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Experiences and Expectations of Russian Immigrants of the Finnish Healthcare services

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Description

With the growth of the Russian speaking diaspora in Finland there is a need to investigate their health care related needs together with experiences and expectations of the Finnish health care services. The aim of the thesis is to identify the experiences of Russian immigrants of Finnish health care services. The purpose of the thesis is to provide information on the specific needs of the clients to improve the healthcare services. The research question of this study is "What are the experiences of Russian immigrants of the Finnish health care services?"

The theoretical basis includes evidence-based theories on cultural diversity concerning health and illness as well as investigations of healthcare habits and attitudes of Russian immigrants in Russia, Finland and other countries towards the represented health care services.

Semi-structured interviews were conducted with three interviewees recruited through snow-ball sampling. The recorded data was transcribed and analyzed by means of thematic analysis.

Through studying this topic and the data we developed an understanding of different perspectives of barriers in accessibility to health care services in Finland.

In future when caring for representatives of this diaspora the staff is better equipped in identifying and addressing possible challenges and obstacles of this customer category when it comes to their access to health care services in Finland. The customers can be educated in better understanding the approaches to care in Finland.

Keywords (subjects)
Russian immigrants, health care services, Finland, experiences, multicultural health care, health care accesibility,

Miscellanous

Table of Contents

1. Introduction

The health and health equity of a nation is subject to influence by every aspect of government and the economy (WHO, 2008). Investigating people's experiences and perspectives on health care allows to identify the needs of a community as well as evaluate the development of health care (WHO, 2016). Engaging with health care users in discourse about their attitudes and habits promotes community empowerment (WHO, 2009). Sociological research demonstrates the importance of understanding health as a complex multidimensional social phenomenon. Lay understanding of the health-related concepts affects the way in which experiences of health and illness are interpreted along with the kind of actions taken towards health promotion. Two areas of knowledge investigated by sociologists include patients' definitions of health and illness and their views on factors that influence them, which, consequently, lead to possible health inequalities (Abbott, Turmov, Wallace, 2006). The number of Russian-speaking residents in Finland has been growing over the course of the past decades. In 2012 this number reached 70,899 (Tilastokeskus, 2012). There seems to be a low number of studies on Russian immigrants in Finland and their attitudes towards the services provided by Finnish Health care services. The primary goal of this work would be to initiate an inquiry about the experiences of Russian-speaking immigrants of Finnish health care services.

2. Health care, Culture, Immigration, and Ethnicity

2.1 Culture and Health

Culture can be defined as an "integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" (Cross et al. 1989, iv). The definition of health is culturally bound and may impact health practices and compliance to medical treatment (Benisovich, King, 2003). Rajaram and Rashid (1998), who studied minority women in critical health conditions (breast cancer), introduced cultural explanatory models (CEMs) as a theoretical framework that allows the understanding of health-related behavior by considering sociocultural context, medical knowledge and attitudes towards health (Rajaram and Rashid, 1998). CEMs encompass both personal and social aspects, such as ethnicity, acculturation and socioeconomic status that influence personal definition of health and individual behavioral patterns.

The important role of culture in healthcare is amplified for those patients who represent an ethnic minority and are offered health care services from medical institutions organized and staffed by representatives of the ethnic majority (Brach, 2000). Acknowledging the patient's individual cultural explanatory models improves the relationship between the provider and the patient (Rajaram, Rashid, 1998, 760). A lack of proper insight into the effects of culture can result in deficient knowledge about the prevalence of health-related risk factors or conditions inherent to ethnic minority groups including the use of traditional remedies. Examples of negative consequences present themselves as absence of proper health promotive measures together with harmful medicine and substance interactions, miscommunications which may lead to diagnostic errors and lack of trust (Brach, 2000). Impersonal, complex or intimidating

health care approaches as perceived by clients are likely to impair the recipient's motivation to collaborate with the health care providers (Rajaram and Rashid, 1998, 760-761). However, ethnicity should not be seen as a direct cause of health inequality, but rather as a factor of interest. The socioeconomic status, on the other hand, has been shown to play an important role in the fight for universally equal access to healthcare (Rajaram and Rashid, 1998; Wilkinson, Marmot, 2003; Greve, 2016).

Chief health care problems such as patient disappointment, irregularities and inequality in accessibility to welfare in addition to escalating costs will become unavailable to conventional biomedical solutions (Kleinman, 1978). To tackle the problems of ethnic inequality a new field of "cultural competence" has been found (Betancourt et al., 2003). Cross et al. (1989) defines "cultural competence" as a framework of attitudes, behaviors and policies in an institution that are implemented for effectiveness in cross-cultural situations. In the context of health care this concept is not limited to knowledge of and respect to different cultural perspectives, it also aims at the effective use of different skills to enhance a productive relationship between healthcare seekers and providers (Cross et al, 1989, Anderson et al., 2010). The movement towards cultural competency in health care should be supported by policy making. (Betancourt et al. 2003). However, the idea of a culturally competent healthcare services that meet the needs of a growing group of diverse parties presents a considerable problem (Cross et al. 1989).

Linguistic skills are also included in the context of cultural competency, mostly because it is grounded in theories that both language and culture play a role in beliefs, and behavioral patterns concerning health (Kleinman, Eisen-

berg, Good, 1978, Betancourt et al. 2003). In immigration contexts, this engenders problems in communication. Patient-doctor communications involve exchanges of explanatory models, which may entail disagreements in understanding therapeutic values, expectations, and goals. This results in mistrust towards the healthcare provider, poor adherence to care and preventive measures along with poor health outcomes (Kleinman et al. 1978, Betancourt et al. 2003). When analyzing language specific terms, it is possible to investigate reasons behind the cultural understanding of a concept. In English, the description of health can be done with many different words, such as "good-looking", "fit", "well". On the other hand, in Russian one word "zdorovyi" may stand for all previously mentioned adjectives. The small distinctions between the English words "sickness", "illness" and "disease" are not found in Russian (Manning, Tikhonova, 2009), which might have an impact on health and illness definitions.

Investigating immigrant attitudes toward healthcare in host countries requires a brief outline of heath care system's characteristics and description of accompanying social services and welfare organization. The Nordic countries' welfare system are known for effectively providing welfare benefits and services as well as advancing health promotion. Among others, Finland provides universal access to its healthcare system to native residents and immigrants with residence permits. However, research shows that there are some aspects, such as low income, insufficient education and lack of knowledge of the healthcare system, which lead to unequal outcomes in healthcare-related situations between immigrants and native residents. The consequences of health inequality include issues such as life expectancy, admission to hospitals and ability to receive efficient treatment. Immigrants reportedly rarely resort to self-management and disease prevention measures and tend to visit general practitioners more frequently than native residents. When it comes to financial issues, the

data shows that immigrants have a higher risk of living in poverty. In Finland, the risk of living in poverty among immigrants is 2,6 higher than for the native population. High medical care fees, high medication prices and lack of trust towards health care professionals in Finland have revealed lower numbers in healthcare institution visits and lower medicine consumption among immigrants (Greve, 2016).

2.2 Healthcare in Post-soviet Russia

Healthcare in post-soviet Russia places great focus and resources on curative care rather than primary health and preventative services. The steep development of the Russian health crisis brought upon an increase of both non-communicable and infectious diseases which most affected working-age men. In 1965 life expectancy in Russia was at the same level as in Finland and the whole of Europe. After the 60's life expectancy began to fall. Increased mortality rates in the years after the collapse of the Soviet Union are attributed to an increase in cardiovascular diseases and violent deaths which affected mostly the strata of less educated citizens (Marmot, 2006; Manning, Tikhonova, 2009). The link between the economic crisis accompanying the fall of the Soviet Union and the poor public health statistics cannot be directly drawn as the already existing health system, public health policies and prior health related behavioral patterns had long before established the unhealthy trend and growing inequalities in service provision (Manning, Tikhonova, 2009).

In 2005, the health care spending in Russia amounted to a little below 5 per cent of GDP (Manning, Tikhonova, 2009) while the GDP percentage allocated to healthcare in Finland in the same year reached 8% (Matveinen, Knape,

2016). Pharmaceuticals in Russia receive 30% of household spending against an average of 12% in OECD countries. However, because of the high prices on medicine it has been estimated that a significant part of the demand for this product in Russia is unmet (Tompson, 2007).

According to Manning and Tikhonova (2009), a broader understanding of health is evolving in among Russia's population as the importance of psychological and social factors grows closer to that of the physiological ones. Deteriorating of one's own health or the one of close relations is the greatest fear of 71% of Russia's population. As far as emergency help is concerned, one in every three person stated their concern that receiving medical care can be impossible even in severe cases. Financially challenged respondents share this fear more often than those who are more financially stable (Manning and Tikhonova, 2009).

The standard of living after the collapse of the Soviet Union has gone through a drastic fall which revealed itself as an important factor of reference in evaluating health of working-age males. The three major strategies stated by respondents as imperative for enhancing one's quality of life are: being engaged in successful employment, acquiring a variety in sources of income and maintaining strong social connections. The two former resources greatly affect the social status, class membership and the potential for a more powerful social network. Class membership backed up with material resources dictates the norms and behavioral patterns, including those related to health. However, some health-related views were universal throughout different classes. These included the improperness of being overly concerned about one's health and a tendency of enduring health related problems while working and going about

their daily routines rather than seeking medical help (Manning and Tikhonova, 2009).

The role of social networks in everyday lives of Russians is of great importance, for it reflects replication of inequality within society and appears to be the main stratifying factor. The informal nature of these social relationships fortifies display of distrust towards formal state institutions. The social resources represent a safety net, which, if needed, offers various kinds of support in different life situations. In cases when social resources are limited or exhausted, especially when the household belongs to a financially unstable stratum, the opportunities of solving problems and reintegrating are restricted. The dependence on the quality of one's social resources is linked to the amount of support a person gets when facing health-related problems (Manning and Tikhonova, 2009).

An in-depth study by Abbot, Turmov and Wallace (2006) of health world views of post-Soviet citizens showed that their understanding of health and illness is multifactorial. The most frequently stated definition of health was linked to the absence of an illness. However, health was still seen as something much more complex than just the presence or absence of an ailment. The respondents of Abbot, Turmov and Wallace's research put an emphasis on their feeling of responsibility for their well-being. However, the cause for taking responsibility varied between respondents. Some believed that responsibility for their health lies with the individual because the health care system's inability to provide required services. Others believed that attending to health is a primary duty of every person. A portion of respondents doubted their own ability to manage their health. On the other hand, they strongly believed that there are factors affecting health which are beyond their control, such as

sanitary conditions, heredity, work environment, as well as financial resources. Another issue raised by the respondents was the level of stress and its effect on health. According to their reports, unhealthy choices were caused by the high level of stress in conditions of financial instability and socio-political unpredictability (Abbott, Turmov, Wallace, 2006). The findings of this research aided in supporting health lifestyle theory that offers a sociological understanding of the poor health statistics in the former Soviet Union. The health lifestyle theory proposed by Cockerham (2002) states that health practices are culturally rooted actions built by socialization and experience supported by material circumstances (Cockerham, 2002). The main factors influencing poor health outcomes are structural factors together with culturally and socially bound habits such as drinking, smoking, poor diet and lack recreational exercise together with a passive orientation to health manifested in the idea that the responsibility lies more on the health care system, rather than the individual. The resulting poor health choices are made in a context where there are limited options (Cockerham, 2002).

The findings in Abbott, Turmov and Wallace's (2006) research also showed a high rate of respondents reporting poor economic conditions in the country. The economic situation was often linked to the lack of proper financial support towards health care, as a number of the respondents reported not being able to afford a visit to a doctor or purchase of needed medication. The majority of respondents mentioned fatigue and stress due to their employment conditions in addition to household chores in which they are forced to endure health problems in order to achieve financial stability and a satisfying standard of living. Respondents shared detailed and complex definitions of health and illness, which also included references to a person's mood, behavior, and appearance. When asked about methods of health problems management respondents shared three ways: the "appropriate" use of health services, self-

management, engaging in a healthy lifestyle. Views on what is considered a healthy lifestyle varied as many claimed to lead healthy lifestyles, however, based on their narrative the opposite could be said. The importance of a healthy diet filled of protein and fresh produce was mentioned. On the other hand according to the respondents' accounts of their eating habit meals with carbohydrates and fats dominated. Sufficient rest and relaxation including an annual holiday at a resort were also considered health enhancing practices. The amount of physical activity necessary was also discussed as opinions differed. Many mentioned going to gyms and taking part in organized sport, while others stated that daily activities provide a sufficient amount of exercise. Bad habits such as cigarette smoking and alcohol consumptions was seen as normal behavior, especially for men. Not all respondents shared the same level of concern of how these habits affect health. Long term smokers despite understanding the health-related risks and consequences did not wish to quit. Drinking was seen as a social activity and a tradition, especially on important life occasions (Abbott, Turmov, Wallace, 2006).

Research aimed at investigating the health care user's perspective on post-Soviet medical care system in 1992 and 1994 carried out by Brown and Rusinova (1997) showed dissatisfaction about the state of the polyclinics and hospitals, especially the limited availability of modern medical equipment and medications. The quality of medical staff, particularly physicians in policlinics, was also a subject of common disapproval and much needed improvement. The link between the socioeconomic status of the respondents and the level of apprehension was mentioned in this work, as members of the intelligentsia were more concerned about the physicians' qualifications while representatives of the unskilled group talked about the expansion of home care and the setting at policlinics as a main focus for future change. Socioeconomic status also

played a role in medical utilization patterns. The lower status individuals reported that their principal criteria in choosing primary medical care are practical: convenience, cost, and habit. The higher status individuals by contrast, were more likely to indicate that they make choices based on the reputations of specific physicians and medical institutions. The high status individuals also indicated that they used their social network and connections to certain people who work in the medical care system and are in a position to assist them with their health-related problems. People utilize this informal medical marketplace in order to receive direct physician services: medical consultations and medical procedures. They also rely on friends and relatives to help them identify and gain access to highly qualified medical personnel, medical equipment as well as highly esteemed medical institutions (Brown, Rusinova, 1997).

2.3 Russian Immigrants as health care seekers

Most of the research examining the diaspora of Russian-speaking immigrants has been undertaken in the U.S.A. Previous findings include patterns of utilization of healthcare services, attitudes towards health and illness and areas of concern. A number of studies emphasize the lack of preventive screening behavioral patterns among Russian immigrants. According to Ivanov and Buck (2002, 18), Duncan and Simmons (1996) stated that the Soviet system health care nurtured dependency of patients on their physicians. This approach undermines the autonomy of the Russian-speaking immigrants in the U.S. to make responsible decisions about self-managing their life in a healthier manner (Ivanov, Buck, 2002, 18). Duncan and Simmons further argue that in accordance with the system in their home country, the immigrants continue to

expect the health care providers "to make them feel better without their input" (ibid, 18).

Previous studies on Russian immigrants (Benisovich, King, 2003; Aroian, Vander, 2007) outline cause and effect of general problems Russian immigrants experience in host countries. Definition of health as the absence of diseases leads to an extreme demand to personal health condition on top of a general distrust towards media as a source of information about health is part of feeling isolated from the current health system, the experience of stress and helplessness due to language barriers and the need to adapt to a new healthcare system complicate immigrants' 'pursue of happiness' in their host countries.

According to statistics, in Finland, in 2012 there were 70,899 Russian-speaking residents, which represents about 1.3 % of the general population of Finland (Tilastokeskus, 2012). The pattern of usage of Finnish healthcare services by Russian immigrants has been studied by Koponen et al. (2012). Despite the fact that according to the Finnish law, all patients have right to culturally aware and competent care, findings include reports of a more critical assessment of Finnish health care by Russian immigrants, especially on information provided by doctors about their treatment plans and treatment prospects. Furthermore those patients who did not think they received appropriate care complained about problems with reaching health care location, excessively high service fees, ineffectiveness of treatment, language barriers and lack of information about their access to health care in Finland. 17% of Russian immigrants reported not getting much wanted follow-up treatment. Indications of distrust towards Finnish policlinic doctors were revealed as respondents had expressed their complete disagreement with doctors' recommendations. The

authors argue that the experiences of health care services shared by immigrants and the level of satisfaction are linked to culture and also to how often the service offered to them in Finland has appeared to be comparable to earlier received experiences of health care in their home countries (Koponen, Kuusio, Keskimäki, Mölsä, 2012).

3. Aims and Purpose

The aim of the thesis is to identify the experiences of Russian immigrants of Finnish health care services. The purpose of the thesis is to provide information on the specific needs of the clients to improve the healthcare services. The research question of this study is "What are the experiences of Russian immigrants of the Finnish health care services?"

4. Methodology

4.1 Research method

This work is based on qualitative empirical research. Qualitative research implies the "investigation and interpretation of phenomena in terms of the meaning people bring to them" (Denzin, 1994). This kind of research aims at studying discourse on issues based on experiences (Patton, 1990). Because the topic is fairly new in relation to studies conducted in Finland, the investigation will begin at the empirical level, which involves data collection. The study continues at the conceptual level, in other words, with the formulation

of findings (Jha, 2008). Being a descriptive research, this work aims at giving a thorough account on the present-day issues. We consider that the most appropriate way to investigate experiences of Russian-speaking immigrants in health care services in Finland would be to carry out an individual in-depth dialogue with representatives of this ethnic minority by means of semi-structured interviewing (Kothari, 2004).

This descriptive qualitative research is carried out by semi-structured face-to-face interviews with Russian immigrants recruited through non-purposive snow-ball sampling. The interviews are audiotaped, transcribed and analyzed using thematic analysis. The participants were informed about the aim, purpose, background and procedure of the research together with their corresponding rights. The interviews were conducted upon having obtained the written consent from all the participants.

4.2 Recruitment of participants

The target population for this research consists of adult Russian immigrants living in Finland. Inclusion criteria for the participants are: having health care insurance from Kela (Finnish Social Insurance Institution) and more than single incident experience in being a customer of Finnish health care services.

The sampling method used in this work is non-probability sampling and thus does not require a sampling frame (Kothari, 2004). The sampling method used will be purposive and snowball sampling. The initial number of interviewees will be recruited from among the people in the nearest social proximity such

as personal acquaintances. The interviewees will be asked if they know anyone else who would be willing to share their stories. The interviewer will be introduced and enlisted as trustworthy to the other participants, who will be more likely to agree to join, if their friends or relatives can assure the reliability of the researcher. Using Dukes (1984) recommendations we use at least 3 participants for our phenomenological study.

4.3 Data collection

Data collection is carried out by audiotape recording individual interviews. Open and frank conversations with long discussions about one's problems, attitudes, frustrations and likings are deemed to be the best mode of collecting data from the ethnic group well known for their narrative traditions both in private and in public communication. For this reason, face-to-face interviews is chosen over online or paper questionnaires. The interviewees answer a number of prepared closed and open-ended questions that allow the discussion of themes and further questions that may arise depending on the experiences (Kothari, 2004). Open-ended questions allow the beginning a line of inquiry into a theme that can later be used as a reference for developing sets of response options for closed questions and a basis for interpreting unexpected responses to closed questions during further research into this topic (Foddy, 1993). The length and span of the conversations are left to be unlimited to ensure maximally extended accounts of experiences aiming at full-fledged narratives that can provide a wider span of accompanying themes and emotional background, which may help to identify attitudinal tendencies (Kothari, 2004).

4.4 Data analysis

In this research we are investigating topics and themes mentioned by Russian immigrants concerning health care services in Finland. For data analysis we chose thematic analysis as it best suits the qualitative nature of our inquiries. Due to the flexibility of this method, thematic analysis presents an opportunity to create an itemized description of the data. Thematic analysis begins with careful reading through the transcribed data before beginning actual the actual evaluation. The next step involves highlighting key issues and grouping them. Braun and Clarke (2006) recommend using visualizing methods, such as mind maps for aiding in this and following steps. During the next stage we look for common themes in the marked issues brought up by the interviewees. The fourth step entails the reviewing of the themes into logically and interconnected topics. The review brings forth the main ideas that reflect the data. The next stage involves the defining and naming the found themes as well as the overall analysis and explanation of the overall picture. The names of the themes must be brief and simple in order for the reader to get a clear understanding of what they are about (Braun, Clarke 2006).

5. Results

We were able to conduct and record three interviews which lasted approximately half an hour. The interviews were transcribed in accordance with transcribing guidelines of the Minnesota Historical society (2001) together with JAMK reporting style of Palatino linotype font in the size 12, left margin 4.3 cm and others – 2 cm with line spacing of 1.5. The produced written text

amounted to 5 pages for the first interview and 4 pages each for the second and third interviews.

Thematic analysis of the raw data produced several wide topics with smaller sub-topics which are illustrated in Figure 1. The main findings fall under one chief concern of accessibility to health care services. The first highlighted issue in accessibility to health care services is the language barrier. Problems of misunderstanding and miscommunication in situations where no interpreter was available have been mentioned by one of the respondents.

> "She kept telling me that I do not speak Finnish and that she does not speak English or Russian. She mentioned it five or six times…For the amount of money I paid, she did not want to try to use understandable words…She did not even try to explain anything"

Another respondent shared how her fear of not understanding the doctor in Finland prevents her from calmly seeking medical care.

> "It feels morally hard to visit doctors here in Finland. I am afraid they will use many terms which I don't know…I do not always understand what doctors in tell me in Russian"

In order to overcome the language barrier some interviewees reported following the recommendations of their Russian-speaking acquaintances and seeking medical help from Russian-speaking doctors. However, the interviewees added that even without the language barrier the medical treatment had no desired effect.

Another revealed theme covers the experiences of our interviewees with Finnish medical staff. In general, there was a positive feedback towards the way in

which medical staff addressed the patients. On the other hand, our respondents also mentioned a feeling that the medical staff is not competent enough and does not want to take responsibility for the treatment.

> "Everyone is smiling and very nice…but to no affect."

> "I think in Finland the care is done on the basis of 'do not harm'. Finnish doctors do not want to take responsibility...It seems as if they are afraid to lose their license if they do something wrong…I also noticed that a lot of medical workers do not have working experience and they do not know how some medicines work. "

Negative attitudes towards the outcomes of care have become one of the main topics of the interviews. There was a reported general dissatisfaction about the results of treatment, which had no reported effect. Respondents also shared that after failing to receive desired results in Finland they successfully traveled to seek medical care in Russia.

> "I was not always satisfied with the results, so I went to Russia were I was cured for kopeks" (Russian coins)

Another mentioned cause for dissatisfaction was the assurance of the medical staff's symptomatic approach towards care, offering in many cases pain medication, such as "Burana".

> "…Here in Finland I know that the doctor will prescribe "Burana". I do not want to pay money for a doctor's appointment if the doctor will prescribe "Burana"…"

Generally, the interviewees reported positive attitudes towards the accessibility to health care services in Finland, stating financial affordability as well as respect and a positive regard of the staff to immigrants. On the other hand, long queues together with a lack of knowledge of how to access health care in certain situations was stated by our respondents. One suggestion for improvement was mandatory use of interpreters.

> "Health care services are accessible. But I did not know where to go when my son cut his hand…My husband told me to go to the emergency unit by our own car. So there are no ambulances here…I was shocked"

Thus, the answer to the research question "What are the experiences of Russian immigrants of the Finnish health care services" can be given through several general issues such as language barriers to communication and health care services, use of social networks to access health care services, experiences with the approach of the medical staff along with dissatisfaction with the provided care.

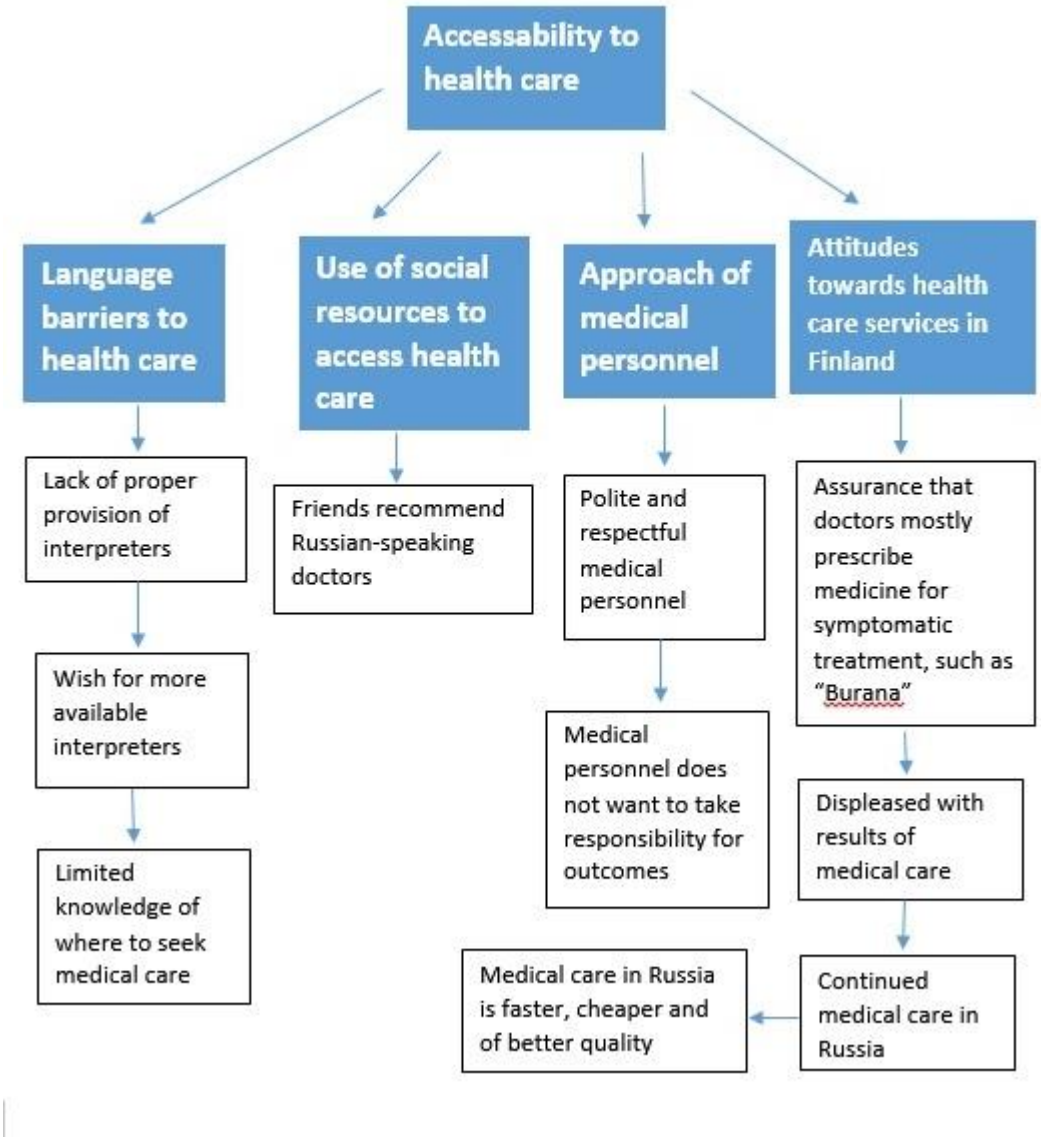

Figure 1. Experiences of Russian immigrants of Finnish health care services

6. Discussion

6.1 Discussion of main results

The findings of our interviews correlate with the reviewed literature. As in Koponen et al.'s (2012) study, our interviewees mentioned language as a barrier to accessing health care services together with the limited information on where to seek care along with a general disappointment with the provided care. Koponen et al. (2012) argued that there is a link between the level of satisfaction and previous experiences gained in the country of origin. In the case of our research, the respondents revealed that not having received the desired care they traveled for medical help to Russia, where, as they stated, the service is faster, cheaper and more effective. The theme of dissatisfaction can also be discussed in correlation to Abbott, Turmov and Wallace's (2006) research, which shed light on the issue of responsibility for the individual's health. After the collapse of the Soviet Union the healthcare system in Russia struggled to manage, which is when responsibility shifted from medical staff to patients. However, our interviewees reported that health care services are generally accessible, medical staff polite and welcoming to foreigners, thus, capable of managing health care related problems including those related to immigrants. Our respondents assume responsibility by seeking medical help, though they report that medical staff in Finland do not exhibit the same level of responsibility and attention. The interviewees' experiences with the analgesic "Burana" can be used as an example of what corresponds to as a seemingly "not so serious" medication, because it can be easily purchased without prescription. Because of this attitude towards the drug, the whole approach of symptomatic treatment even in non-critical cases, such as a tooth ache, seems disappointing to the health service's clients. This approach towards medication also results in the idea shared by the interviewees that medical staff is reluctant to take responsibility in fear of losing their license in the case that something

goes wrong when prescribing so-called "serious", prescription drugs. Further support for this argument lies in the interviewees' experiences with Russian-speaking doctors practicing in Finland, which have also led to the respondents' disagreement with the recommended treatment. In other words, even in the absence of linguistic and cultural barriers the common approach towards treatment is shared by doctors, all doctors in Finland, which inevitably leads to dissatisfaction and a loss of trust towards general medical practices in Finland. As a result our interviewees chose to travel to Russia, where they reportedly succeed in solving their health-related problems. Thus, we can conclude that the language barrier plays a lesser part in health care accessibility and acceptability, it is the issues of acceptance and trust that appear to be the most important factors in immigrants' general approach towards treatment offered to them in Finland.

The results of our inquiry could be beneficial for medical staff as well as for the health care services' users by means of educating both parties in particular aspects of cultural differences and ethnicity-related approaches to heath care established in medical institutions in Finland. The goal would be to establish a mutual understanding of the clients' needs and available modes of care; and as a result, the enhancement of trust towards health care services and elimination of cultural and social barriers in the way of equal health care access.

6.2 Ethical considerations

The research method used in this work is qualitative and thus includes investigation of personal attitudes and experiences. Because this work requires engaging people, ethical questions must be considered prior and upon interaction, data collection, analysis and handling. The first step before beginning

data collection was to give the interviewee a detailed explanation of aim, purpose and procedure of the study (Lipson, 1994; Lewis-Beck, Bryman, Futing Liao, 2004). An official document with the mentioned issues was presented to the interviewee to read, acknowledge and sign as an agreement of understanding. It is the researcher's responsibility to ensure that that the subject fully understands the presented information, the procedure and his rights by compiling the document in a lay language along with assessing comprehension before signing the document (Beauchamp, Childress, 2001). This document is also considered to be a contract that guarantees the rights of the interviewees to autonomy, anonymity and confidentiality (Lewis-Beck, Bryman, Futing Liao, 2004). Autonomy of the participants includes the right to withdraw from the interview and the whole research at any time. The concept of anonymity and confidentiality is safeguarded by coding or omitting all personal information, names, addresses, or any information that can help identify the interviewees (Lewis-Beck, Bryman, Futing Liao, 2004; Creswell, 2007). The signed document of informed consent means that the participation of the studied party is completely voluntary. In summary, a valid informed consent must contain three essential constituents: disclosure of general information, capacity of the participant to understand and draw out a judgment, and voluntariness of the participant to exercise his right to make a decision without external pressure (Beauchamp, Childress, 2001).

6.3 Credibility, integrity and objectivity

A research can be perceived as worthless if it is not considered trustworthy. In this work, the number or depth of experiences the interviewees have is not assigned or restricted due to the fact that the experiences of Finland's health care services by Russian immigrants are diverse and vary between participants

who may come from different backgrounds. On one hand, the assortment of situations in the interviews allow a broader view on the various services provided and their perceived quality (Shenton, 2004). On the other hand, differences in contextual factors in the stories of the immigrants produce inconsistencies. Various stories may bring insight on new phenomena, which could drive the structure and point of view followed in some interviews to shift to a broader or narrower angle (Shenton, 2004). Even though the extent of experiences has not been restricted in any way for the interviewees, the aim of this research is to investigate public discourse on attitudes towards Finnish health care services. For this reason, the same general questions will be asked from a similar point of view.

Shenton (2004) stresses the importance of suitable data collection method selection and data analyzing methods as a part of the research's credibility. The cultural closeness and knowledge of traditional communication styles that we share with the interviewees can be considered a good foundation for developing a trustful relationship not counting an open and frank conversation with the participants. The data analysis of this work includes the transcription and translation of all recorded material. The transcriptions was reexamined several times for recurring themes present in the stories of the interviewees.

On the other hand, this research presents a number of limitations in view of its credibility. According to Denzin (1994), credibility of a research encompasses a combination of more than one aspect to support its right to be considered accurate. The credibility of the presented research could be further enhanced by observing the subjects during their interactions with Finnish medical personnel. Another approach could be to include precise contexts of analysis, for example, investigating experiences in specific health care settings, such as nursing homes, child care or in-patient hospital care (Denzin, 1994).

The chosen methodology presents a few limitations in credibility, which are linked to the choice of open question interviewing and convenience sampling. Open questions create data that is inconsistent which leads to difficulties in coding along with a lower level of reliability (Foddy, 1993). Convenience sampling limits the range of available data at the same time hindering the credibility (Creswell, 2007). Major criticisms of qualitative studies also involve the problem of multidimensional understanding of concepts brought up in the interview. For the necessary data to be produced a mutual understanding of a concept must be agreed upon. In this case credibility is enhanced by including explanations of the concepts before providing each question (Foddy, 1993).

Integrity is a golden compass that guides the researcher to act honestly and truthfully. As far as data collection and analysis is concerned, it is the researcher's responsibility not to alter data or findings in order to meet the hypothesis or be desirable by the researcher and the clients (Korenman, 2006). The research integrity is an aspect of morality and experience. We consider our approach to data, data collection and data handling as honest and responsible. Data handling and analysis were conducted fairly, aiming at objectivity and full understanding of respondents' motivation and possible restraints along with their potential culture-related prejudice and bias. We consider ourselves committed to honesty and feel personally responsible for our intervention into the lives of our respondents. To ensure their privacy, our research practices were based on long time traditions of sociological studies and meet the requirements of fair conduct.

In relation to the study of Russian immigrants in progress, it is possible to identify a risk of bias due to the closeness of the author to this particular ethnicity, which entails the researcher's own beliefs, stereotypes and familiarity

with the studied cultures. This in turn may be reflected in the author's analyzing technique and expectations of the findings. Nevertheless, with the use of thematic analysis, all opinions and attitudes mentioned by the participants were acknowledged and recognized and included into the overall scope. In order to avoid misinterpretation, the interviewers' recorded answers and asked clarifying questions.

Objectivity refers to the ability of the researcher to separate his own thoughts, opinions and expectations of the outcome from the factual data during analysis. The human subjectivity may present a biased conclusion and stain the objectivity by selectively assigning meaning to data which is desirable and overlooking unwanted and seemingly insignificant, yet valuable records (Payne & Payne, 2004). It is thus important to acknowledge and evaluate one's own attitudes and hypothesis that may be clouded by projecting one's own experiences, cultural stereotypes in addition to expectations of what might be said by the interviewees. Therefore, the interview was structured in such a way that did not interfere or shed any tone of expected answers upon the interviewees, who may themselves feel obliged to answer in a certain way, depending on the questions queues, undertones and vocabulary (Lewis-Beck, Bryman, Futing Liao, 2004).

Risks of errors occurring during data collection mentioned by Belson (1986) include a lack of interest or reluctance to admit certain attitudes or behavior on the respondents' part as well as a change in their memory or understanding processes due to the possible stressful experience of taking part in an interview. Furthermore, according to Belson's hypothesis (1981), the respondent may interpret an incomprehensible question and modify it in such a way as to be able to answer it. This limitation should prompts us to use simple language when compiling the questions (Foddy, 1993). We use Creswell (2007),

Foddy (1993) and McNamara's (2009) recommendations on data collection in addition to risk minimizing strategies.

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