Health inequalities in post-Soviet Russia: A case study of St. Petersburg. unpublished paper presented at the Annual Meeting of the Southern Sociological Society, New Orleans, 199T.
- Brown, J.V. and Rusinova, N.L. (1999). Personal effort, external constraint: responsibility and control over health. *Journal of Sociology and Social Anthropology*, 2(1), 103–14.
- Brown, J.V. and Rusinova, N.L. (2002). Curing and crippling: Bio-medical and alternative healing in post-Soviet Russia. *The Annals of the American Academy of Political and Social Science* (in press).
- Crawford, R. (1984). A cultural account of 'health': Control, release and the social body. In J. McKinlay (Ed.), *Issues in the political economy of health care*, pp. 60–103. London: Tavistock.
- Curtis, S. et al. (1995). Health care reforms in Russia: the example of St. Petersburg. *Social Science and Medicine*, 40, T55–65.

- Evans, R.G., Barer, M.L. and Marmor, T.R., Eds. (1994). *Why are some people healthy and others not: The determinants of health in populations*. New York: Aldine de Gruyter.
- Feinstein, J.S. (1993). The relationships between socioeconomic status and health: A review of the Literature. *Milbank Quarterly*, 71, 2T9–322.
- Field, Mark G. (195T). *Doctor and patient in Soviet Russia*. Cambridge, MA: Harvard University Press.
- Field, M.G. (2000). The health and demographic crisis in post-Soviet Russia: A two phase development. In Mark G. Field and Judyth L. Twigg (Eds.), *Russia's torn safety nets: Health and social welfare during the transition*, pp. 11–42. New York: St. Martin's Press.
- Freund, P.E.S. and McGuire, M.B. (1999). *Health, illness, and the social body: A critical sociology*. Upper Saddle River, NJ: Prentice Hall.
- Grigor'eva, N. (1998). Pravovoe obosnovanie realizatsii kontseptsii ob okhrane zdorov'ia naseleniia Rossii. In *Kuda idet Rossiia? Transformatsiia sotsial'noi sfery i sotsial'naia Politika*. Moscow.
- Hyde, Gordon. (19T4). *The Soviet health service*. London: Lawrence and Wishart.
- Knaus, William. (1981). *Inside Russian medicine: An American doctor's first-hand report*. New York: Everest House.
- Korchagin, V. (199T). Problemy finansirovaniia zdravookhraneniia. In I.S. Maslovoi (Ed.), *Regulirovanie sotsial'nogo razvitiia Rossii*. Moscow: RAN.
- Kronenfeld, J., Ed. (2000). *Health, illness and use of care: The impact of social factors*. Greenwich, CT: JAI Press.
- Lahelma, E. and Rahkonen, O., Eds. (199T). Health inequalities in modern societies and beyond. *Social Science and Medicine*, 44(6), T21–22.
- Ledeneva, A.V. (1998). *Russia's economy of favours: Blat, networking and informal exchange*. Cambridge: Cambridge University Press.
- Lynch, J.W., Kaplan, G.A. and Salonen, J.T. (199T). Why do poor people behave poorly? *Social Science and Medicine*, 44, 809–19.
- Pappas, G., Hadden, W.C., Kozak, L.J. and Fisher, G.F. (199T). Potentially avoidable hospitalizations: inequalities in rates between US socioeconomic groups. *American Journal of Public Health*, 87, 811–1T.
- Pierret, J. (1993). Constructing discourses about health and their social determinants. In A. Radley (Ed.), *Worlds of illness*. New York: Routledge.
- Rusinova, N.L. and Brown, J.V. (199T). Sotsial'no-statusnye gruppy: razlichiiia v sub'ektivnom Zdorov'e. *Peterburgskaia sotsiologiiia*, 1, 38–59.
- Ryan, M. (19T8). *The organization of Soviet medical care*. Oxford: Blackwell.
- Shishkin, S. (1998). Dilemmy reformy Zdravookhraneniia. *Voprosy Ekonomiki*, 3, 90–104.
- Shkol'nikov, V., Andreev, E. and Maleva, T., Eds. (2000). *Inequality and mortality in Russia*. Moscow: Carnegie.
- Twigg, J.L. (2000). Unfulfilled hopes: The Struggle to reform Russian health care and its financing. In M.G. Field and J.L. Twigg (Eds.), *Russia's torn safety nets: Health and social welfare during the transition*, pp. 43–64. New York: St. Martin's Press.
- Vishnevskii, A. and Shkol'nikov, V. (199T). *Smertnost' v Rossii: Glavnye gruppy riska and priority Deistviia*. Moscow: Carnegie.
- Weber, M. (194T). *The theory of social and economic organization*. New York: Oxford University Press.

### Author biographies

Nina L. Rusinova is Head of the Sociology of Health Research Group at the Institute of Sociology, St. Petersburg branch of the Russian Academy of Sciences. She has published numerous articles on social aspects of health care, health policy, and health reform in Russia and the USSR.

Julie V. Brown is Associate Professor of Sociology at the University of North Carolina at Greensboro. She is the author of numerous articles on socio-cultural aspects of health and illness, responses to mental disabilities, the medical system, and physicians in Russia and the Soviet Union.