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Regional Health Promotion: Health Care Development and Improvement of Health Care System

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Abstract
The article is devoted to current problems of public health care development and health promotion in the Russian Federation and the main trends of health policy. The role and the responsibility of the state and regional authority in the field of public health care are discussed; consideration is also given to public health priorities. Necessity of acceptance of the public health policy at the regional level to improve the efficiency of health care system, accessibility and quality of public medical care for the population is proved. The article presents a working model of health and discusses contemporary health approaches in health promotion.

Keywords: *development policy, health care, modernization, region, model of health, approaches in health promotion, mental health, social health, spiritual health, Health Resources.*

I. INTRODUCTION

Currently, health care in the Russian Federation is in crisis and requires modernization. Because the subjects of the Russian Federation were pretty much given free rein in decision making concerning health care development, issues of the development of the regional health care policy are real. Analysis of the current Russian situation in health care area has revealed that during the last 10 years governmental actions were mainly tactical, unsystematically and not strategic (Shilenko, 2012). This is due to the lack of effective scientific public health care policy, taking into account not only the negative impact of the external environment on health care, but also the structure and features of its internal capacity. The development of the regional health care policy is necessary because of the following reasons.

For the past 25 years, the health promotion field has been emphasizing the importance of public policy in effectively addressing the macro-level determinants of health. However, translating this need into action has proven challenging. This article aims to provide health promoters with a range of tools and experiences that will help them make inroads into the field of public policy in Russian Federation. These tools and experiences have not been selected randomly: rather, they are rooted in theories of the policy process. We argue that such theories represent very practical tools for understanding, appraising, and developing health promotion action on the determinants of health at the societal level.

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This article pursues two distinct goals. The first is to set the stage for the work presented in this research through a close examination of the nature of public policy and the policy process, and their implications for health promotion. We examine the unique characteristics of public policy and the policy process that explain why the health promotion community has been struggling with the call, from within its own ranks, for the development of policies that will support integrated efforts to achieve human health. We show how public policy processes are complex and iterative, and how they obey a rationality all their own, and hence require specific analyses.

The second goal is to underline their distinctive contributions to this field of knowledge and practice. The work serves to situate public policy within theories from the health promotion literature and to show how such theories are powerful allies in understanding not only whether public policies work, but mostly how they work, thus providing invaluable practical and critical knowledge to health promoters.

II. RESEARCH METHODS

Many scientific publications are devoted to studies of functioning and development of health care system. A number of researchers discussed issues of the health care system relationships and dynamics of socio-economic development of the state. In addition, a number of authors reveal in detail in their works the essence of governance mechanisms of health care administration, the priorities of the state policy in the field of health. In addition, such questions are being actively covered in the reports of the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD).

The evaluation designs of these exemplar projects attempted to emulate the gold standard experiment design as far as possible, but practical and financial limitations resulted in weak designs in practice. Comparing communities exposed to special interventions with communities not exposed to special interventions was a common feature, but there were very few communities enrolled, and there was no randomization.

These projects were not, in fact, experiments at all. They followed much more closely the model of quasiexperimental designs introduced by Campbell and Stanley (Bracht, 1999). But even as quasiexperimental designs, they were weak, lacking the multiple control groups needed to control for various biases introduced by sampling methods, lacking randomization, and displaying other design weaknesses. However, it was believed that strong effects of education programs could be obtained and detected even with relatively weak study designs. More to the point, strong experimental designs with many units of analysis, control groups, and random assignment were not affordable or practical (Kottke, 1995).These four projects, among the many conducted, are singled out here for close examination. That is because they have been held out by many workers in health promotion as exemplar projects, representing the highest state of the art of community-based disease prevention research. Their approach to study design, to community, to intervention, and to measurement has been widely emulated. Scientific reviewers, funding agencies, and journal editors have employed these four exemplar projects as yardsticks against which to measure the adequacy of other community-based disease prevention initiatives.

III. PUBLIC POLICY AND THE POLICY PROCESS BY HEALTH PROMOTION

Looking closely at the relationship between health promotion and public policy, we suggest that the reason public policies are elusive for health promotion is two-fold. On the one hand, the characteristics of public policies make it challenging to identify their contours, to keep track of their changes, and to isolate the different

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influences that shape them. On the other hand, health promotion is currently ill equipped to fully understand and work with these characteristics of public policy.

An abstract construct. The first defining feature of public policy that makes it hard for health promoters to grasp is that it is largely invisible. Let us be clear: it is not the abstract nature of public policies that makes them difficult for health promotion researchers and practitioners to identify. On the contrary, health promoters are generally quite skilled at dealing with the abstract, as they do when studying attitudes, beliefs, and social norms (e.g. Fishbein and Ajzen, 1975; Godin and Kok, 1996). Rather, health promotion tends to 'materialize' public policy, to conceive of it not as an abstraction but rather as a document that can be held, leafed through, and (ultimately) rewritten.

It is not uncommon for health promotion researchers and practitioners to consider a law or plan – namely the visible, concrete portion of public policy – and take it to be the only representation of the policy.

The three main elements are comprehensibility, manageability and meaningfulness.

Health and empowerment.

We will confine discussion to the relationship between empowerment and health. If we accept that having control is central to definitions of health, a number of alternatives follow. First, empowerment could be seen as synonymous with positive health in general. In other words, to be healthy one must be empowered. Alternatively, empowerment could be seen as instrumental - that is, as a means to achieving (positive) health. A third conceptualization is also possible. Empowerment could be viewed as both a terminal and an instrumental value. The standpoint here is that empowerment will necessarily be a key component of positive health as an end. At the same time, it will be a means, if not the most important means, of achieving disease prevention and management goals, which are components of holistic interpretations of health.

The Commission on Social Determinants of Health (2007) emphasizes the importance of empowerment as a means of achieving health equity. It identifies three key dimensions of empowerment - material, psycho-social and political - and focuses attention on the structural factors necessary for empowerment. It notes particularly the disadvantaged position of women.

We might make two further observations on empowerment in the context of salutogenesis. First, two of the three key requisites of a sense of coherence - notably comprehensibility and manageability - are concerned with beliefs about control and these figure prominently in conceptualizations of empowerment. Secondly, there is potential conflict between empowerment and the sense of meaningfulness, which is the third element of a sense of coherence. In short, while the feeling that "all is for the best in the best of all possible worlds' will doubtless make people feel better, and that life, from a salutogenic perspective, is more meaningful, it may well be delusory and hence disempowering.

IV. HEALTH: A WORKING MODEL

As may be seen from Figure 4.1, for all practical purposes, health is defined as having both positive and negative aspects. The term 'wellbeing' is used as shorthand for the positive dimension. Rather than seeing wellbeing and disease as opposite ends of a single spectrum, they are represented as coexisting. Furthermore, although each may influence the other, they can vary independently. For example, although wellbeing may be affected by the presence of negative disease states, it is possible, even desirable, to have high levels of wellbeing regardless of disease being present. Conversely,

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there may be high or low states of wellbeing in the absence of disease. We are quite clear that preventing and managing disease and disability is a laudable goal in its own right and a central concern of those who are professionally involved in healthcare and health promotion. On the other hand, it is equally clear that the more positive dimensions must also figure prominently in the formulation of a satisfactory definition of health. In the first place, those involved in public health and health promotion cannot ignore its importance. In addition, those measures that result in the achievement of positive goals are frequently more effective in achieving preventive outcomes than the more limited tactics employed by espousing a narrow disease prevention model.

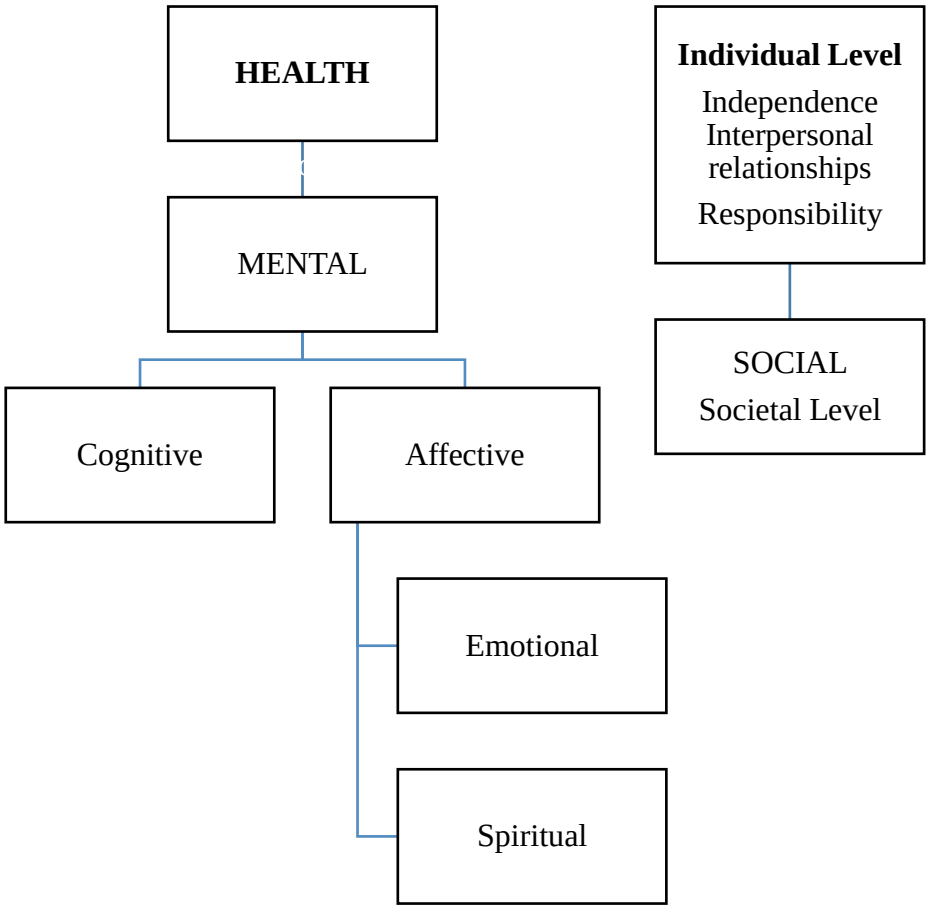

Figure 4.1 A working model of health

The three components that make up WHO's holistic conception of health are featured in the model. Following self-actualization principles, it is tempting to argue that maximal health status involves 'being all that you can be'. Healthy individuals would thus be those who had fulfilled their mental, physical and social potential. As we have argued, the attainment of complete mental, physical and social health is logically and practically impossible. Furthermore, it would be feasible to achieve high levels of potential in relation to one component of health at the expense of others. For example, the degree of commitment required to achieve maximal physical fitness might not only militate against social health and, possibly, be inconsistent with cultural norms, it might also be viewed as evidence of obsessional neurosis! Equally, a lifestyle characterized by sloth and self-abuse might lead to considerable happiness and a very successful social life, but result in an early death.

Accordingly, health must involve some kind of balance between mental, physical and

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social components. How, though, is such a balance to be determined? Do individuals themselves make the decision or should society decide for them? As the second option is inconsistent with the principles of empowerment (which are intrinsically healthy), only the first option is a serious contender. We will, first, emphasize the importance of healthy individuals being guided by commitment to a considerate way of life. Thus, individuals should be in a sufficiently empowered position to enable them to choose a course of action, provided only that the rights of other people are not damaged and, ideally, take action to support those who may be disadvantaged.

Mental, social and spiritual health.

The definition of physical health is comparatively straightforward. On the one hand, it is associated with minimizing disease and disability; on the other hand, it may involve having a sufficient level of fitness necessary for achieving other (more important) life goals or/and the experience of high-level wellness or, more realistically, the feelings of wellbeing (allegedly) associated with a high degree of physical fitness. Wellbeing may thus be associated with fitness, but is by no means an identical dimension of health. A person might, for example, exhibit high levels of fitness, but limited feelings of wellbeing or, alternatively, high levels of wellbeing but minimal fitness!

Defining mental health is rather more complicated and problematic. We will confine current discussion to making just two observations. First, it is useful to consider mental health as having both cognitive and affective dimensions. The affective dimension includes emotions and feelings and most discourse on mental health centers on this aspect. The cognitive dimension rarely features in definitions of mental health, but might be incorporated in a holistic model. 'Being all you can be' in cognitive terms refers to the extent to which individuals fulfil their intellectual potential. The reasons for failure to fulfil intellectual potential have been a source of considerable study and evidence of inequity in this regard has provoked concern. It is thus intimately associated with broad-based health promotion initiatives designed to address general social inequalities and break cycles of deprivation, as exemplified by SureStart, the UK Government program designed to deliver the best start in life for every child' (SureStart, 2005). Second, many people have asserted that any serious consideration of positive health must include the spiritual dimension. This is itself open to several interpretations, but features in Figure 1 in the context of mental health and wellbeing. It has both a cognitive element, consisting of the doctrinal aspects of, for instance, a religious system, and the emotional commitment associated, in this case, with the value system central to the notion of faith - that has been referred to as'... an illogical belief in the occurrence of the improbable' (an observation attributed to the American journalist H.L. Mencken). Notwithstanding such scepticism, faith can be integral to meaningfulness and the sense of coherence which is central to salutogenesis. Furthermore, religious values can underpin personal health choices and a sense of responsibility towards upholding the rights of others to health.

Currently, health care in the Russian Federation is in crisis. The main problems of its development, in our opinion, are the following:

1. Lack of financial resources in the health care system, which in turn, generates a number of negative consequences: the low salaries of medical personnel, problems of providing the population with free medicines, absence of the possibility of compliance with treatment standards and providing hospitals with modern equipment and consumables (WHO, 2011, Voncina, 2007). Thus, in the Russian Federation in 2012, public expenditures on health care (including expenses on the program of state guarantees, education,

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investment in infrastructure and sanitary-epidemiological safety) were $48,9 billion dollars, or about 4% of GDP, that is at least two times lower than the average in the EU countries and the USA (Gusmano,2014, Mackenbach, 2013, Vertakova,Vlasova, 2013)

2. Deficit and suboptimal quality of medical personnel. A shortage of medical personnel, first of all, is associated with low payment for their work, it is 22% lower than the average salary in the Russian Federation and almost 10 times lower than in developed countries (OECD, 2009, Ettelt, 2012, Ifanti, 2013). While, for example, in Europe the profession of doctor is one of the highly paid professions (doctor's income is from 1,5 to 2,5 times more than the average salary in the country).

3. Poor qualifications of medical personnel and, as a consequence, the low quality of medical care. For example, the survival rate of breast cancer patients, the ratio of intra-hospital mortality, the proportion of patients who had infectious complications in hospitals in the Russian Federation in 2 times above, than on the average in developed countries (Okma, 2013, Vlasova, 2013).

4. The backlog of standards of medical care on the Program of state guaranteed benefit package (SGBP) free medical care to the real needs of the population of the Russian Federation. For example, from 1999 to 2010, standards of medical care for the SGBP haven't been changed, and some types of medical services even have been declined, however, the incidence of the population (which identifies the need for medical care) in the period from 1990 to 2010 has increased by 1,5 times(Vertakova, Vlasova, 2013). Our population is also insufficiently provided with free medicines on a doctor's prescription in polyclinics. So, in the Russian Federation in 2010 expenditure per capita on drugs from public sources were 5.6 times lower than in the countries of Europe, considering that drug prices are almost the same(Mackenbach, 2013, Mur-Veeman,2008).

5. Very low volumes of high technology medical aid. For example, the number of heart revascularizing surgeries (i.e. restoration of patency of the heart vessels), which constitute 25% in the volumes of quotas on hi-tech medical aid in the Russian Federation is done 5 times less than in EU countries, average procedures of hemodialysis - 4 times less, the number of operations of knee and hip joints – 6,5 times less (Ifanti,2013, Kringos, 2013, WHO, 2009).

6. Ineffective management of the health care system at all levels. For example, in the Russian Federation there is no strategic planning and responsibility of managers of all levels for the achievement of results (including annual reports) on indicators accepted in developed countries, e.g. on indicators of quality and safety of the medical aid, economic effectiveness. Ineffective management is manifested in the irrational allocation of public funds. So, the focus of government programs is on poorly controlled, having a high risk of corruption payments investment costs (construction and purchase of expensive equipment) instead of development of preventive ways and human resource capacity. Inefficient use of equipment and hospital beds also takes place. Cost-effective management tools, such as competition on the criterion of quality in the purchase of medical assistance for health care providers, ranking of medical institutions, the application of economic incentives for achievement of planned results are insufficiently used (Cabiedes, 2001, Groenewegen, 2013).

7. The demographic problem is still urgent due to the projected reduction in the number of women of active reproductive age and growth of the elderly population. Many specialists in the field of health care believe that large budget funds are spent inefficiently: over the past 50 years, life expectancy in the world increased by 11 years, and in India -21 years. In Russia it has remained

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the same, although its catastrophic decline of the past decades has been overcome. But tasks set to the socio-economic system do not always accurately reflect the real needs of society (WHO, 2011, White, 2013).

V. CONTEMPORARY HEALTH APPROACHES IN HEALTH PROMOTION

There are at least five established approaches to health promotion that are discussed in the literature: the medical approach; the behavioral approach; the educational approach; the client centered approach; and the socio-environmental approach. These are discussed elsewhere and here I focus on three of the main contemporary approaches in health promotion - the medical, the behavioral and the socio-environmental - as being especially relevant to shaping the way in which we design, implement and evaluate programs. For example, the medical approach views health as an absence of disease or disease-producing physiological conditions. The behavioral approach views health in terms of the behavior and lifestyle of individuals, and the socio-environmental approach views health as being influenced by social and environmental conditions. These differing views largely determine the strategies program planners select, and the outcomes or criteria they use to evaluate success. The development of these approaches in recent decades has resulted not only from the changes in our scientific understanding of health determinants and risk factors, but also from a growing pressure from individuals, groups and social movements concerned with the health impacts of social and environmental conditions.

The medical approach.

Despite the evolution of competing health approaches, it is the medical approach that remains dominant, socially and within health bureaucracies.

This approach evolved as a result of scientific discoveries and technological advances in the eighteenth and nineteenth centuries and a greater understanding of the structure and functioning of the human body. As knowledge and understanding increased, the body became viewed as a machine that needed to be fixed. A professional split between the body and mind developed; the body and its physical illness was the responsibility of physicians, while psychologists and psychiatrists looked after the condition of the psyche. The focus remained on the external causes of ill health and was reinforced by the constant threat of disease and death, particularly to children, from epidemics such as polio and scarlet fever. The medical profession established itself in the dominant position, and many other health professions modelled themselves on the medical approach to gain legitimacy. These include the fields of nursing, physiotherapy and, until recently, health promotion (Baum, 2015).

The medical approach is primarily concerned with the absence of disease and the treatment of illness. More recently it has become concerned with disease prevention amongst high-risk individuals, those persons whose genetic predisposition, behaviour or family and personal history place them at statistically greater risk of disease. The medical approach historically has assumed that elite 'experts' know best. Disease prevention programmes in the medical approach are usually delivered in a top-down approach based upon the experts' knowledge. However, a growing body of new knowledge and pressure from social movements challenged the dominance of the medical approach. By the 1970s this had led to a broadening of health knowledge to include a variety of behavioral, lifestyle and social factors.

The behavioral and lifestyle approach.

Lifestyle and behaviors became increasingly central to health promotion in the 1970s. During this period, health promoters (though many still called themselves health educators) recognized that individuals' behaviors

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and lifestyle could directly influence their own health and the health of others. Examples of programs from this era include school education, public education and social marketing campaigns around smoking, alcohol abuse, eating high-fat foods, not wearing a seat belt and physical inactivity. The predominant approach to address these issues was education and awareness campaigns to inform individuals about their high-risk behaviors.

Given the complex social and cultural circumstances associated with lifestyle, it is not surprising that many practitioners and researchers found that health education campaigns alone did not succeed very much in changing behavior.

Social health: individual and society.

The social dimension of health is equally complex. As can be seen from Figure 4.1, there are two categories. The first of these refers to the social health of the individual; the second is concerned with the health of society itself. Three main aspects of individual social health have been identified.

Independence: a socially mature individual acts with greater independence and autonomy than a relatively immature individual.

Interpersonal relationships: a socially healthy individual is characterized by the capacity to relate to a number of significant others and cooperate with them.

Responsibility: a person who is socially mature accepts responsibility for others.

The distinction between the social health of individuals and the health of society is recognized in everyday parlance with references to 'sick societies' and 'social malaise'.

VI. STRATEGIES TO ELIMINATE HEALTH DISPARITIES AMONG MINORITIES

Improve Cross-Cultural Staff Training. Studies have noted that minorities generally receive lower-quality health care than non-minorities; however, researchers haw also found a major difference in where minorities seek health care. Arthur Kleinman, a Harvard psychiatrist and anthropologist, has said that every encounter between a health care provider and a client is a cross-cultural experience (National Alliance for Hispanic Health, 2001). This cross-cultural situation is particularly salient when the interaction is between minority and non-minority individuals or when older adults, people who are poor, or people for whom English is a second language are involved. These categories of individuals often have low health literacy skills. Those with low health literacy skills have difficulty understanding health care directions, completing complex health forms that provide the basis for treatment, sharing their medical history with physicians, and even locating providers and services.

Culture can be thought of as a shared worldview. Culture is the ways in which a group of people organize their beliefs and make sense of life. Culture can be the glue that holds a community or group together. Cultural variations reflect what people bold to be worthwhile and help to determine what is believed about what is worth knowing and doing. There is wide variability between cultures, and there is diversity within cultures, being a member of a culture means that you are in unity with your community, but you also have individual characteristics, tastes, experiences, and desires. Generalizing about persons within a culture is not useful. In any one culture, for instance, there are age differences, race differences, differences in sexual orientation, gender differences, religious differences, class differences, and educational differences. In

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addition, most persons inhabit several cultures simultaneously, existing within layers and collections of cultural identities. Sometimes those different cultural identities clash or conflict with each other. Mistakes to avoid in thinking about culture include having a deficit perspective (that is, thinking less of a person's abilities for no reason), stereotyping, victim blaming, and confusing culture with other concepts. The concept of culture is sometimes confused with concepts of race, color, or ethnicity. Culture is a much broader concept, encompassing all of the aspects and skin color can vary greatly within cultural groups.

The Health Resources and Services Administration has defined cultural competence as a set of behaviors, attitudes, and policies that come together in an institution or agency or among a group of individuals and allow people to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates the dynamics of culture, an analysis of potential cross-cultural misunderstanding, a focus on interactions that can result from cultural differences and ethnocentric approaches.

VII. CONCLUSION

Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.

As a core function of public health, health promotion supports governments, communities and individuals to cope with and address health challenges. This is accomplished by building healthy public policies, creating supportive environments, and strengthening community action and personal skills.

Here we are faced with the current unsolved problems of health care system in Russia. Nowadays, the Government of the Russian Federation sets the goal to improve the socio-economic policy of the health care system development in regions. All regions differ by their socio-economic development, demographic parameters. Thus, there is a need to develop a socio-economic policy for every region separately. The policy should take into account the interests of the population of a particular region, weakness and strength of its internal potential. The main goal of the policy must be improving the level of health and well-being of the population of the region and the country as a whole.

Health promotion programs, broadly defined, can produce a variety of effects, including disease prevention, increases in health awareness, risk reduction, and reduction in demand for marginal health services. The most immediate impact should be seen on morbidity and disability from common problems such as respiratory and musculoskeletal conditions, and reduction in demand for medically marginal or unnecessary services.

Because they address interrelated risks as well as health service use, integrated programs should have the greatest cost-benefit impact. They may include treatment and counseling at teachable moments. They may address risks in the population, not just those individuals seeking care. They also demonstrate and generate organizational support for healthier practices. The most effective programs include organizational commitments, such as policy changes, on-site facilities, benefits changes, and support from senior management. Follow-up and reinforcement are critical for sustained improvement.

Programs that target higher risk individuals appear to increase their cost-effectiveness, as they logically should. The "dose" of intervention should be graded as risk increases, again a logical approach to changing entrenched behaviors. In studying the results of such programs, one would want to stratify the risk-

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benefit calculations by risk level to more clearly define the relationship between inputs and outputs.

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