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The Russian Health Care Experiment: Transition of the Health Care System and Rethinking Medical Sociology

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The health situation in Russia has become crucially important after the massive social, political, and economic changes that have taken place since the 1980s. High morbidity, epidemics of infectious diseases, and high rates of heart disease mortality have caused concern about the state of health in contemporary Russia. In the 1990s, for the first time since World War II, the country faces the problem of depopulation as mortality rates exceed birth rates (Gorbachova 1999). The birth rate, for example, fell from 12.1 births per 1,000 in 1991 to 8.6 in 1997; however, the 1997 mortality rate was 13.8 deaths per 1,000 persons indicating a net decrease in population. Likewise, there has been an unprecedented decline of life expectancy from 65.1 (1987) to 60.7 years (1997) for men and from 73.1 (1987) to 72.9 years (1997) for women in Russia (Goskomstat 1998). There is also a steadily growing number of poor people, who constituted 62 percent of the total population in 1996 (Kara-Murza 1997).

As a result of living conditions, deterioration of the immune system of many individuals has weakened and infectious diseases increased by two fold (Gorbachova 1999). For instance, tuberculosis morbidity is steadily growing and increased 9.5 percent for the adult population and 11.4 percent among children in 1997 (State Report on Health of the Citizens of the Russian Federation 1997). As of January 1, 1999, there were 10,758 HIV-positive persons, of whom 449 were children (Aloyan and Nikolay 1999), while the number of HIV-positive persons in 1988 was only 69. There has also been a dramatic increase in the number of individuals with sexually-transmitted diseases, with more than 2 million people registered annually with these diseases in the late 1990s compared to 640,000 in 1989 (State Report on Health of the Citizens of the Russian Federation 1997). Most of these diseases are socially determined and they, along with Russia's other health problems, require serious sociological analysis.

The Historical Background of Medical Sociology in Russia

The first studies of health, illness, and morbidity were conducted in Moscow and later extended elsewhere in Russia. Studies done by P. I. Kurkina and E. A. Osipova date back to the nineteenth century (Zhuravleva 1989). Russian scientist A. Shingarev was one of the first to investigate the population's health in rural regions using such variables as household, income, food variety, and mortality. He established a correlation between health and the social economic situation of peasants (Shingarev 1907). At the beginning of the twentieth century, the most significant medical–sociological research using a sampling method were carried out by N. Semashko. At the beginning of the 1920s most of the research shifted to social hygiene and medical demography. Between that time and the 1960s, the development of medical sociology in the USSR was restricted, because Stalin ordered the replacement of sociology by historic materialism. Sociology was proclaimed as a "bourgeois" science opposed to Marxist–Leninist theory; the word "sociology" was illegal, and all fundamental research was halted (Osipov et al. 1995).

In the 1960s, after Stalin's death, some initial attempts were taken to develop theoretical and applied sociology, and to distinguish medical sociology from social hygiene and medical demography (Chikin 1966; Izutkin 1967; Tzaregorodtzev 1968). One of the first definitions was provided by N. Dobronravov in 1970, who described medical sociology "as a integral part of the sociology studying the social problems correlated with health, illness, health care, and the role of health and working ability of the population in social development" (Dobronravov 1970). In a handbook on medical sociology, its main subject was defined as the study of the correlation between medicine as a social phenomenon with society and different social institutions (Izutkin et al. 1981). In the 1970s and 1980s, there were a number of works devoted to the methodology and techniques of sociological research in medical sociology (Bedniy 1979; Dmitriev 1983) and developing basic concepts (Ivanov and Lupandin 1984). It is worth mentioning that up until the present, quantitative methodology dominates the field and very few studies of health have been done using qualitative techniques.

Research in the Soviet Union and Post-Soviet Russia

Up to the 1990s there were few sociological studies of health representative of the entire Russian population, rather they were limited to different social and professional groups (Alexandrova 1984) or geographical regions. In the meantime, there were studies covering health issues conducted by Soviet demographers (Bedniy 1979) and social hygienists (Lisitzin 1998; Sadvokasova 1969). However, these studies were predominantly based on data from medical screenings, filled in by medical professionals instead of respondents. They focused on patients and ignored critical assessments of the health care system and the role of medicine in society.

Most of the research at that time was guided by Marxist–Leninist ideology. It was stated that "historic materialism as well as Marxist–Leninist philosophy gave an important perspective of great methodological importance for medicine and other sciences including medicine, biology and social sciences . . . The object of these sciences is health and the health care of communities in general with respect to social relations" (Izutkin et al. 1981). Theoretically, Soviet society was described as a classless society, without class oppression, private property, or health inequalities. Considerable attention has been paid to studies of the socialist system and small groups ("collectives"). In some sociological works, the authors pointed out that a good psychological climate within a group could raise work effectiveness and even compensate for negative factors influencing individual health (Alexandrov and Sluchevsky 1984). Research conducted in 1982–3 stated that a strong association was found "between the rise of individual weariness and a decrease of the 'collectivism' index in the observed groups" (Tolmachov and Karaga 1984). It is apparent that during the Soviet period the role of kinship, neighborhood, and community in health maintenance was overestimated and exaggerated.

Medical sociology was not institutionalized in the Soviet Union. There were no departments or chairs of medical sociology. This discipline was not taught to either sociologists or medical professionals. A few conferences on health were held in the Ukraine (1984), Novosibirsk (1986), and Lithuania (1987). The fact that those conferences were not held in Moscow demonstrates that health issues were not the focus of social scientists and not supported by the official ideology.

Sociological accounts of health issues were initiated in the 1980s. The value of health was studied in research about the lifestyle of Soviet citizens, while the Department of Social Issues of Health was organized in the Institute of Sociology of the Russian Academy of Science at the beginning of the 1980s. The Institute of Sociology participated in the projects "Health of the Population" (1985) and "Your Health" (1987, 1989). Comparative studies of Finns and Russians in 1991 examined attitudes about life expectancy, and individual estimates of health (Palosuo et al. 1998). MONICA research that was part of the WHO project on health examined the role of risk factors in mortality and morbidity (1985–6), while Shilova (1989) elaborated on the concept of self-protective behavior as a "system of actions and attitudes influencing health and individual life expectancy."

The theme of the Soviet citizens' health was covered in a case study of the Russian city Taganrog entitled "Taganrog." The panel research conducted by the Institute for Socio-Economic Problems of Population consisted of four stages. The first was conducted in 1968–9 with focus on the reaction of the Soviet people to Khrushchev's reforms. The second study was carried out in 1978–9 during Brezhnev's stagnation period and it was followed by "Taganrog-3" (1988–9) during Gorbachov's *perestroika*. "Taganrog-3.5" (1993–4) was aimed at studying the public's reaction to economic reforms. The most recent part of this study dates to 1998–9. As a whole, the research has revealed health deterioration over time, along with an intensive decrease of living standards. One researcher pointed out that the focus on the health decline of retired people has shifted to the poor health of children and youth

(Rimachevskaya 1998). "As a result the upcoming generation with poor health couldn't reproduce a healthy new generation . . . This might be explained by the drastic worsening of children's health, and particularly newborn's health" (Rimachevskaya 1997).

Sociological Accounts of Health Evaluation

Health as a Value and Real Behavior

At the beginning of the 1990s a number of research projects were begun by sociologists. Among them were studies of social adaptation by the handicapped (Ellansky and Peshkov 1995); families of children with chronic diseases (Silaste 1997; Smirnova 1997); doctors' research and their values (Lavrikova 1999), the transition of the health care system (Kucherenko 1995; Malachova 1995; Boikov 1999) and others. Some projects had a unique character, like one study of the health and living conditions of the population persecuted by Nazis during World War II in the former Soviet Union (Knazev 1996).

It is hard to find comprehensive research on health and health behavior in the former Soviet Union, because sociologists were limited by Marxist–Leninist theory that dominated Soviet society. In a representative research of Soviet citizens' lifestyle, a majority of the respondents (87%) put a priority on "health," choosing it from among 16 main values (such as talent, education, and money) important for the achievement of the success in life (Shilova 1989). There were, however, a number of inconsistencies between a person's declared value of health and actual behavior.

Evidence supporting this fact is seen in the data. For example, in Nizniy Novgorod, only 16 percent of the students took meals regularly (3 times per day). Most of them (40%) didn't seek physicians in case of illness. In Moscow, only 28 percent of respondents said they followed their physician's prescriptions. Others (24%) undergo their own medical treatment and continue to work in case of disease (28%) (Aktualnie medico-sozialnie aspecti propagandi zdorovogo obraza zhizni 1986). Research from 1987 in Kamchatskaya oblast has demonstrated that three-fourths of Russians recognized the importance of physical exercise for people of their age, but in fact less than 40 percent exercise. Half of the respondents realized the harm in smoking and drinking, but less than one-third stopped these behaviors (Adametz 1990). Visiting a general practitioner if required is one of the indicators of self-protective behavior. However, 60 percent of respondents see a general practitioner only if they need a document confirming their illness for their employer (Shilova 1999).

Since the introduction of the free market economy in Russia, attitudes toward work have changed. As a result of restricted work opportunities, people place a higher priority on work and less on health. Fewer people in all age groups have been to a hospital or stay home because of illness than in past years (Nazarova 1998). This situation may possibly be due to high competition in the labor market and fear of unemployment, even in the case of illness.

Health Evaluation

An important measure of health status is self-reported health. In research conducted in 1978 in seven cities of the former Soviet Union, the majority (66.7%) evaluated their health as "normal," 21.1 percent as "good," and 13.2 percent as "bad." For a decade this distribution did not change significantly, and in 1988 most Russians (59.6%) evaluated their health as "normal," 24.6 percent as "good," and 8.4 percent as "bad" (Kogan 1993). There were also observed geographical differences in attitudes toward health. Self-esteem and health were found to worsen from the west to the east, with the lowest self-esteem in the Permskaya region. "With equal proportions of 'normal' self-esteem (54–6%) in all three groups, the proportion of 'bad' increased from 13 to 17 percent, while 'good' decreased from 33 to 36 percent from Latvia to the Urals or from west to the east" (Kogan 1993).

Evaluations of health are also correlated with gender. In the former Soviet Union, men evaluated health more pessimistically than women: 30 percent of men think their health is "good" compared to 48 percent of women, and 10 percent evaluate their health as "bad" compared to 4 percent of women (Zhuravleva 1988). Women, however, have higher rates of morbidity and Bedniy (1984) accounts for this situation by pointing out that: "Women address a general practitioner more often than men because they take health more seriously and not because of their poor health. As a result women's illnesses are registered more often then men's."

Social changes that have occurred in Russia since *perestroika* (1985) likewise influenced health perception and health behavior. In 1991, one study found that most of the respondents evaluated their health as "normal" (68% of men and 60% of women), while others (14% of men, 7% of women) chose "very good" and "fairly good" to describe their health. Noticeably, the situation with women's evaluation of health has reversed. Thus one-third of women (34%) qualified their health as "bad" compared to 17 percent of men (Palosuo and Zhuravleva 1998). A negative perception of health among women has to do with unfair working opportunities for men and women in contemporary Russia. Women's choices are restricted and most of the unemployed are women. The proportion of women going to work with different illnesses has increased. In the meantime, fewer men in 1995 said they "frequently go to work in case of illness" compared to 1988 (Shilova 1999).

The monitoring of the Russian population from 1994 to 1996 demonstrated that men evaluated their health higher than women in all age categories: more men (37.6%) have "good" and "very good" health compared to women (25.4%). More women reported that they feel "bad" and "very bad" (18.8%) than did the men (13.8%) (Nazarova 1998). Russian adolescents have also shown low self-esteem about health. Most Russian young people (45.4%) aged 13–16 thought of their health as normal; 22.2 percent had problems with their health (choosing "very bad" and "satisfactory"), and only one-third of all respondents considered their health as "fairly good" and "very good" (Zhuravleva 1997).

Morbidity of the Russian Population

To describe the health situation accurately, it is necessary to correlate health perception with morbidity. Data confirmed the fact that Russians tend to think more optimistically about their health than in fact they feel. Among those who evaluated their health as "good rather then bad," 50.3 percent have chronic illnesses. Correlation between professional groups and morbidity in Russia has shown that highest morbidity registered among low-qualified workers (63.8%) and among directors of big enterprises (62.5%) (Adametz 1990). The most frequent morbidity factors experienced by Soviet people were colds (47.9%), chronic illness (38.6%), and accidents (13.4%) (Shilova 1989).

Health in post-Soviet Russia has deteriorated noticeably. A high proportion of people (77.8%) have health problems. More specifically, 15.4 percent have serious diseases, more than one-third have at least two diseases, and still others have more than two chronic illnesses (McKeehan et al. 1993). Russians see doctors most often in case of intestinal diseases (18% of men and 16% of women) and back injuries (14% of men and 18% of women). Women also tend to be concerned about abnormal blood pressure (27%) (Palosuo and Zhuravleva 1998). Poor health has been reported particularly in certain regions of Russia. In the Tumenskaya region, for instance, only 16.5 percent consider themselves healthy, and most citizens (83.5%) think that they have some disease (Gubin 1999).

Lifestyle Factors Influencing Health

Any sociological account of health requires an analysis of the factors influencing it. Research shows that self-protective health behavior and healthy lifestyles are not prevalent in the Russian population. Middle-age, working-class males, in particular show especially high levels of alcohol consumption, smoking, fatty diets, and little or no participation in leisure-time exercises (Cockerham 1999). Furthermore, social, economic, and political changes have imposed significant stress on the Russian population. Russians experienced more stress in 1991 than any year after *perestroika*, but later research shows an adjustment to the stress factor (Shilova 1999).

"Life conditions" are increasingly recognized as important for health since the early 1990s as noted by Palosuo and Zhuravleva (1998). In 1991, 45 percent of the respondents in a Moscow study considered their nourishment "fairly unhealthy" or "very unhealthy," and less than one-third could claim a healthy diet (Palosuo and Zhuravleva 1998). In fact, most people in the former Soviet Union (48.9%) could not participate in a healthy lifestyle for social and economic reasons and more than half of Russians could not take a rest after work since they have to work at more than one job to earn money (Adametz 1990).

In the period 1995–6 the proportion of Russians playing sports did not change and constituted only 8 percent of the population, mostly males (Nazarova 1998). This indicator will not increase in the near future because of the high costs of

sports facilities in Russia. Currently, only 15.4 percent of the population exercise at least three times a week and only 1.1 percent more then three times a week (Nazarova 1998). Smoking behavior is very stable among Russians as there were 44 percent of men smoking daily in Moscow in 1986 compared to 46 percent in 1991. Smoking in 1991 was considered a method of "coping with stress" for 61 percent of women smokers and 47 percent of the men (Palosuo and Zhuravleva 1998). However, in some parts of Russia, like Siberia, nearly 70 percent of the men have been found to smoke and in some industrial areas the figures may be even higher (Hurt 1995). Russian males also have the highest per capita rate of alcohol consumption in the world and excessive alcohol use is the singly most important determinant of the premature mortality among males (Shkolnikov and Nemtsov 1994). Russian men exercise more than women, but women show healthier overall lifestyle than men in that they drink and smoke much less, and eat more fruits and vegetables, while consuming less fat (Cockerham 1999).

Only the deterioration of their health causes Russians to consider their health behaviors. Most people say that they would start taking care of their health after its worsening (57.4%); special medical information (10.9%) or other peoples' behavior influences (15.2%) are not taken seriously as factors to incite change (Kogan 1993). Health perception is also influenced by the images of age that dominate in a society. Both Russian men and women correlate women's aging with biological age and men's aging with changes in their social and professional status and appearance. Women start feeling "old" earlier then men. Respondents marked the age of being "elderly" as 48.1 years for men and 43.3 years for women (Shilova 1989).

Individuals appear to largely rely on doctors and their own willingness to take prescription drugs for their health outcomes. Research in Rostov showed that almost all cancer patients (94%) expected favorable conditions after surgery and did not plan on doing anything themselves to promote their health. The patients were "alienated somatically and morally from the active treatment of their own health, relying purely on medical professionals" (Sidorenko and Maksimov 1988). A large proportion of people (38.6%) in the Tumenskaya region indicate that their health depends primarily on the health care system rather than themselves (Gubin 1999).

Consequently, we may state that Russian citizens' health has deteriorated over time, health esteem is declining, and the morbidity level is growing. This happened because self-protective behavior is not typical for Russians and health is considered to be a functional characteristic and not a value. Moreover, the main factor influencing health perception in Russia is its deterioration, which can be defined as the expected or real decline of health. Most people rely on external factors like state support and the provision of health and diagnostic services. Also, they consider deterioration of life conditions to be a key factor in health status and do not believe in individual abilities. The lack of self-protective culture in Russia is a result of Soviet times that neglected the individual, its life, and, consequently its health. Certain types of health care systems and a dominating model of doctor–patient relations have also contributed to the neglect of health.

Transition of the Health Care System

Health Care System in Russia

The history of the Russian health care system up to 1917 was ignored in Soviet textbooks, and its importance in the contemporary state of medicine was underestimated. The health care system introduced in 1864 by the Zemskaya reform made medical care available for rural areas that sometimes was free of charge and included a hospital for each administrative district (Lisitzin 1998). In 1910, for the first time in Russian history, a Ministry of Health was established. In the early 1900s Russia ranked fourth in Europe in the number of physicians. Russia had 13,475 physicians, compared to 22,105 in England, 16,270 in Germany, and 14,380 in France (Samoilov 1997). More than 7,000 students studied at the medical departments of nine Russian universities. St. Petersburg and Moscow established new refresher training institutes for doctors (Samoilov 1997).

After 1917, the Soviet government set up a new concept of health care guided by the Marxist–Leninist theory. Soviet medicine was based on the principal of universal, free access to all levels of care as a fundamental human right. It became possible within the new system to stop epidemics like the typhus epidemic of 1907–17. Also, from 1926 to 1927 life expectancy increased to 44 years (Lisitzin 1998) and in 1965 it increased to 64 years for males and 72.1 years for females (Shkolnikov 1995). A network of local "polyclinics" provided primary care. As of 1995, there were 38 physicians and 95 nurses per 10,000 people. At the current time these figures vary largely throughout Russia: from 67.7 per 10,000 physicians in Moscow to 20.8 per 10,000 in Ingushetia (Ministry of Health Care of the Russian Federation 1996). The former Soviet Union declared the importance of preventive medicine and health promotion. From the mid-1980s a costly campaign of annual mandatory population screening was introduced. In fact, this campaign is not really effective because of the medical bureaucracy, and a lack of motivation in general practitioners.

Since 1991 Russia has been undergoing a reform in the health care system. Currently, it is changing from being financed by the state budget to a system of combined finance from the state budget and insurance system. Health care in Russia consists of a state health care system, a municipal health care system, and a private system. The Russian constitution guarantees health care free of charge within the state and municipal health care system. But the most profitable services (such as dental, diagnostic, gynecological, and obstetric services) have shifted to the private sector and are not covered by the compulsory medical insurance provided by the state.

Private medicine was a new phenomenon for Russians who were used to the free health care system. At the very beginning of reforms, people were positive about private medicine. According to a 1991 telephone survey in Moscow, most of the respondents (83.6%) stated that they would be ready to pay for the right to choose a physician and clinic instead of going to the "polyclinic" to which they were assigned (McKeehan et al. 1993). Most of the clients at that time had

to give bribes in state clinics for better medical care or pay illegally for the medicine. Physicians sometimes asked for under-the-table money, gifts, or services from their patients in exchange for medical care. The dynamic over time has shown that attitudes toward the privatization of medicine and paid services have changed and Russian citizens tend to visit state clinics instead of private ones. The percentage of clients visiting private polyclinics was the following: 3 percent of patients (compared to 88.6% visiting a state polyclinic) in 1994; 2.7 percent (as to 88.5%) in 1995 and 2.9 percent (as to 88.5%) in 1996 (Nazarova 1998). The relatively small proportion of clients who went to private clinics is explained by the high cost charged for medical services compared to the average salary, not because the bureaucratic attitude of medical professionals changed over time.

Russian attitudes about the health care system are ambivalent. On one hand, they distrust it and on the other totally rely on it. At the beginning of the 1980s, 20 percent of the respondents preferred to stay at home rather than visiting a general practitioner; 6 percent waited until the disease ended on its own (Dmitriev 1983). In rural regions access to the health care system was more complicated compared to metropolitan areas. One-third of rural residents didn't see a physician because of difficulties in finding one near their residence. Other reasons that patients didn't see a general practitioner were because medical professionals were rude toward them (0.7%), lack of time (22%), fear of having to go to a hospital (9%), and distrust of the general practitioner (0.9%) (Usachev 1988). Most residents of small cities said that health care was bad (58%). About one-third were satisfied with it and only 1.8 percent of the respondents thought of it as "good" or "excellent" (Zibzev and Dolzhanskiy 1990). Because of the distrust about the quality of health services, Russians tend to see doctors only if they need to be registered as sick and stay at home. Most people visit medical professionals very rarely (62.7%) and one-fifth never go to the doctor if they catch a cold. With respect to chronic illnesses, one-fourth of the respondents still don't see a doctor (Adametz 1990). This distrust of the health care system was aroused by a medical bureaucracy that "judged a physician's work mainly by quantitative indicators of care (numbers of visits and procedures) while the quality was rarely considered" (Remennick and Shtarkshall 1997). Physicians and nurses had low salaries, so that their work motivation steadily diminished over time.

As a result of distrust of the official health care system, Russians establish informal contacts with general practitioners. Thus about half of surveyed people (46.9%) answered positively the question: "Do you have someone among your relatives and friends who work in the health care system, or do you have access to a health care system that helps to resolve your health problems?" Most of those aged 18–40 years who have informal contacts have a high level of education. This variable doesn't correlate with income, and this group consists of those who have an income higher then average as well as students and women having children up to 3 years who receive state welfare insufficient for food coverage (Rusinova and Brown 1997). Although most people distrust it, they also tend to rely on the state provision of health services. This mode of behavior is more typical for people over 40 years of age. Reliance on the health care

system and distrust in individual abilities might be explained in terms of strong state support of individuals' health and ideology that existed in Soviet times.

The transition of the health care system was followed by social inequalities in health (Field and Twigg 2000). Analysis of health distribution is one of the key aspects of medical sociology, but issues of social inequality in health were not studied by the social sciences in the former Soviet Union because of ideological reasons. According to Marx and Lenin, the existence of inequality in a capitalist society was a result of the relationships within the sphere of production where one class subordinated another class. After eliminating antagonism among the classes in 1917, the Soviet Union destroyed the conditions required for social inequality. As a result, health inequalities were ignored. Some differences in access to health were supposed to be eliminated over the time. For a long time Soviet society was described as a community with equal access of all the citizens to the health services. In the meantime the resources were distributed unevenly giving a priority to big cities versus small ones and rural regions. The general health network available for the majority of the population differs from the medical institutions serving certain professional groups, the Communist Party, and state functionaries. The system of elite clinics ignored such at-risk groups as children, adolescents, retired people, and invalids. Therefore, any research on differentiation and inequality in care were prohibited and prosecuted.

Sociological research carried out in the early 1990s demonstrated differences in health access among observed groups. Significant differences were found between the highly professional group ("stable intelligentsia") and the group of "less qualified" workers. Respondents from the first group are characterized by a low level of chronic illness and morbidity in general compared to the "less qualified" group in which 51 percent of respondents have "poor health," or at least one chronic illness and abnormal blood pressure. In the first group only 5.5 percent required external assistance because of their health compared to 33 percent in the latter group (Rusinova and Brown 1997). Health inequalities affect the elderly in particular. Most eyesight problems (77.6%) happen mostly to people aged 55 years and older. Many of these patients have only an average income and a high proportion (81.3%) have a below average income. This type of medical service is quite expensive (US $950) when compared to the average person's salary of $103.90 (in 1994), who is not covered by compulsory medical insurance. As a result, retired people often cannot afford to have eye care (Tankovsky and Shamshurina 1997). The issue of health inequalities is shifting into the focus of Russian sociologists.

Conclusion

In conclusion, medical sociology in Russia has faced an intriguing situation with health. One could observe unprecedented deterioration of health in an industrialized nation: a decline of life expectancy, a low birth rate, a revival of epidemics, an increase of the number of HIV-positive people, a high mortality rate among the working population, and a high proportion of people with chronic illness, which shifted to the younger groups in the population.

The theoretical foundation of medical sociology in Russia is fairly poor as a result of the previous dominance of Marxist–Leninist theory. Western theories, methodology, and techniques are not incorporated in the theoretical body. Russian sociology is positivistically oriented and its interpretive tradition is very weak. Therefore, quantitative methods dominate in medical sociology and very few qualitative techniques are being used in the field. Theories of interactionism, phenomenology, ethnomethodology approaches, and postmodernism are underrepresented in Russian medical sociology.

Since health research shifted in the early 1920s to social hygiene and medical demography, sociological indicators were replaced by environmental and ecological factors. Moreover, social hygiene as a part of medicine was focused on the patients, ignoring critical analysis of the health care system, doctor–patient relations, and interpretation of the role of medicine in the society. There were very few sociological studies of health since sociology was prohibited up to the 1960s. Health in Russia has been studied using the concept of health-protective behavior. However, in using this concept, researchers discovered that a health-protective mode is not typical for Russians and that their concern for health is usually stimulated only by its deterioration. This attitude might be considered a result of the neglect of the individual during Soviet times. Since Russian society has faced a market economy, the health care system has changed from state-provided health care to a combination of state and private provision. The introduction of private medicine caused significant inequalities in health care distribution in Russian society. All of these issues require sociological analysis and new research to explain the health of Russians.

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