

Faculty of Social Sciences  
University of Helsinki

**PROFESSIONAL AGENCY AND  
INSTITUTIONAL CHANGE:**  
CASE OF MATERNITY SERVICES IN SMALL-TOWN  
RUSSIA

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DOCTORAL DISSERTATION

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# ABSTRACT

## *Background*

The system of healthcare in Russia since the 1990s undergoes perpetual and considerable transformation and has become a particular field of concern to the state. Maternity care services, in particular, appear to be even more symbolically significant to the authorities, provoking additional efforts to redesign their provision and organization. Previous researches focused their attention on the importance of commercialisation and consumerisation for the institutional change, but neglected the role of health professionals in the local organisation and provision of maternity care in the context of this top-down led institutional change. In addition, relatively little is known about these social settings characterised by a lack or constraints of resources, including economic and cultural ones.

This study addresses institutional changes that have occurred since 2006, when the most appreciable state measures to improve maternity care were taken and a new, 'statist' policy model emerged in Russian healthcare. It focuses on the perspective of healthcare practitioners, working in maternity facilities in small-town Russia. This scope enables analysis of professional agency in apparently unfavourable settings, characterised by a lack of choice, limited number of private medical organisations, not appreciably rising patient demand, and insufficient economic and social resources.

## *Methods and data*

The research is designed as a multiple case study and allows comparison of the differing limits to and opportunities for professional agency emerging in formally similar institutional settings. Each case (n = 4) addresses a complex of antenatal and maternity care facilities located in one small Russian town, located in a distance from regional, economic and cultural centres.

The data were collected between 2011 and 2017 years. The qualitative methods of in-depth interviews (N= 28) and participatory observations in two cases under investigation provide an opportunity for closer examination of the healthcare professionals' perspectives and insights into micro-level initiatives and unintended consequences of the macro-level policies. The main method of data analysis is common thematic content analysis.

## *Results*

This study revealed the diversity of medical approaches, doctor–patient relations, dispositions toward change and notions of professional commitment in practices by a formally homogeneous social group of practitioners providing maternity services. Focusing on the provision, regulation and arrangement of maternity care, analysis of the health professionals' narratives provided

evidence of aggravated working conditions in terms of a growing domination of managerial and market institutional logics.

Managerial, market and professional organisational principles considerably shape medical practices and affect professional autonomy. The institutional logic of informality can be employed to manage the rivalry of all the other organising principles, but all together these multiple logics are being converged on the organisational level and in the professional practices of healthcare practitioners, producing various hybrid forms.

In such conditions of the institutional complexity, healthcare professionals find some forms, in which professional agency can be practices in the field of maternity services. As a result, both organisational transformations and micro-scale changes took place in one of the cases under investigation over the course of a decade from 2007. The case of 'stealthy innovators' exemplified the substantial internal restructuring initiated by healthcare professionals in order to integrate a new, more patient-centred and family-friendly approach to childbirth. The narratives of midwives, doctors and administrators working in maternity facilities in a remote Russian town reconstructed a particular kind of institutional work accomplished by them in adopting new medical practices and modes of interaction with patients and their families.

### *Conclusions*

The study results confirm a top-down approach to change in the field of maternity care in Russia, and suggest that most recent state-led changes have been centralised in character and have resulted in the predominance of managerial and market logics of regulation. Different organisational settings present various combinations of institutional logics and their hybrids, and some of them favour institutional alterations initiated by health professionals, at least at the level of their practices. The process that reveals professional agency in changing the approach to childbirth includes the stages of gaining new professional knowledge, changing the conceptualisation of maternity care and its ideal, altering professional practices, and changing perceptions of what professionalism actually consists of.

In spite of some positive examples of the institutional change occurred in the field of maternity care, this work has identified that some state reforms may have unintended consequences for healthcare professionals working in the maternity units of small Russian towns, and that there is a particular vulnerability of health practitioners in Russia. The key suggestion of the study is to consider healthcare professionals' perspective in future reforms, in order to provide more space for their agency in terms of the institutional work they might accomplish to make the system of maternity care more safe, accessible and patient-friendly.

# ABSTRAKTI

## AMMATILLINEN TOIMIJUUS JA INSTITUTIONAALINEN MUUTOS: ÄITIYSHUOLLON PALVELUT VENÄLÄISISSÄ PIKKUKAUPUNGEISSA

### *Tutkimuksen tausta*

Venäjän terveydenhuoltojärjestelmä on käynyt 1990-luvun jälkeen läpi jatkuvia isoja muutoksia ja siitä on kehkeytynyt erityinen valtiovallan huolen kohde. Erityisesti äitiyshuollon palveluilla on ollut suuri symbolinen merkitys viranomaisille, minkä seurauksena niitä on yritetty järjestää monin tavoin uudelleen.

Aiemmat tutkimukset ovat keskittyneet pohtimaan markkina- ja kuluttajanäkökulmien merkityksiä tässä institutionaalisessa muutoksessa. Ne ovat kuitenkin jättäneet huomiotta terveydenhuollon ammattilaisten roolin paikallisissa organisaatioissa ja äitiyshuollon tuottamisessa ylhäältä johdetussa institutionaalisessa muutoksessa. Tämän lisäksi tiedämme vain vähän toimintaympäristöistä, joissa terveydenhuollon ammattilaisilla on käytössään vähän taloudellisia ja kulttuurisia resursseja.

Tämä tutkimus käsittelee niitä institutionaalisia muutoksia, jotka saivat alkunsa vuonna 2006 valtiovallan toteuttaessa huomattavia toimenpiteitä äitiyshuollon parantamiseksi. Tällöin Venäjän terveydenhuoltoon tuotiin myös uudenlainen "valtiojohtoinen" politiikkamalli. Tutkimus keskittyy äitiyspalveluihin venäläisissä pikkukaupungeissa, jotka sijaitsevat kaukana alueellisista, taloudellisista ja kulttuurisista keskuksista. Tämä antaa mahdollisuuden analysoida ammatillista toimijuutta ilmeisen epäsuotuisissa olosuhteissa, joita luonnehtivat valinnanvapauden puute, vähäinen yksityisten terveyspalveluiden määrä, kysynnän lasku sekä riittämättömät taloudelliset ja yhteiskunnalliset resurssit.

### *Tutkimuksessa käytetyt menetöt ja aineisto*

Tutkimus on toteutettu tapaustutkimuksena, mikä antaa mahdollisuuden vertailla ammatillisen toimijuuden erilaisia rajoitteita ja mahdollisuuksia muodollisesti samankaltaisissa institutionaalisissa olosuhteissa. Kukin neljästä tapaustutkimuksesta käsittelee aina yhden venäläisen pikkukaupungin neuvoloita sekä synnytys- ja äitiyshuollon laitoksia.

Aineisto on kerätty vuosina 2011-2017. Analyysi pohjaa syvähaastatteluiden (N=28) ja kahden tapaustutkimuksen kohdalla lisäksi havainnointiaineiston laadulliseen analyysiin. Tämä tarjoaa mahdollisuuden tarkastella tarkemmin terveydenhuollon ammattilaisten käsityksiä ja näkemyksiä mikrotason aloitteista sekä makrotason politiikan tarkoittamattomia seurauksia. Aineiston analyysissä on käytetty etupäässä laadullista teema- ja sisällönanalyysia.

### *Tulokset*

Tutkimus tuo esille sen, kuinka käytännön toiminnassa esiintyy erilaisia lääketieteellisiä lähestymistapoja ja lääkäri-potilassuhteita, erilaisia asenteita muutosta kohtaan sekä erilaista ammatillista sitoutumista muodollisesti homogeenisten ammatinharjoittajien parissa. Äitiyshuollon järjestelyä, sääntelyä ja turvaamista käsittelevien terveydenhuollon ammattilaisten kertomusten analyysi paljastaa työolosuhteita, jotka ovat huonontuneet dominoivan managerialistisen ja markkinavetoisen institutionaalisen logiikan seurauksena.

Managerialistiset, markkinavetoiset, ammatillisen organisoitumisen periaatteet muokkaavat huomattavasti terveydenhuollon käytäntöjä ja vaikuttavat ammatilliseen autonomiaan. Epävirallisiin käytäntöihin pohjaavaa institutionaalista logiikkaa käytetään kilpailevien periaatteiden tuottamien ristiriitojen ratkaisemiseksi. Kaiken kaikkiaan nämä monenlaiset mallit kuroutuvat yhteen palveluiden tasolla ja äitiyspalveluiden ammattilaisten käytännöissä tuottaen erilaisten logiikoiden hybridejä.

Näissä monimutkaisissa institutionaalisisissa olosuhteissa terveydenhuollon ammattilaiset löytävät kuitenkin tapoja, joilla ammatillista toimijuutta voi harjoittaa äitiyshuollon palveluissa. Sekä organisatorisia että mikrotasoisia muutoksia käytännöissä saatiin aikaan yhdessä tapaustutkimuksessa. "Vaivihkaisten innovaattorien" (stealthy innovators) tapaus havainnollisti, kuinka äitiyspalveluiden ammattilaiset panivat alulle mittavan sisäisen uudelleenorganisoinnin uusien, potilas- ja perhekeskeisten lähestymistapojen integroimiseksi synnytyspalveluihin. Venäjän syrjäisissä pikkukaupungeissa toimivien kättilöiden, lääkäreiden ja hallinnon edustajien kertomukset tuovat esiin heidän tekemäänsä institutionaalista työtä uusien äitiyspalvelukäytäntöjen sekä potilas- ja perhevuorovaikutustyylien omaksumiseksi.

### *Johtopäätökset*

Tutkimuksen tulokset vahvistavat, että Venäjän äitiyshuollon uudistukset ovat olleet ylhäältä ohjattuja. Viimeisimmät valtiojohtoiset muutokset ovat olleet luonteeltaan keskusjohtoisia ja johtaneet managerialistisen ja markkinapohjaisen säätelymallin ylivaltaan. Erilaiset palvelukontekstit tuovat esille erilaisia institutionaalisia malleja sekä niiden hybridejä. Toiset näistä ovat suotuisampia institutionaalisille muutoksille, joita tehtiin terveydenhuollon ammattilaisten aloitteesta ainakin heidän omien käytäntöjensä tasolla. Tämänkaltainen ammatilliseen toimijuuteen perustava prosessi sisältää seuraavat vaiheet: uuden ammatillisen tietämyksen omaksuminen, äitiyshuollon ja siihen liittyvien ihanteiden käsitteellinen muutos, ammatillisten käytäntöjen muuttaminen sekä käsityksen muuttuminen siitä, mitä ammatillisuus on.

Näistä yksittäisistä positiivisista äitiyshuollon institutionaalisista muutoksista huolimatta tutkimus löysi monia valtiojohtoisten uudistuksen mukanaan tuomia tarkoittamattomia seurauksia äitiyspalveluiden parissa

työskenteleville ammattilaisille venäläisissä pikkukaupungeissa. Tutkimus osoittaa, että Venäjän terveydenhuollon harjoittajat ovat tiettyssä mielessä suojaamattomia. Tämän tutkimuksen tärkein suositus on, että tulevaisuudistuksissa terveydenhuollon ammattilaisten näkökulma otetaan huomioon, jotta heidän toimijuudelleen ja sille institutionaaliselle työlle, jonka avulla he voivat tehdä äitiyshuollon järjestelmästä turvallisemman, helppopääsysisemmän ja potilasystävällisemmän, jää tilaa.



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## ABBREVIATIONS

etc.	et cetera
i.e.	id est
e.g.	exempli gratia
ibid.	ibidem, at the same place
DMS	voluntary health insurance in Russia
FAP	feldsher-midwifery stations – medical facilities providing only paramedical services, located in villages and rural areas in Russia
GDP	gross domestic product
HIV	the human immunodeficiency viruses
MHI	mandatory health insurance in Russia
NHS	National Health Service in the United Kingdom
WHO	World Health Organisation
UNESCO	United Nations Educational, Scientific and Cultural Organization
USSR	Union of Soviet Socialist Republics



# 1 INTRODUCTION

*“The Government of the Russian Federation was instructed to introduce legislative amendments requiring healthcare workers to follow clinical recommendations and treatment protocols when providing medical services and establishing liability for actions preventing the execution by healthcare workers of their professional duties.”*

*(President of Russia 2018a)*

The quality and accessibility of medical care in Russia have become central issues over recent decades, and are a formal goal of state-initiated social restructuring. Many reforms have been implemented since 2006 in order to develop the provision and improve the performance of healthcare services. The Ministry of Health, the federal government and regional authorities regularly address various problems emerging in this field, and issue different laws, projects and orders aimed at solving them. In this way, the state is building new technologically-developed healthcare facilities, introducing a system of patient hospitalisation within the regions, investing money in hospitals' material provision, designing new medical protocols, and implementing many other innovative measures. In other words, it claims that healthcare quality is its direct responsibility and concern (Federal Law 2011; President of Russia 2012a, 2014).

At the same time, the formal role of healthcare practitioners remains vague and ambiguous in this complex and multi-stage process of institutional transformation. In political discourse, professionals themselves are seldom articulated as social actors responsible for the quality or reform of healthcare. Medical workers are addressed by the state primarily as state employees. Successive presidents have constantly spoken of the necessity to increase their salaries (President of Russia 2012b, 2016, 2018), improve their working conditions (President of Russia 2018b) and stimulate their interest in working in remote areas (Federal Law 2010). However, with regard to the content of medical practices and rules, such as protocols and standards that govern and shape their work, healthcare professionals in practical medicine seldom emerge as decision makers or key actors in this institutional field.

Maternity services have become a particular field of concern to the state, in the context of “demographic crisis” – severe decline in population which has been constructed as a national threat, since they deal directly with childbirth, and hence with issues of reproduction and demography. This sphere is symbolically significant to the authorities, provoking additional efforts to redesign their provision and organisation. Almost every annual President's Address has mentioned the topicality of demographic problems and has drawn attention to any ‘positive’ statistical tendencies in this sphere (President of



Russia 2018b). The increasing number of legal claims and the amount of compensation paid out for inappropriate medical actions in gynaecology and obstetrics (Radzinsky et al. 2017) also confirm the growing significance of social experience related to maternity care for people. Hence, the sphere of reproduction with its concomitant healthcare services has become a field of symbolic struggle with rising value at stake, but questions concerning the balance of power remain unresolved.

The detected 'statist' turn in welfare policy (Cook 2011), characterised by a pronatalist agenda in political discourse (Chernova 2013; Rivkin-Fish, 2010: 702), marks an important disposition of power exerted by the state in the field of maternity care. In other words, this sphere has become a recognised part of the moral and symbolic order (Zdravomyslova, Temkina 2011: 28-29), and a core part of the state's political agenda. Authorities at various levels target the sphere of childbirth as a priority for their political programmes. Consequently, the state appears to be reluctant to establish more egalitarian relationships between key social actors interacting in this sphere. Paternalism can thus be considered to be a core characteristic of the sphere of healthcare in post-Soviet Russia, in terms of both doctor-patient interactions, and relations between the state and medical practitioners as state employees.

Since the Soviet collapse, social processes such as the consumerisation of patients' behaviour (Temkina 2017), the commercialisation of medicine (Temkina 2016), and the (neo)liberalisation of healthcare regulation (Cook 2014) have been challenging this paternalistic state of affairs from different angles. Patient demand is rising for more person-centred and less medicalised approaches, care and patient-friendliness are articulated as key components of medical services, and new institutions protecting patients' interests and wellbeing are appearing. On the other side, healthcare practitioners are forming new institutions or amending existing ones, such as professional associations, medical schools and private organisations, allowing the introduction of new medical approaches, practices and forms of health care, and realisation of their professional commitment. In large cities, in particular, home-birth practices, private maternity hospitals and paid-for services are emerging, reflecting both patients' demands and professionals' interest in qualitative change.

However, in many other areas healthcare remains only state-funded and facility-based, with few signs of such profound transformation. Furthermore, it seems unlikely that the state (or at least the Russian government and the Ministry of Health) will recognise professional agency. The quote by the Russian President at the head of this chapter illustrates this paternalistic approach: the government, not healthcare workers themselves, is responsible for altering their status, protecting them from violations, and providing appropriate working conditions. In addition, some restructuring initiatives implemented in the sphere of healthcare services, relating to its provision and financing, reforms to medical education and other aspects, can be considered as aggravating rather than enhancing the working conditions of healthcare

practitioners. A growing bureaucratic burden (Borozdina, Titaev 2011), increasing demand and exacting requirements from both patients and the various controlling authorities, and the rising dependence of state employees' salaries on a range of efficiency indicators (Larivaara et al. 2008: 368) are leading to a worsening of working conditions and limiting possibilities for professional autonomy.

This research focuses directly on sectors of the obstetric institutional field characterised by limited opportunities for professional initiatives and innovations, and problematises the changing relations between healthcare professionals and different social agents acting in these settings. In particular, my research addresses arrangements for maternity care provided in the context of small Russian towns remote from regional centres, and focuses on the social actors responsible for it – healthcare practitioners in small maternity facilities. Thus, I aim to investigate possible spaces for professional agency, and challenges to its performance, in the field of highly sensitive and heavily symbolic maternity care services provided in the context of scarce economic and social resources, and under heavy top-down regulation. Analytically, the key issue addressed by this work are the opportunity for agency within structural constraints, and the micro-level challenges of macro-level settings.

## **1.1 RESEARCH QUESTION AND DESIGN: PROFESSIONAL AGENCY IN POST-SOCIALIST SETTINGS**

This thesis investigates professional agency in the context of the institutional transformation of maternity care in small Russian towns in remote areas. Designed as a multiple case study, the research focuses on the organisational context of healthcare practitioners' professional practices and interactions, their particular perspectives, the provision of maternity services, and local settings in Russia's regional periphery.

The subject of this research is the space for professional agency in the particular institutional context of maternity care services in small Russian towns, which are perpetually changing under the influence of state reforms. The key research question is: **what is the role of health professionals in the local organisation and provision of maternity care in the context of top-down led institutional change?** I investigate these issues through a multiple case study, consisting of both analysis of institutional arrangements for maternity care in Russia and healthcare practitioners' position toward it. Each of the subsequent empirical chapters addresses one of the following sub-questions:

a) How has the institutional field of maternity care services in Russia been transformed in recent decades and how is it arranged, financed and

regulated nowadays? How do macro-scale changes and reforms are brought to the ground level and shape professionals' grass-root practices and interactions?

b) What are the spaces and conditions for professional agency, in terms of the organisational structure of maternity care and methods for its regulation, financing and provision does this perpetual institutional change produce? Which professional practices and ground-level alterations of maternity care in small towns do reveal the agency of healthcare practitioners? How is healthcare practitioners' agency restricted or enabled by the organisational context and the remoteness of the settings?

c) Which organisational principles appear to be dominating the field of maternity care in small-town Russia? How do healthcare practitioners manage the rivalry of different organisational principles, and which mechanisms do they elaborate to maintain their professionalism?

Several studies have revealed discrepancies between macro-level tendencies and micro-level processes of institutional change in the field of healthcare (Annandale 1989; Currie, Spyridonidis 2016). My research zooms these inconsistencies and shows that there is no uni-directional, coherent and straightforward process of institutional transformation in the field of Russian maternity services provision. Rather, I propose that various grassroots initiatives and micro-/meso-level changes are taking place in formally homogeneous facility-based and state-funded childbirth. In order to provide evidence of this multiplicity of professionals' opportunities and practices which reveal agency, the subject matter of the research – the institutional field of obstetric services in small Russian towns – is investigated through different cases. Each case consists of the system of all healthcare units providing antenatal, obstetric and neonatological services in a remote district in Russian regions.

The scope of this research is both temporal and spatial. First, I address institutional changes that have occurred since 2006, when the most appreciable state reforms were initiated and a new, 'statist' policy model emerged in Russian welfare. Second, I focus on maternity facilities in small Russian towns remote from regional, economic and cultural centres. This scope allows analysis of professional agency in apparently unfavourable settings, characterised by a lack of choice, limited number of private medical organisations, not appreciably rising patient demand, and insufficient economic and social resources.

The conceptual framework of this research employs a neo-institutionalist approach in order to examine different levels of change in the institutional field of maternity care. I apply the following conceptual tools, which allow exploration of different forms of institutional change in the object under investigation, as well as the agency of these alterations. Throughout the thesis I will use the term **obstetric institutional field**, defined within the frame of a neo-institutionalist approach as 'organizations that constitute a recognized area of institutional life; key suppliers, resource and product

consumers, regulatory agencies, and other organizations that produce similar services or products' (DiMaggio, Powell 1983: 148). In this study institutional field of maternity care refers to those organisations and collective or individual actors, which comprise an area with stable social, economic and regulatory relationships, directed at the arrangement, provision and consumption of maternity care services.

The concept of **institutional change** denotes any alteration occurring in the institutional field under investigation, including micro-scale changes at the level of interpersonal interactions, and macro-scale shifts in the organisational structure, financing and regulation of maternity services. In particular, the term is adopted from the neo-institutionalist approach applied to the sociology of professions (Harrington 2015; Muzio et al. 2013; Suddaby, Viale 2011; Zietsma, Lawrence 2010), which also examines the way, in which structured relationships between social actors are being bound together by a common meaning system – institutional logic (Hinings 2012: 99).

This research adopts the concept of **institutional logics** to denote those organisational principles, which shape the behavior of field participants (Reay, Hinings 2009: 631) and underlie a particular set of institutional changes. At least four types of logic are investigated in this research project, as shaping professionals' practices, conditions and the content of their work in the organisational context, and affecting the possibility for professional agency: managerial, market, professional and informal (Bévort, Suddaby 2015; Blomgren, Waks 2015; Freidson 2001). Based on the neo-institutionalist approach I propose that any institutional field is regulated by multiple, often competing logics (Martin et al. 2015: 379), which at the same time work as organising principles on different levels of the social order (Scott 2008: 232).

The key concept, which I use in this research to delineate actions taken by individuals or organisations that may cause institutional change in terms of creating, maintaining or disrupting institutions is **institutional work** (Lawrence, Suddaby 2006: 215; Cloutier et al. 2016; Zietsma, Lawrence 2010). In this research, I use this concept as a key lens, allowing analysis of professionals' agency in the process of institutional change in the investigated field. This category enables to examine the micro-level changes (Currie, Spyridonidis 2016: 79), which can both maintain separateness of different institutional logics or hybridise them (McGivern 2015: 414).

In this way the notion of **hybridity** becomes one of the central concepts as well. The concept of hybridity is adopted from the organisational studies and sociology of professions and refers to those forms of institutional change, which involve multiple organisational principles simultaneously (Noordegraaf 2015). The study analyses hybridity on multiple levels of the institutional field: on dimensions of the institutional context, organizational structure (design of maternity care), professional agency, activities and identities (Denis et al. 2015: 275).

Another important dimension in the analysis of the institutional change is the possibility of **unintended consequences** – structural changes and

practices that emerge neither by design nor as an outcome of healthcare practitioners' institutional work. This concept in particular catches the probable discrepancy between policy goals and intentions and street-level practise and action, as well as unexpected or mixed outcomes of the reforms (Cloutier et al. 2015: 259). In addition, in this research I propose that the professional agency itself can involve not only creative and more prospective activities, but more routine-based and iterative as well (Scott 2008: 223). Thus, the analytical framework of the research presupposes that even agentic attempt to design and change institutions can have unintended effects (ibid.).

## **1.2 INVESTIGATING MATERNITY CARE AND HEALTHCARE PROFESSIONALS IN RUSSIA**

The research addresses two main analytical problems. The first is the relationship between macro-level social structures, such as state-funded and -regulated maternity services in Russia, and micro-level professional agency, analysed through the concept of healthcare practitioners' institutional work to alter the content and the conditions of their work in the organisational context. The second dimension of analysis focuses explicitly on the institutional change in Russian maternity services and the interplay of macro-structural reforms with micro-level alterations. The research seeks to determine which social actors are responsible for altering the institutional field, what kinds of social processes affect the work of maternity services, and whether these specificities have inherited the Soviet organisation of healthcare or correspond with the global neoliberalisation of social structures.

The search for answers to the questions formulated above positions my research within at least two discussions in social sciences and Russian studies. The first refers to the issue of institutional transformation in post-socialist societies, addressing the continuous nature of change in Russian social services. The second contributes to sociological debate on professionals and their role in the process of institutional change. Institutional change in post-Soviet Russia is often described by social scholars as a never-ending story: social restructuring appears to be a recurrent process, with ideologically incoherent and contradictory stages. Healthcare services in general (Cook 2017; Shishkin et al. 2017), and maternity services in particular (Shuvalova et al. 2015), are undergoing the same efforts to alter their design and logic of regulation. Some tendencies revealed in these reforms are in line with those of global neoliberalism, such as cuts in state expenditure on social services, the introduction of new indices of market efficiency, and reductions in state employees and services (Cloutier et al. 2015; McGivern et al. 2015; Currie, Spyridonidis 2016).

However, as social researchers demonstrate, there are some important specificities of the post-Soviet social restructuring in terms of state policy

implemented and some features of the concrete results. Transformation of the post-socialist society, in general, and of the welfare and health care in particular, have received much attention over the last two decades. For example, in the analysis of the social restructuring in Russia during 1990, social scholars highlighted, that in many ways it resulted in deterioration of the health crisis in terms of high mortality rates (Cockerham 1999: 99), natural population decrease, worsening economic and social conditions and a deteriorating health care delivery system, the major rise in sexually transmitted diseases (*ibid.*: 100-102). As William C. Cockerham concludes in his research at the end of 1990s the Soviet system of healthcare is still in place, while Russian policy efforts have brought little change to date regarding the health crisis (*ibid.*: 104).

Other scholars, which investigated health and social welfare during the transition in 1990s Russia argued that the transition from the socialist to capitalist society created several 'unintended consequences' aggravating many problems, inherited from the Soviet past and creating new ones (Field, Twigg 2000: 2-3). In the introduction to the collective monography, Mark G. Field and Judith L. Twigg emphasized that, in spite all the efforts to introduce the market mechanisms, at the turn of the centuries Russia still lacked the respect for property rights, and legal mechanisms for the marketisation, which was also aggravated by the extensive corruption (*ibid.*: 4). Thus, the first stage of the post-socialist welfare and healthcare systems only boosted the spread of informality, which still appear to be an important feature of healthcare in Russia (Zasimova 2016). As other researchers emphasise, the healthcare crisis and state failure to overcome it produces conditions, in which different actors exercised their agency in informal, indirect and covert ways (Zvonareva, Horstman 2018: 23).

A growing body of literature has examined the further restructuring of healthcare in Russia, which proceeded in 2000s and in 2010s. As Maryna Y. Bazylevych and Ema Hresanova argued, the sphere of healthcare in postsocialist settings 'has been struggling with adapting to changes, yet inadequate GDP percentiles and political instability often deem reforms fruitless due to the lack of consistent approach and implementation strategies' (Bazylevych, Hresanova 2011: 1). In particular, scholars addressed the problem of quality and accessibility of healthcare services for Russian citizens, and described the system of services provision as uneven in terms of equal access to public healthcare services (*ibid.*). Researchers emphasise that the quality and accessibility of healthcare varies across the Russian regions (Kainu et al. 2017), and between urban and rural settings (Krashennnikova 2017; Panova 2019). However, precious works has only focused only on interregional differences and urban-rural division in differences of the healthcare organisation and delivery. I propose, that there is an additional spatial unevenness, which reveals itself in centre-periphery dimension.

Another specificity of the Russian socio-political context lies in the contradiction between the market-led logic of restructuring and the statist

mode of welfare policy (Kulmala et al. 2014; Kainu et al 2017). The particularity of this setting makes this research highly topical, since the role of Russian healthcare professionals differs from those previously investigated in Western contexts, in terms of the histories of other professions' formation and the political institutions affecting their work (Saks 2015). It has long been a major assumption of the sociology of professions that professional agency and autonomy during both the Soviet period and in post-socialist societies was and is limited (Brown 1987; Balzer 1996). In most cases, professionals have been described rather as state bureaucrats with no resources, and lacking initiative to alter their position in the institutional field (Mansurov, Yurchenko 2005; Stepurko et al. 2016). Studies have demonstrated that doctors experience a lack of autonomy in their relations with the hospital administration, at the same time experiencing substantial authority in their relations with patients (Rivkin-Fish 2005).

As the marketisation of healthcare services and consumerisation of patients' attitudes continue, this state of affairs, especially relating to doctor-patient relations, is being challenged. Growing tension between patients' demands, professionals' integrity and the rigid formal regulatory framework has often been relieved by the elaboration of informal relations (Larivaara et al. 2008). Thus, the field of healthcare in Russia has been shaped as a market setting, with a growing segment of informal payments (Shishkin et al. 2014; Gordeev et al. 2013) as in some other post-Soviet countries (Stepurko et al. 2013; Habibov 2016). The symbolically sensitive field of maternity services (Zdravomyslova, Temkina 2018) has formed a quite developed quazi-market, with high consumer demand and a broad supply spectrum (Temkina 2016).

Addressing the field of maternity care and health professionals in Russia few scholars focused on power relationships between providers and patients, and issues of authority. For example, Inna Leykin in her research (2011) demonstrated that medical professionals exercise their authority not only through the individual patient care, but in non-medical setting as well – through the participation in demographic debate, and elaboration of family planning programs' (Leykin 2011: 60). Meri Larivaara in the similar research of gynaecologists, counselling women in state-funded antenatal clinics, also examines the issue of power, which is experience by health professionals through paternalistic practices and within the moral, not only medical, domain (Larivaara 2010). Anna Temkina and Michele Rivkin-Fish in their recent work (2019) address the issue of doctor-patient relations in Russian maternity care throughout the last two decades and demonstrate how consumerisation of patients' behaviour transforms providers' power, authority and domination, but at the same time, how Russian childbirth services still remain a limited means of empowerment for patients and providers (Temkina, Rivkin-Fish 2019).

There are still only few researches, which investigate other professional groups in the field of maternity care. Among them Ekaterina Borozdina's latest research shows, healthcare practitioners are also reacting to this demand as

active agents. Her case study of a midwifery care centre for natural childbirth describes how midwives' agency is manifested in terms of practice independent of the doctor's power, articulating their professional jurisdiction (Borozdina 2014; 2017b). Although the analytical focus of this research is very close to the one, I aim to address in this thesis, there is another research gap, consisting of the lack of attention on the organisational settings of maternity care and professional agency (or lack of) exercised within it.

The studies referred to above provide evidence of institutional change in the state-led field of healthcare and maternity services in Russia, shaped by state reforms on the one hand, and by patients and professionals on the other. However, most research in Russia has been conducted in large cities, in which different economic and social resources are accumulated. These conditions are important for analysis of institutional transformation, but cannot be considered to be common to the more general field of healthcare services in Russia. In other words, previous researches emphasised the importance of commercialisation and consumerisation for the institutional change, but neglect other social settings characterised by a lack or constraints of resources, including economic and cultural ones. My study aims to fill these gaps. In addition, the aim of the study is to examine not only one professional group, working in the field of maternity care as previous studies (Rivkin-Fish 2005; Leykin 2011; Borozdina 2014), but rather the multiplicity of health practitioners encountering in the organisational setting.

The Russian political regime and its changes can generally be characterised as authoritarian (Gel'man 2015) and centralised, with top-down leadership, meaning that institutionally there are few opportunities to shape the design of social systems. Small Russian towns represent a particular kind of setting located both institutionally and geographically at the periphery of these changes, and are of particular interest in terms of relatively undetectable and previously uninvestigated institutional alterations.

### **1.3 THE CONTEXT OF SMALL-TOWN RUSSIA**

Small Russian towns constitute a particular social setting in which the same restructuring as implemented across the whole country may have different effects. During the 1990s, places remote from administrative and industrial centres faced quite negative economic and demographic challenges, aggravated by the state's withdrawal (Kay 2011). Another specificity of this context, highlighted by other researchers, is that the number of people active in each sphere is quite limited – the same people may work in both public offices and informal activities, leading to the blurring of state and non-state activities (Kulmala 2011: 191). Unlike large cities, small towns actualise the role of personified social networks, where the state's welfare responsibility may be supplemented or even replaced by the institutionalisation of informal



care, reciprocity and social responsibility (*ibid.*). This context is therefore also a research field in which the role of personal interactions and social networks is of greater importance (for more detail, see Chapter 4).

As recent research has shown, there are more small towns in Russia than any other type of settlement, and small towns rank in second place by population, accommodating more than 16 million people (Barkovskaya et al. 2013: 3-5). However, economically and infrastructurally, these areas appear to be the most deprived: 'the smaller the size of a city, the more possible its socio-economic depression becomes' (Nefedova 2008: 17). In particular, small towns in Russia (except for some established as military centres or in which huge enterprises are located) face problems such as depopulation and a lack of financing and social services (e.g. institutions of higher education, specialist healthcare), intensified by the inaccessibility of peripheral areas. In turn, these factors shape the arrangement of healthcare services.

Small-town Russia is a contrasting social context to both large cultural and economic centres, and rural areas. Some are located more than 100-200 kilometres from regional centres, and such areas often appear to be quite economically deprived and lacking in material resources for infrastructural improvement. In such settings, obstetric services comprise gynaecology departments and obstetrics wards of central (inter-)district hospitals and other city hospitals, representing the least equipped and the smallest maternity facilities (Barkovskaya et al. 2013: 4; Starodubov, Suhanova 2012: 100; Shuvalova et al. 2015). Such institutional arrangements give rise to particular aspects of both financing and regulation of such units, particularly their decreased autonomy in relation to both organisational decision-making and healthcare specialists' practice.

In particular, all medical facilities available to patients in this context provide basic medical assistance with pregnancy and during labour, but complex surgical operations and other medical procedures relating to complications or pathologies should be delegated to better equipped facilities. Another specificity of the obstetric field in small Russian towns is that it has few, if any, private clinics or commercial services. Paid-for services are considerably restricted: as researchers have shown, commercialisation of maternity care services in such settings is inadmissible owing to their inaccessibility to the majority of Russian families (Starodubov, Suhanova 2012: 305).

So, what is happening as the institutional field of maternity care services proceeds along 'a difficult path' of social reforms (Shishkin 2013; for more details see subchapter 2.1) in the context of the regional periphery? Cases of small Russian towns provide evidence that the transformation of medical services caused by state reforms formally aimed at their improvement may, at a practical level, result in additional institutional limitations and practical problems. Some organisational changes may lead not only to the realisation of explicitly stated and projected goals, but also to the deterioration of both patients' access to services and service quality (Rugol' et al. 2018).

Although healthcare reforms may also have undesirable and negative effects in large cities, there are important aspects to this transformation in small towns. As recent quantitative research has demonstrated, patients from Russian small towns and rural areas described the following problems as the most actual: the long time of waiting for an appointment with the needed specialist; low qualification of healthcare practitioners, and the poor medical equipment available in healthcare facilities (Levada-center 2016: 12). As a consequence, people living in remote areas more often abandon the required healthcare services (ibid.: 13), as statistics shows, about 40 % of rural residents have not got any medical care during a year. People living in such areas, evaluate accessibility and quality of healthcare as poor, but lack any choice of services due to the limited number of health practitioners, and lack of economic resources to move to the regional centre. To conclude, as survey and focus groups, conducted by Levada centre have shown, the context of remote areas in Russian regions exacerbates inequality in access to the qualitative healthcare (Levada-center 2016: 22; Panova 2019).

I also propose that this institutional context appears to be particular not only in terms of the patients' opportunities of choice and access to the qualitative care, but of the way health professionals can influence their working conditions and exercise professional autonomy. The following section outlines the key issues, addressed in this research and proposes the structure of the thesis.

## **1.4 THE TOPICALITY OF THE RESEARCH AND THE STRUCTURE OF THE THESIS**

This study elaborates on the particular issue of professional agency in top-down led Russian healthcare. Medical practitioners in Russia frequently work as state employees with limited professional autonomy, and are consequently quite often described in the literature as state representatives with overwhelming bureaucratic responsibilities (Saks 2015). My research challenges this notion, and aims to identify the space for agency emerging under the current state reforms, allowing these professionals to somehow alter their routines, attitudes toward patients and approaches to maternity care. The following aspects of this research project contribute to its analytical and empirical topicality.

First, it fills a research gap in relation to the specific social context of remote Russian districts and its effects on the professional routines of medical personnel. On the one hand, such settings predetermine the heavy dependence of social services on state provision owing to the almost total lack of private organisations, and on the other, their remoteness brings greater informality and community-like relations into the daily routines of healthcare practitioners.

Second, the research is designed as a multiple case study and allows comparison of the differing limits to and opportunities for professional agency emerging in formally similar institutional settings. It reveals the diversity of medical approaches, doctor–patient relations, dispositions toward change and notions of professional commitment in practices by a formally homogeneous social group of practitioners providing maternity services.

Third, my research addresses the organisational context of healthcare practitioners' work to identify and analyse concrete examples of institutional work accomplished by the doctors, nurses and midwives. This scope allows the detection of micro-scale initiatives that shape the institutional field, which cannot be discerned, for example, from medical statistics reflecting macro-level processes. It is proposed that the context of perpetual social transformation, aligned with both statist and neoliberal logics, appears to constrain rather than stimulate professional agency at the macro level. Nevertheless, loopholes in the formal rules and newly-designed institutions, combined with informality, may be employed as tools for particular kinds of institutional work undertaken by healthcare practitioners.

Finally, the qualitative methods of in-depth interviews and participatory observation applied in this study provide an opportunity for closer examination of the healthcare professionals' perspectives and insights into micro-level initiatives and unintended consequences of the macro-level policies. In addition, reflection on the researcher's position during the fieldwork, and how it developed during the empirical work also gives rise to methodological insights.

The thesis is organised as follows. In Chapter 2 I examine the macro-structural context of the object of study, which is the institutional field of maternity care – how it has been shaped during the last decades, and which particular organisational forms have resulted in. In order to outline key specificities of the social settings of the investigated cases, the chapter builds up the wider structural context in which the obstetric institutional field in Russia has been transformed since 2006. I aim to reconstruct general, macro-level changes that have occurred in the field at structural, regulatory and financial levels, and to link these with both global and national political trends. The chapter builds up the succession of healthcare reforms in Russia since the Soviet collapse (stages, goals and mechanisms of reforms, and contradictions and controversies between them), and traces their ideological components. The chapter 2 also includes a description of how maternity services in Russia are organised nowadays, their institutional specificities, and the place of medical professionals in their current arrangement. In particular, I delineate the formal position of healthcare practitioners as simultaneously state employees and service providers, and how this position and their agency is shaped by the reformed institutional environment.

The research analyses this hybrid position of Russian healthcare practitioners in terms of both the ambivalent distribution of power in their relations with the state and with their patients, and the different logics of

regulation affecting the conditions and content of their work. In this way, the conceptual framework enables analysis of maternity healthcare services in Russia as an institutional field characterised by high symbolic significance and regulated by a set of rules, setting the social interactions within it at macro, organisational and micro levels. In order to investigate opportunities for professional agency in this field, Chapter 3 outlines the conceptual model of the research, elaborating the concept of institutional work as the key instrument of analysis. The theoretical framework attunes the neo-institutionalist approach in the sociology of professions and organisations to the context of healthcare services in post-Soviet Russia, and considers healthcare practitioners as agents of institutional change.

Chapter 4 introduces and discusses the research design and reflects on the researcher's position and role in the field. It details the qualitative methods used to collect and analyse the empirical data and, more specifically, introduces the qualitative multiple case study model for studying maternity services' potential institutional variability in different social contexts. It reflects on the method of in-depth semi-structured interviews as the most appropriate for investigation of healthcare practitioners' perspectives on how their work is organised, regulated and accomplished. In addition, problems linked with entry to the field and the researcher's position are considered as influencing both the amount and quality of data that can be collected. The chapter introduces four cases initially approached as research sites, describes the struggle for access, and explains why only two of these became major research settings. Later empirical parts of the thesis analyse the data collected from these two cases to address different aspects of the institutional transformation of maternity services in Russia, and the role of medical professionals within it.

Chapter 5 reveals the institutional changes that have affected the work of healthcare practitioners. Focusing on the provision, regulation and arrangement of maternity services, analysis of the health professionals' narratives provides evidence of aggravated working conditions in terms of a growing domination of managerial and market institutional logics. In particular, the research addresses the process of social restructuring from the perspective of the state employees, and the unintended consequences of reforms to the work of maternity facilities located in remote areas, at a distance from regional centres, in implementing state reforms.

Chapter 6 narrows the scope of analysis to healthcare practitioners' diverse positions toward different institutional logics competing in the field of maternity care. Particularly, it examines, how managerial, market and professional organisational principles shape medical practices and affect professional autonomy. The chapter also introduces the institutional logic of informality and analyses how it can be employed to manage the rivalry of all the other organising principles. In addition, the analysis of the empirical data allows revealing how these multiple logics are being converged on the

organisational level and in the professional practices of healthcare practitioners, producing various hybrid forms.

In order to investigate the conditions in which professional agency can be practices in the field of maternity services in Russia, Chapter 7 addresses organisational transformations and micro-scale changes which occurred in one of the cases under investigation over the course of a decade from 2007. Analysis of the empirical data provides evidence of considerable change at the organisational level. The case of 'stealthy innovators' exemplifies the substantial internal restructuring initiated by healthcare professionals in order to integrate a new, more patient-centred and family-friendly approach to childbirth. The narratives of midwives, doctors and administrators working in maternity facilities in a remote Russian town reconstruct a particular kind of institutional work accomplished by them in adopting new medical practices and modes of interaction with patients and their families. The chapter also includes analysis of structural conditions that limit opportunities for professional agency, since the maternity department investigated in this case has been closed.

The conclusion chapter 8 sums up the key findings of the research and proposes some policy recommendations, which could help to address the challenges for maternity care provision and professional agency, which emerge in the context of small-town Russia.

## 2 REFORMED MATERNITY CARE SERVICES IN RUSSIA

*Imagine you (your partner, close relative or friend) are pregnant or are just planning a pregnancy and are now puzzled about what will happen next. If we focus on the period between the decision to continue with the pregnancy and the necessity to take care of the newborn, childbirth is obviously a prime area of interest. Sooner or later you will figure out that there are different conditions (hospital or home childbirth, paid for or provided by health insurance, in an individual or shared delivery room, etc.), different formats (with a partner, with a doula or with a medical team on duty), and different methods of delivery (vertical, conservative, surgical, 'natural', with or without anaesthesia, and so on). If you are in Russia and live in a regional centre, you probably have some options; indeed, these depend considerably on the resources you possess.*

*Suppose you live at some distance from the regional centre. In this case, your options are considerably reduced. There is only one maternity department at the central hospital in your district, and if you do not have access to certain materials (a personal car at least) or social resources, you will have to give birth in this department. Now imagine there is no maternity department in your district at all, or that you live in a village, say 40 kilometres (or much more) from it. If birth is on term, you will probably just spend a few more days in a hospital, but in the case of urgent delivery, you will go by ambulance and rely on luck to reach a hospital in time.*

(Novkunskaia 2017)

This excerpt is from a text written and published two years ago for my colleagues and friends living in Russia to help them envisage the key aspects of the context in which I was conducting my research. The arts and media provide quite a few cultural representations of pregnancy and childbirth in different social contexts and historical periods, but there is definitely no single way to give birth, even in given social settings, and this multiplicity is difficult to describe in detail. However, details of the context are necessary to frame the key problem of the research, and to analyse how it shapes the experiences of pregnant women themselves and of the health practitioners responsible for their wellbeing and safety. Moreover, I consider that the key task of this chapter is not only to provide background information on the object of study, but also to present a preliminary analysis of how it is changing at the structural level of state reforms and the design of healthcare services. In particular, I focus here on the top-down approach to reforming and regulating maternity

services, because it gives premises and sets the rules of the game, how the street-level services are then arranged.

This chapter discusses the arrangement of and most significant and recent changes to maternity care services in Russia. Nowadays, the Russian system of maternity care is a complex of public, mainly state-funded facilities, assisting pregnant women, those in labour, and women and newborns during the postpartum period. Commercial gynaecological clinics are more widespread across the regions and in the centre–periphery dimension within it, and in general ‘private health care funding currently represents about a third of total Russian health funding’ (Shishkin 2018: 232). However, there are only a few private maternity hospitals, in Moscow, Saint Petersburg and four other large regional centres, and commercial maternity services are provided in informal or state-funded facilities (Temkina 2016).

The field of maternity care in Russia consists of both ambulatory services in antenatal clinics, and stationary services in hospitals’ gynaecological and maternity departments, independent maternity homes and perinatal centres. It is important to note that, by legislation, all forms of maternity care other than facility-based childbirth are prohibited for health practitioners. Although parents themselves can opt for home or alternative childbirth practices (Novkunskaia 2014), it is illegal for midwives and doctors to attend them (Borozdina 2014).

This chapter addresses both current arrangements for Russian maternity care services, in terms of their organisational structure, financing and logics of regulation, and how they have been reformed over recent decades. It starts by outlining the reforms that have shaped this field in the last decade. It then proceeds with a description of arrangements for maternity care services and the position of healthcare practitioners within it, and concludes with an analysis of these outcomes in the local context of small Russian towns. I aim to examine data on the design of maternity services in Russia, and how they are being changed by state reforms. Based on these data, subsequent chapters of the thesis will focus on particular dimensions of maternity care arrangements and the space for professional agency within them.

Childbirth generally appears to be closely related to the rhetoric and process of the nation’s and population’s reproduction, and is thus inevitably part of the symbolic and moral order involved in the political agenda (Chernova 2008; Zdravomyslova, Temkina 2011: 28-29). A key feature of post-Soviet demography was a quite considerable decrease in both natural population growth and childbirth rates (Vishnevsky 2012: 8-10). With a new, statist turn in public policy since the mid 2000s, this decline in population has become a core concern for the state, signalling the rise of the state’s pronatalist agenda (Cook 2011: 14; Rivkin-Fish 2010: 702). For instance, in his address to the Federal Assembly in 2006, President Putin described current demographic trends as ‘the most acute problem’ for the state, and declared that the development of maternity services in Russia thus deserved particular attention (President of Russia 2006). Almost every presidential annual

address since then has mentioned the topic, and several specific programmes and projects have been established to stimulate Russian families to have more children. Ideological and institutional initiatives under this pronatalist agenda since 2006 have consisted, in particular, of the introduction of so-called ‘maternity capital’, in the form of non-recurrent payments to mothers who give birth to a second or subsequent child (Borozdina et al. 2016), a ‘*childbirth voucher*’ programme (for more detail, see Section 2.3) and alterations to maternity care policy.

The state’s increased attention to the sphere of maternity care has given rise to quite frequent attempts to modernise and rearrange it in order to improve service quality and accessibility (Ministry of Health 2012). The current model of maternity care is thus a result of continuous and multi-stage reforms in Russia since the late 1980s, in healthcare in general and with regard to some features of midwifery and obstetrics in particular. In order to analyse how this field has been shaped, and the reasons for features that affect both women’s strategies to obtain desired services and healthcare practitioners’ opportunities to arrange it, the first subchapter examines the path of healthcare reforms in Russia. Subsequent sections, focusing on arrangements, financing and regulation of maternity care services, describe the field investigated and outline key institutional players inhabiting it.

In particular, this chapter demonstrates that the services are designed so that neither pregnant women themselves nor healthcare practitioners are expected to shape the arrangement of maternity care, whereas various state bodies, medical organisations, controlling institutions and funding bodies appear to be key decision makers in this field. Thus, the following analysis of the macro-structural level of maternity care addresses the state’s extensive control and the subordinate to the state position of health professionals and (pregnant) women in modern Russia.

## **2.1 PATH OF REFORMS AFFECTING THE WORK OF MATERNITY CARE SERVICES**

In this section, I investigate the timeline of state reforms and programmes that have occurred in recent decades and that have caused the most significant and appreciable changes to institutional arrangements for facility-based childbirth. The section describes the path of healthcare restructuring, and analyses key political trends manifested through the logic of change. It aims to provide evidence of the top-down, state-led nature of changes in the field of healthcare in Russia, and the relative rigidity of its institutional arrangements, which retains quite a few principles for the regulation and organisation of care inherited from the Soviet system.

The tendency of considerable transformation of the healthcare sector and professional work is a world-wide phenomenon (Currie, Spyridonidis 2016).



Under the influence of neoliberal policy, the dominance of managerialism and market principles of regulation and financing are recognised by social scholars as common trends in healthcare worldwide (Martin et al. 2015: 378). In particular international researches demonstrate how New Public Management reforms lead to the formation of different 'hybrid' forms of public sector in terms of creation of quasi markets and executive agencies with more private income (Denis et al. 2015: 273). This literature suggests that recent public services reforms blur boundaries between previously distinct private-public bodies and broaden mix of values, logics, and organizing principles in public healthcare (ibid.: 274). However, the absence of historically autonomous professional bodies (Brown 1987) and the domination of the state regulation of the field of healthcare, make the case of Russian maternity care and its transformation quite specific.

Another specificity of the further elaborated path of the reform of maternity care in Russia is its starting point – which is so-called *Semashko* system of healthcare, established and performed during the Soviet period. The Semashko system – a model of healthcare organisation introduced by Nikolai Semashko, the first Minister of Health in the USSR, aimed to provide universal access to care, and was characterised by the domination of state-funded medical facilities, salaried health workers and extensive governmental administration (Sheiman et al. 2018: 209). It was built as a multilevel system with rural, district, city, regional and federal hospitals, supplemented with numerous specialty care facilities, coordinated through a referral system from one level to another (Sheiman, Shevski 2014:130). As the other spheres – under the omnipotent Soviet state – healthcare is recognised as one of the most centralized in terms of regulation and provision (Yonger 2016: 1086).

Researchers, who examined the healthcare in Hungary described Semashko system as the one, which 'assumed a virtually exclusive role for the state in financing and service delivery' (Gaal, McKee 2004: 171). In addition, the scholars emphasised that such a model 'left little room for the public's voice to be heard. The channels of voice were strictly controlled, and complaints were regarded as an assault against the ruling regime' (ibid.). This is analysed as a condition which favours the emergence of informal payments, as the only way to overcome institutional rigidity. As a result, at the dawn of the Soviet era the health system was characterised by lack of modern equipment drugs, and disposable items, overcrowded wards, and scarce conveniences available in hospitals (Paton 1989: 45). Social scientists criticised the Soviet healthcare for its 'lack of incentives, distorted structure of skewed inpatient care, predominance of administration over management, and a desire to promote integration through central administrative instruments' (Yonger 2016: 1086). Thus, 'perestroika' started as a political process initiated the change of healthcare as well.

Significant changes to the arrangement of maternity services began in the late 1980s, in the frame of the more general process of '*Perestroika*'. In particular, from 1988 a project to rearrange obstetrics was discussed, aiming

to introduce a new system around the principle of ‘perinatal risk’ (Starodubov, Suhanova 2012). This presupposed the opening of perinatal centres targeted to assist with complicated and pathological cases, and the assignment of all maternity services to one of three levels. However, in the early 1990s, realisation of this programme was suspended owing to a lack of economic provision and the politically unstable situation in the country.

During the 1990s, after the Perestroika period, a political situation characterised by considerable changes and transformations gave rise to particular aspects of the arrangement and regulation of obstetrics. Substantial commercialisation of healthcare services occurred during this period, with the emergence of private clinics and paid-for services within budgetary organisations (Borozdina 2014). Management of this sphere became palpably more liberal, particularly in the regionalisation of its financing and regulation (Rivkin-Fish 2005). In general, the institutional transformation of this period was carried out through the processes of ‘chaotic privatization and decentralization of the welfare responsibilities’ (Jäppinen et al. 2011: 2-3).

As other scholars emphasized, the key directions of restructuring during this period referred or to the process of *liberalisation* either to *internationalisation of healthcare services*. Particularly, the economic liberalisation was realized through the health financing reforms and the introduction of a *Mandatory Health Insurance* (MHI) model in 1993 (Younger 2016: 1087) (for more details, see subchapter 2.3 on financing of healthcare in Russia). This model was introduced as a market mechanism, by design decreasing the state regulation of healthcare sector, which in many ways failed to compensate for the key imperfections of healthcare provision (Twigg 1998). At the same time, the state itself forced the process of internalization in particular – through the participation in various international programs and collaboration with international organisations.

With support from the World Health Organization (WHO) and Unicef, a new federal programme of ‘safe motherhood’ was initiated and later extended (1995–1997, 1998–2000, 2000–2001). Initiatives within this programme included reorientation of some maternity homes to the ‘Baby-friendly Hospital Initiative’, the opening of family planning centres in the regions, and consultations concerning contraception and prevention of abortion. However, owing to the decentralised regulation of these initiatives and their uneven financing across the regions (they received 80 per cent of their financing through regional budgets), the development of maternity services was patchy.

As a result of the welfare transformation during the 1990s, the quality and accessibility of Russian social services in general, and health services in particular, became extremely uneven. This fragmentation generated new types of social inequality that, however, were not always appreciated at the federal level (Cook 2017: 13), and new regional disparities in the accessibility and quality of healthcare services emerged (Shuvalova et al. 2015; Shishkin et al, 2017: 9). In order to address these challenges, the state initiated a new set of

the reforms at the turn of the century, denoted by social scholars as *the statist turn in Russian welfare policy*.

Since 2006, the state's political course has changed from a liberal to a more 'statist' one (Cook 2011), and the state has started to explicitly declare and strengthen its responsibility for public health and health services' improvement. In 2006 a Foreground National Project on 'Health' was initiated, which brought increased funding to the sphere of reproductive health services. Through the so called '*childbirth voucher*' system, the material and technical conditions of maternity services were developed, health practitioners' salaries were increased, and better provision of medicines was accomplished (for more details see subchapter 2.3). This system also allowed pregnant women to choose which doctors to consult with and in which organisations to give birth (Borozdina, Titaev 2011).

During this period, the Russian Ministry of Health implemented a model of 'routing' pregnant women in each region of the country. This model inherited the principle of 'risk-oriented' maternity services adopted in the Soviet Union at the end of the 1980s. Its measures entailed the division of all maternity hospitals and departments into a three-level system according to the services provided to assist with defined risks, complications and pathologies during pregnancy, labour and the postpartum period (Ministry of Health 2009). However, this initiative did not change the obstetrics system considerably, since FAPs (feldsher-midwifery stations – medical facilities providing only paramedical services, located in villages and rural areas) were initially assigned first-level status.

At the beginning of the 2010s, a new programme of '*modernisation*' was initiated, realised through regional programmes between 2011 and 2013 to fulfil three main goals: to improve the material and technical base of healthcare facilities, to implement information systems, and to introduce standards for medical care. These measures were formally aimed at the technological development of social and medical care in Russia, and in practice were realised through additional state subsidies given to public institutions to purchase new equipment and increase public employees' salaries. Within the framework of this programme, intensive construction of regional and federal perinatal centres continued (Government 2013), as the most technically developed institutions assisting with pregnancy and childbirth. Since then, the technological development of maternity services has advanced through the opening of perinatal centres (61 perinatal centres were opened by 2015; Ministry of Health 2015), the introduction of new medical standards, and an orientation toward a more evidence-based approach, at least at the level of professional and official discourses<sup>1</sup>.

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<sup>1</sup> See, for example, a conference entitled 'Evidence-based medicine: achievements and barriers' (2015) in which the Russian Ministry of Health participated (<https://www.rosminzdrav.ru/events/2015/12/07/568-konferentsiya-dokazatel'naya-meditsina-dostizheniya-i-bariery>).

In addition, in 2011, standards for healthcare and registration of the terms and weights of newborns were changed (Ministry of Health 2011). On the one hand, these measures allowed statistically mark the increase in the birth rates across the regions, but on the other, the working conditions of healthcare practitioners became more complicated and challenging. According to Starodubov and Suhanova (2013), ‘the birth rate is being raised, but the number of obstetrics and gynaecological beds is decreasing – the intensity of their exploitation grows, leading to the worsening of the situation in the childbirth facilities in conditions of the new maternity care’s functioning’, and ‘The dynamics of personnel maintenance in the maternity care services appear to be adverse as well – during 2012, the number of obstetrician-gynaecologists and their sufficiency shrank’ (ibid.). Thus, formal goals of the welfare and healthcare reforms in some dimensions resulted in deterioration of the services provision and professionals’ work condition. Some further stages of the health care restructuring proceeded the same path of *the hidden neoliberalisation of welfare*.

In 2012, two significant changes occurred in the regulation and financing of the obstetrics system. The first was an update to the ‘routing of pregnant women’ (‘marshrutizatsia’) scheme (Ministry of Health 2012), which clarified the level of maternity care services and led to their considerable reduction in some cases. Decree № 572n specified rules on pregnant women’s hospitalisation, depending on the risk of complications and pathologies linked with pregnancy or childbirth and defined in the process of ‘pregnancy monitoring’. Thus, definitely risky cases are directed to a facility equipped to assist with definite pathology, illness or complication, each of which has different equipment and personnel, provides different services, and receives different levels of financing, defined not by the complication of the case but by the level of the institution (for details, see Section 2.2).

In the same year, the so-called Presidential May decrees<sup>2</sup> were implemented, aimed at improving the quality and accessibility of healthcare services and increasing health practitioners’ salaries. However, in practice, owing to a lack of regional financing, fulfilment of the May decrees’ goals led to a considerable reduction in both hospital beds and medical personnel. Importantly, ‘the cutback of beds for newborns, pregnant and labouring women happens predominantly at the expense of the smallest facilities, located in the most remote areas’ (Starodubov, Suhanova 2013: 27). Considerable reductions in services, personnel and hospital capacity occurred in the most distant and economically deprived healthcare institutions, in some cases in the form of the complete liquidation of maternity departments (first-level institutions) in district hospitals (Barkovskaya et al. 2013).

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<sup>2</sup> Some programs and political measures, aimed at the improvement of the quality of state services and betterment of working conditions of the state-employees, initiated by the President Putin after his inauguration in May 2012.

The tendency to reduce maternity care in peripheral areas is not Russia-specific; there is evidence of the same process in other contexts as well (McCourt et al. 2016). However, what appears to be quite particular to Russia is the size of the regions and the quality of the healthcare infrastructure. The quality of roads in rural areas and of medical transport in the regions leaves much to be desired. Such conditions also cause appreciable difficulties for the hospitalisation of pregnant women and women in labour who have low levels of prenatal risks. While women with complications and pathologies are hospitalised in advance in the better equipped hospitals, all other patients are referred to first- and second-level facilities, which are less equipped and have experienced more cuts. Hence, reducing beds in first- and second-level facilities seems to be both illogical and adverse, since it leads to worsened accessibility to urgent maternity care services (Starodubov, Suhanova 2013: 27; Kochkina et al. 2015).

Another important institutional rearrangement in recent years has been the modernisation of the Mandatory Health Insurance system (MHI), which occurred between 2011 and 2015 (Federal Law 2010). In particular, in 2015 all public healthcare organisations shifted to single-channel financing, which means that the MHI is now the only provider of financing for healthcare institutions, having previously been supplemented by budgetary subsidies (Shishkin et al. 2015; Shuvalova et al. 2015). In some cases, this has led to insufficient financing, since insurance tariffs are set not according to economic analysis and a rationale for necessary costs, but by the size of the previous year's financing. As a consequence, the actual cost of curing the same illness in different regions and in different institutions varies considerably. The system has produced neither an informational nor a methodical basis for reliably evaluating acceptable differences in the costs of realised programmes (Shishkin et al. 2016: 51).

As analytical report by the Levada center demonstrates (2016), 'Modernisation' of healthcare coupled with the process of standardisation and shift to the one-channel financing have caused some unintended outcomes in terms of cutbacks in financing and number of healthcare workers. As well as have amplified institutional tensions between consumers' demands and expectations, state provision of healthcare, and health professional' capability to navigate between them (Levada-center 2016: 4). Both, patients and healthcare practitioners in Russia evaluate negatively the results of all these reforms, in particular, they complain that it have caused deterioration of healthcare financing, increase in medical practitioners' workload, cutbacks of facilities and personnel, and some others (Levada-center 2016: 23, 26).

Healthcare managers and experts also evaluate the results of the recent reforms quite pessimistically – in particular, they argue that 'reforms aimed at improving healthcare effectiveness, strengthening its infrastructure, improving conditions of the patient stay in medical organizations, improving quality of medical care, and improving health of the population have failed to achieve the targets' (Rugol' et al. 2018: 2). Hence, it is evident that the reform

of maternity services in Russia has been subject to the main logics of social restructuring since Perestroika. Liberal changes during the 1990s proceeded with the commercialisation of services, when maternity services became an important part of the healthcare market. During this period, the Russian public welfare sector suffered not only economic decline, but also a process of 'shadow commercialisation' (Cook 2014; Shishkin 2003).

Later, the system was subject to the 'statist' turn in state welfare policy, meaning an increase in the state's role in regulating and financing the sphere. Maternity services, in particular, became an important focus of state attention, since this field is symbolically intertwined with notions of demography and the nation's reproduction. However, the field of maternity care did not simply reflect the main logics of state policy during this period, but also exhibited internal controversies and logical inconsistencies in the reform. Analysis of the practical consequences of the state reforms, including the formally 'statist' reform, reveals a tendency toward profound neoliberalisation, particularly relating to public service cutbacks and implementation of a market logic.

Consequently, all stages of the reforms to maternity services have caused controversy in practice. On the one hand, maternity care is being improved technologically, the range of services is broadening and the qualifications of medical personnel are improving in third-level institutions (perinatal centres and large maternity homes) located predominantly in the regional centres. On the other hand, in remote areas, for pregnant women with no complications, access to childbirth facilities is being hampered: they must either give birth in institutions providing a narrow range of services with no scope for choice, or travel long distances to reach alternative facilities.

Moreover, for healthcare practitioners themselves, working conditions have changed, and formal and informal rules for professional practice have become more complicated. In practice, reductions in the number of hospital beds and personnel, determined statistically (Ministry of Health 2015), mean increased workloads for doctors, midwives and nurses. Such contradictions between formally articulated policy goals and actual outcomes confirm Kulmala et al.'s (2014: 540) finding that 'federal policies that appear at first glance to be neoliberal or statist might actually function through very different logics locally'.

As a result of all the reform stages described in this section, the current structure of maternity services has changed since the Soviet model, although it still exhibits some aspects of it (Shuvalova et al. 2015). In particular, health professionals still suffer a considerable bureaucratic burden (Barskova et al. 2018; Levada-Center 2016; Romanov, Yarskaya-Smirnova 2011) and the healthcare system in general is still centrally regulated, not through a professional association but through state institutions headed by the Ministry of Health. The further subchapters address in details the way maternity services are organised, regulated and financed nowadays.

## 2.2 ORGANISATIONAL STRUCTURE OF MATERNITY CARE SERVICES IN RUSSIA

By law, childbirth in Russia can take place only in specialist facilities such as independent perinatal centres, maternity homes or the maternity wards of hospitals. Any patient (pregnant woman) can refuse to be hospitalised and may opt, for example, for a homebirth (Federal Law 2011), but it appears to be a criminal act for any healthcare practitioner to attend such births. Hence, institutionally, the model of maternity care does not recognise or regulate any alternative forms of childbirth, and delineates only medically-assisted and hospital-based services.

There are several structural divisions in the field of maternity care: between ambulatory and stationary services and between different levels of care. Thus, multiple practitioners appear to be responsible for the health of a mother and a newborn. For example, a pregnant woman must consult multiple practitioners during her pregnancy and labour: an obstetrician-gynaecologist and a midwife in the antenatal clinic regularly monitor her pregnancy, while various practitioners in the maternity facility assist her in labour and during the postpartum period. Moreover, there is a considerable institutional gap in coordinating the work of these practitioners, who not only use dissimilar diagnostics and equipment, but also practice different approaches to reproductive healthcare (Shubina, Makarova 2016). As a result, these branches appear to be uncoordinated, or even provide conflicting views on the same problems or aspects of gestation. In addition, within the same maternity facility, medical practitioners in different departments and units, despite formally having the same profile, quite often practise different approaches to childbirth.

Another important organisational feature of maternity services arrangements in Russia, is how different facilities within each region coordinate with each other. The general trend in the Russian healthcare system is to establish a three-level model (municipal, inter-municipal and regional levels). This is accompanied by the formation of inter-municipal centres with specific profiles, and the elaboration of patient *routing* schemes (Shishkin et al. 2016; Shuvalova et al. 2015). In particular, routing of pregnant women within the regional system of maternity care is regulated by Russian Ministry of Health Law № 572n '*On the order of rendering of medical aid according to the "obstetrics and gynaecology" specialty*', effective from 1 November 2012.

According to this order, doctors in antenatal clinics must channel pregnant women to an appropriate stationary obstetric facility after considering the estimated risk of complications arising during pregnancy and labour (Ministry of Health 2012). Prior to this order, healthcare practitioners themselves, in most cases informally, coordinated the hospitalisation of pregnant women within a region. Following the implementation of the order in 2012, such schemes were formalised and institutionalised and referred to as the '*routing*

*law*'. As a result, since 2012 maternity care has adopted the three-level system of medical facilities, which provide different services, have different equipment and receive different financing (with a fixed price for services at each level) in accordance with their assigned status:

*First-level facilities* comprise basic, low-capacity obstetric wards (less than 30 beds, accommodating less than 500 births per year), equipped to assist with low-risk childbirths without complications during gestation. These are usually maternity wards (2–4 obstetrician-gynaecologists and 4–6 midwives) in central district hospitals in remote areas of a region.

*Second-level facilities* provide maternity care to patients with moderate risk of complications during pregnancy, labour and the postpartum period. These are usually maternity wards in central between-district hospitals located in medium-sized and large cities, and wards in city hospitals or independent maternity homes, accommodating more than 500 births per year and equipped with intensive care and resuscitation units.

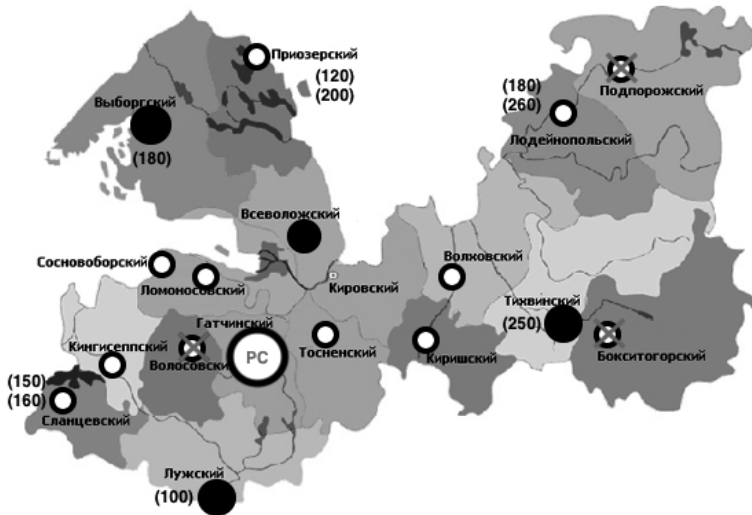
*Third-level maternity hospitals and perinatal centres* are medical organisations that ensure life-saving interventions for mothers and newborns. Women with high-risk pregnancies are admitted to such facilities, which are equipped with advanced technologies and highly skilled personnel. These are usually independent maternity homes, research institutes or perinatal centres providing high-tech services, providing the only such care in each regional centre.

The routing itself as the process of transportation of pregnant women with complications between different levels of maternity care is being realised through the particular health service called '*sanaviation*' (literary '*sanitary aviation*'). The key tasks of this service are to either transport qualified specialists (depending on the type of complication and urgency) to remote area, where a pregnant/labouring woman or a newborn requires special care, operation or medication, absent on this level, or to evacuate a patient to the more equipped hospital or center. Although in some extreme cases *sanaviation* is realised with aircraft, usually it works as an ambulance care, equipped with resuscitation hardware. Such a service is based in a central regional hospital that can be used for routing patients in critical condition, for example, with an artificial respiration apparatus.





The routing model as a whole forms the basis for the development of perinatal services, which also appear to be an important part of the state's modernisation programme. In particular, the Russian government's Decree № 2302-p, of 9 December 2013, introduced a programme for the development of perinatal centres, entailing the construction of 32 new perinatal centres in 30 regions (Government 2013). This has led to a concentration of women with high prenatal risks in regional centres, and has reduced the rates of maternal and infant mortality (Shuvalova et al. 2017). However, second- and first-level maternity facilities still provide the largest capacity in terms of the number of beds, and the majority of childbirths (59.6% in second-level and 19.4% in first-level institutions; Ministry of Health 2015). This means that, although



maternity care services are becoming more technologised and developed, owing to the centralisation of facilities most pregnant women still give birth at a distance from the regional centres, and hence receive less advanced care.



**Figure 1** The organization of different level maternity care services in Leningradskaya Oblast'

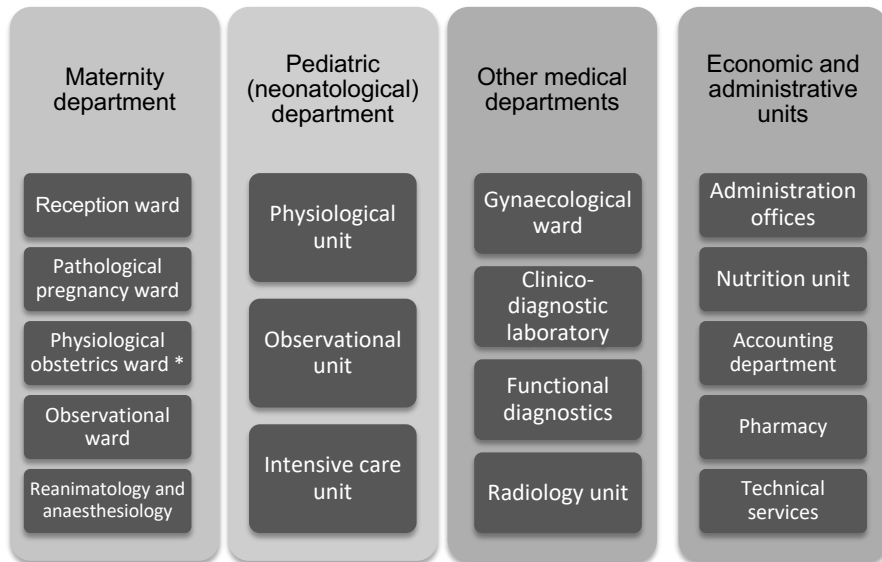
-  The third level of maternity care (maternity hospital/perinatal center)
-  The second level of maternity care (maternity hospital/department of a Hospital)
-  The first level of maternity care (maternity department of a Central District Hospital)
-  Recently closed maternity facility (after 2012)
- (100)** The distance in kilometers from the facility to the next level/s of maternity care

As an example, the figure 1 illustrates the organisation of different levels of maternity services in Leningradskaya oblast' (square footage of the region is around 84 500 km<sup>2</sup>). It demonstrates that remote areas of a region are poorly covered with maternity services, while the distance between districts can be quite considerable. Importantly, the new model of maternity care services does not take account of the system of FAPs. Since the Soviet Semashko model, these facilities used to provide healthcare in the most remote areas and villages. In recent years, the number of FAPs has reduced, and in some cases they have been substituted with 'mobile FAPs' providing only emergency maternity services (when sanaviation is not available, for example) and monthly gynaecological consultations.

Reductions in units, services and personnel in remote areas occur because modernising reforms, such as implementing the 'routing' scheme in regional maternity services, often fail to consider the quality of infrastructure and transportation in peripheral areas, especially during winter, and the distance

between settlements (Barkovskaya et al. 2013: 5). It is worth noting here that maternity wards in small towns also provide maternity services to the rural population, which means that medical professionals are responsible for transporting women from remote villages. At the same time, this population is characterised by a much higher level of fertility than among urban women (Zakharov, Surkov 2009), while levels of maternal mortality in rural areas are higher than in urban areas (Starodubov, Suhanova 2012: 83).

As a result, maternity facilities in Russia are highly heterogeneous, and the development of rural healthcare services is generally much slower. Improvements to maternity services are generally carried out by developing third-level maternity facilities' indicators of maternal and infant mortality. However, hospitalisations in perinatal centres are supposed to happen only as planned occurrences, while in practice some emergency childbirths with complications are taken on by first- and second-level facilities. Reducing their capacity therefore gives rise to new risks (Starodubov, Suhanova 2012: 267).



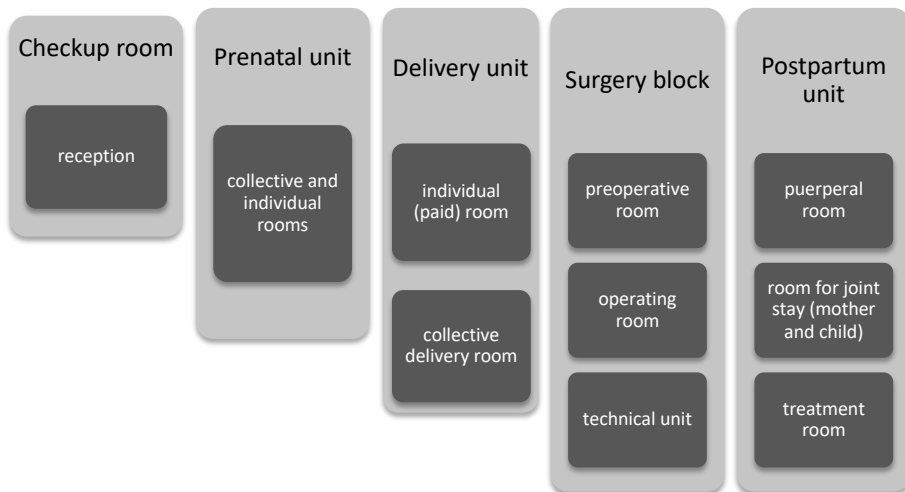
**Figure 2** Organisational structure of a maternity care facility (hospital as an example)<sup>3</sup>

The coordination of maternity services appears to be even more complicated, considering the range of medical specialists, including neonatologists and child nurses, as well as anaesthesiologists, operational nurses and specialists in case of complication, who by law must attend any delivery (Ministry of Health 2012). Figure 2 outlines the entire organisational structure of a

<sup>3</sup> All schemes and figures used in this thesis are constructed by me, based on open data from state orders, laws and regulations.

maternity care facility, although small facilities may lack some features, and large perinatal centres may be even more complex.

This figure is built up to illustrate organisational complexity of any maternity care facility, although depending on the size and specialization of a hospital, center or ward, they could be named differently and can take various configurations. However, according to the order 572n by the Ministry of Health (2012), such a division is considered to be a minimum for the work of any maternity facility and lack of some units can lead to its reorganisation or even closure. There are different amount of working health specialists and available beds in each of the unit on different levels if maternity care. For example, in first-level facilities there could be only two or three obstetrician-gynecologists, working in all the wards of a maternity department, while there could be more than five ones, working only in a physiological ward of a perinatal center.



**Figure 3** Arrangement of a physiological obstetrics ward

The organisational structure of maternity facilities appears to be even more complicated if we look in detail at how a physiological obstetrics ward (marked with an asterisk in Figure 2) is usually organised. It consists of several units, between which pregnant and labouring woman navigate depending on their stage of labour, in most cases dealing with different specialists at each stage (see Figure 3). This multiplicity of healthcare practitioners monitoring the same pregnancy gives rise to a situation of fragmented maternity care, where the continuity of care recommended by evidence-based research and leading international organisations (Sandall et al. 2016; WHO 2018) is hindered or even impossible (Novkunskaia 2019).

The figures 2 and 3 illustrate not only the complexity of the maternity facility, but also the attitude toward women’s reproductive experience in

general. Social scientists investigating this issue define the Russian context of social and medical services dealing with women's bodies and childbirth as considerably medicalised (Temkina 2014). This gives rise to at least two important features. First, the medical profession of obstetrician-gynaecologists (doctors) has more power and authority than the professional group of midwives (Borozdina 2014) in terms of decision making in the medical context. This means that, by law, a midwife cannot single-handedly monitor or assist with any childbirth, including physiological care (Ministry of Health 2012), as almost without exception an obstetrician-gynaecologist, a midwife and a neonatologist must attend a delivery. Second, medicalisation manifests itself in rules governing pregnancy monitoring. The Ministry of Health (2012) prescribes, as a minimum for physiological pregnancy care, no fewer than seven obstetrician-gynaecologist appointments, two general practitioner consultations, two dental check-ups, one ophthalmological and one otorhinolaryngological appointment. In addition, pregnant women must have ultrasound diagnostics, and HIV, syphilis and hepatitis tests every trimester.

To sum up, the organisational structure of maternity care in Russia is characterised by several key features. It, firstly, develops on the way of more technologisation and medicalisation, at the risk-oriented model at the core. Secondly, it represents quite centralised system of care, with uneven quality and accessibility of maternity services across a region, especially in centre-periphery dimension (Panova 2019: 178). Thirdly, organisation of maternity care in Russia appears to be quite complex with multiple levels of specialisation and multiple health providers working on them. To supplement this analysis with more details on the arrangement of the field investigated, the next subchapter addresses the way it is financed.

## **2.3 FINANCING OF MATERNITY CARE SERVICES**

Maternity services in Russia are predominantly public services, which means there are only a few private maternity clinics, located in megapolises (two in Saint Petersburg, a few in Moscow and one in each of Novosibirsk, Ufa, Samara and Ekaterinburg). There are quite commonly paid-for services in public maternity care institutions within regional centres, which form a specific maternity care quasi-market (Temkina 2016, 2017). Prices in these organisations are not fixed but are set randomly. However, private (mainly antenatal and gynaecological) clinics are less widespread in remote areas and small towns. Where any such facilities exist outside the regional centres, they provide a narrow range of services and cannot assist with childbirth. It is important to mention that, unlike some other social services provided by non-commercial organisations (Kulmala 2011; Kay 2011), no prominent non-governmental and non-commercial organisations provide medical or social care for pregnant women in the Russian regions.

My research project focuses on public-sector maternity care, which is the most common form across the country and is financed in a similar way, regulated by federal laws. Therefore, in order to describe the financing of these services in Russia, this section outlines some general schemes for the material provision of healthcare services, delineates key problems in the existing model of provision, and highlights some key aspects of maternity services' financing.

Healthcare services are generally financed through the single-channel MHI, a supplementary system of healthcare funding to which employers contribute for employees' health insurance. The system was founded in 1993 as a supplement to the state's subsidies for medical services, and until 2015 the system of financing was mixed. For example, in 2015, mandatory health insurance comprised 54 per cent of public resources for healthcare services, while 46 per cent was provided from state budgetary funding (Shishkin 2018: 233). However, overall public funding for healthcare amounts to only half as much as in EU countries, and in 2014 expenditure on healthcare amounted to only 3.7 per cent of GDP (Shishkin et al. 2017: 8).

Four main social actors define how and how much of this expenditure is spent: healthcare regulatory committees (The Ministry of Health and its departments), MHI funds (federal and regional), medical insurance companies (in some cases, intermediaries between MHI and hospitals or clinics) and managers of public healthcare services. Thus, despite the restricted economic provisions, the forms of expenditure on healthcare facilities are quite varied. Moreover, different models of financing are used for different segments of medicine. For example, ambulatory care services (particularly antenatal) are financed according to a 'per capita' principle, i.e. organisations receive money for the number of patients 'attached' to them, and only if they fulfil efficiency indicators. In contrast, hospitals and in-patient clinics are financed for each completed case of treatment or therapy, classified according to clinic-statistical groups (Shishkin et al. 2017: 9).

Other forms of healthcare financing include voluntary medical insurance (DMS), public-private partnerships (generally very limited and less developed in Russia) and out-of-pocket patients' payments. As some scholars highlight, there is an increase over the past fifteen years of health care expenses, not covered by the MHI among the Russian population (Panova 2019: 188). However, use of each of these in the context of modernised Russian healthcare services is restricted in various ways. For example, only six per cent of the population can afford voluntary medical insurance (DMS), and this form of payment appears to be unavailable to the majority of the middle class (Shishkin et al. 2017: 8).

At the same time, quite a few people prefer to make informal payments (especially for stationary care) directly to medical practitioners, and through medical institutions or other mediators such as insurance companies. In particular, there are various forms in which informal financing occurs: patients can give the money as a 'thank' to the already provided service, or in advance both, according the fixed 'price list' or 'as much as they can afford'.

There are also some cases, when healthcare practitioners ask a patient to pay additionally, i.e. to give a bribe for more qualitative care (Chirikova et al. 2002: 123). However, the proportion of individual payments for ambulatory services appears to have increased between 1994 (4%) and 2012 (14.7%), but then reduced, and in 2015, 87 per cent of the population was receiving only free outpatient consultations provided through MHI (Shishkin et al. 2016: 20). Such specificity of healthcare financing is considered to be one of the key features of the post-socialist societies, which experience considerable transformation of all types of social institutions (Gordeev et al. 2013; Habibov 2016; Stepurko et al. 2015).

All these forms of payment or their combination (including formal fees and official charges) are quite widespread in the field of reproductive health services, as symbolically linked with notions of risk and gender identity (Temkina 2016). For example, mothers-to-be who prefer to give birth with a partner, to have an individual delivery room or to meet the healthcare practitioner assisting them in advance can pay for all these options both formally and informally. This quasi-market for maternity services is much more developed in large cities and regional centres, but may be absent from small Russian towns. Paid-for services can be established formally within facilities for first- and second-level maternity care, but quite often are not available.

Several important problems are evident in financial provisions for healthcare services in Russia. The main issue, identified by both patients and medical practitioners, is the insufficiency of financing in terms of a considerable gap between the state's guarantee of free medical care and its actual provision (Shishkin et al. 2017; Levada-center 2016). As already mentioned, healthcare's share of GDP is quite modest in comparison with other countries' expenditure in this sphere. In Russia it is further exacerbated by regional inequalities: 'due to insufficient financing of healthcare, there are considerable differences in the chances of getting qualitative medical care for residents in different regions and different types of settlement' (Shishkin et al. 2017: 8; Shishkin 2018: 234). In addition, regional heterogeneity is aggravated by the way in which prices or tariffs for medical services are set in each case, with reference to previous expenditure rather than to a hospital or clinic's actual needs (ibid.: 9).

Some efforts to improve this system have actually caused additional complications for medical work. For example, new rules within MHI regulations were introduced to stimulate private medical insurance companies to expend funds more effectively. This unexpectedly caused an increase in the penalties imposed on healthcare institutions for mistakes in the preparation of financial and medical documents (ibid.: 10). Thus, medical organisations have received much less money, even though during the financial crisis their actual costs have grown. In addition, healthcare financing has been reduced owing to shifts in budgetary priorities. In 2013, the rise in state expenditure on healthcare was halted, and subsequently, under conditions of economic

crisis, budgetary income fell, worsening public financing in general. State expenditure on healthcare decreased in 2014 by 1.0 per cent in real terms, and in 2015 by 2.9 per cent (Shishkin et al. 2017: 13). This was aggravated by the mechanism for raising funding implied by the new programme: “1/3 of assets were supposed to be attracted at the expense of intra-industry reserves. This has led to simplified services restructuring, not through the substitution of one service by another, but through a reduction in beds, personnel and facilities, causing inevitable deterioration in the quality and accessibility of healthcare and intensive development of paid medical services’ (ibid.: 23).

Another feature of healthcare services provision in Russia is that it is often linked with non-recurrent federal or regional transfers that are not subsequently extended. For example, since 2006 there has been considerable investment in the framework of the National Foreground Project on ‘Health’ within the ‘healthcare modernisation’ programme (2011–2013). In particular, ‘modernisation’ has implied additional financing in three main areas: development of the material and technical base of medical services; the introduction of information systems; and the implementation of medical care standards. However, according to some experts, technical innovations and equipment purchased within the modernisation programme have not been used as intended owing to a lack of professional qualifications. Moreover, some technical innovations have become out-of-date or need additional maintenance, for which there are no resources (Shishkin et al. 2016: 13).

The scheme for calculating health practitioners’ salaries and wages consists of three parts: 1) basic salary, 2) compensatory payments for special working conditions, overtime or night work, and 3) payments such as bonuses intended to stimulate the intensity, quality, results, length or continuity of work. In this regard, the modernisation programme has introduced a new method of salary calculation – the so called ‘*effectiveness contract*’ – which presupposes a specific form of labour agreement. In particular, the stimulatory part of salaries depends directly on concrete indicators and criteria for the effectiveness, amount and quality of public services provided. In practice, as health practitioners state, the implementation of ‘effectiveness contracts’ has led to increased workloads disproportionate to actual rises in salary, causing additional tensions in this sphere (ibid.: 18).

Some aspects of maternity care service financing arise from its status as a symbolically significant sphere linked with notions of reproduction and nation building. Thus, in 2006 the system of ‘childbirth vouchers’ was introduced as an additional source to fund improvements to medical equipment and health professionals’ salaries. This system was supposed to bring financial transfers to antenatal clinics, maternity wards or homes, and children’s outpatient clinics for each case of childbirth (Borozdina 2010). The program is financed in the same way that any other health service – through the MHI regional funds, however, it realises the principle ‘money follow a patient’ and allows women officially chose an obstetrician-gynaecologist for antenatal care, as well as a maternity facility to give birth in. This program represents a three-part

voucher, given to a woman on the 36 weeks of gestation (or earlier if there is a need of hospitalisation in advance) in the antenatal clinic, which keeps the first part of certificate. The second part of the voucher goes to a maternity ward or hospital, to which a woman comes to deliver, and the third part – to a children polyclinic to cover the costs for the infant care during a year.

Some additional efforts were required to develop the provision of maternity care within the frameworks of the two federal projects ('Health' and 'modernisation') between 2008 and 2012, 23 perinatal centres were built, and 32 more were under construction (Shishkin et al. 2017: 13). Another important aspect of maternity service financing for the following analysis are fixed payments for each birth, depending not on the level of complication (natural or caesarean birth), but on the level of the childbirth facility assisting in each case. However, as mentioned above, in spite of all the measures taken to improve the quality of healthcare in Russia, health practitioners, managers and experts still negatively evaluate the sufficiency and allocation of its financing (Levada-center 2016; Rugol' et al. 2018).

As other researchers argue, medicine all over the world is being challenged from different sides: from a public, more prone to question and to complain, from social movement groups contesting the medicalisation, and from governments, which reduces health care budgets and introduce the principle of efficiency in public-sector spending (Davies 2006: 138). Besides, the state affects the healthcare arrangement and provision not only in terms of financing, but through the regulatory framework, shaping its design, as well. The next subchapter examines in details, how healthcare in general and maternity care in particular is being coordinated and controlled in Russia.

## **2.4 REGULATORY FRAMEWORK OF MATERNITY CARE IN RUSSIA**

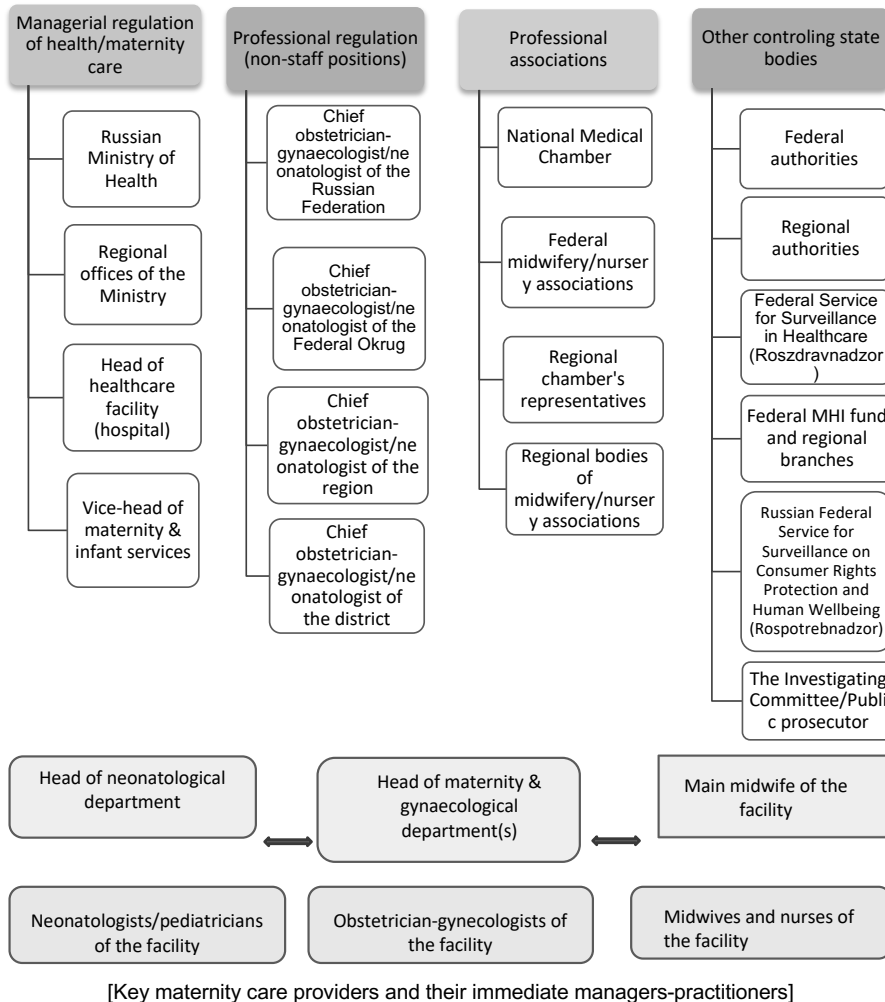
Previous studies have shown that, introducing or reinforcing market mechanisms in healthcare systems is often accompanied by expanded managerial control (Kuhlmann, Annandale 2012: 401). Although the reforms introduced following the Soviet collapse (in both the 1990s and 2000s) aimed to overcome problems associated with the Semashko healthcare model, including overwhelming administrative regulation, some of that system's features remain institutionally intact (Barskova et al. 2018). Among the most obvious continuity is that Russian medical institutions still retain the structure and arrangement of the Soviet healthcare system, with its strong hierarchical relations, and a bureaucratised logic of organisation that controls professional regulation (Saks 2015; Borozdina 2010, 2014; Troitskaya 2009: 173). In this sense, contemporary state healthcare services in general, and reproductive services in particular, are still centrally regulated and substantially bureaucratised (Nikolaev 2015; Barskova et al. 2018).



The complicated logic of institutional regulation is also replicated in other social interactions, particularly in relations between doctors and their patients. Rivkin-Fish (2005: 74) defines these structural conditions as those 'in which physicians were disenfranchised from political and economic power but constantly promoted as authorities with disciplinary power'. Paradoxically, policies in the early post-Soviet period targeted and transformed mainly economic relations between patients (redefined as consumers), the state and healthcare services, while institutional arrangements for doctor–patient relations remained unequal, as did those between health providers and their managers or administrators. As a result, the regulation of maternity services in Russia cannot consistently be regarded as either professional, managerial or market-led, as it combines features of each type in different spheres.

For example, as shown in the previous section, health practitioners have little influence or opportunity to affect decision making in the sphere of financing and the material provision of healthcare services. This sometimes takes irrational and inadequate forms, such as purchasing equipment that cannot be used owing to either poor quality or excessive technological complexity. The regulation of both organisational and medical issues also appears quite complicated, since it is carried out not only by professional associations, but also through managerial structures such as the Ministry of Health. In particular, there are different managerial, professional and controlling institutions, which affect the regulation of maternity services in Russia, as shown in Figure 4.

This scheme positions healthcare practitioners, providing maternity care at the bottom, to denote that they have quite little autonomy to affect the conditions of their work. It also outlines four different dimensions of coordination and control, which routinely shape the organisation of health services, set its design and control its financing. Such multiplicity of actors influencing the work of health organisations and professional in social theory is referred to as institutional complexity. Scholars analyse institutional environments as 'consisting of multiple different fields with often contradictory institutional demands that organizations must navigate to succeed' (Madsen, Waldorff 2019: 23). Although in general, legislators, customers and societal stakeholders are considered to be key stakeholders in the field of healthcare, Russia represents a case with quite limited role of both professional and consumers' organisations, overbalanced by various state bodies.



**Figure 4** Coordinating, regulatory and controlling hierarchies in the field of maternity care in Russia.

The hierarchies, illustrated in the figure 4 are not entirely parallel, as they often intersect in different combinations. For example, the head of the hospital may be a regional representative for the medical chamber, while the district's main obstetrician-gynaecologist is often also head of the maternity (or gynaecological) department, vice-head of maternity and infant services, or even a staff obstetrician-gynaecologist in the facility. In addition, coordination and regulation of services is constantly complicated by the necessity for collaboration with other state and commercial institutions, such as regional

and district governments (for example, maternal and infant mortality rates are a key parameter of governments' work evaluation), insurance companies, MHI funds, and other bodies.

Sometimes, the interests of professional and managerial structures are contradictory, but health professionals have some autonomy in a few issues. One of these is the system of education which, as a result of lobbying by the National Medical Chamber, has recently been changed from a system of qualifications improvement (once every five years) to a model of continuous medical education. However, professional associations have little effect on doctors' and midwives' bureaucratic burden, the structural reorganisation of healthcare services, and sometimes even the regulation of medical practice. As a result, both facilities' capacity and the number of medical practitioners are being reduced according to cost-effectiveness and administrative rationales, complicating the work of remaining services and their providers. Regional executive authorities have initiated considerable 'optimisation' of healthcare facilities: in 2014, the number of medical organisations was reduced by 4.1 per cent (297 organisations); and in 2013, the number of obstetrician gynaecologists was reduced from 38,050 to 37,205, and midwives from 59,127 to 58,737, a trend that has continued (Shishkin et al. 2016).

The prevalence of managerial regulation over the professional one is also revealed in other changes. For example, in 2013, all material provision of healthcare services was reorganised into a tender system regulated by Federal Law № 44 (Federal Law 2013). Although this measure is articulated as being technical, not referring to the neoliberal or 'statist' logic of social restructuring, it has significantly complicated medical work and bureaucratised health services provision. The orientation toward fulfilling reporting requirements in medical practice leads to considerable bureaucratisation: 'The productive time of health practitioners' work is being reduced due to the growing and excessive paperwork, preparation of documentation and reports' (Shishkin et al. 2017: 15). Moreover, the dominance of the managerial control gives rise to a necessity for statistical data and manipulation of reports: 'positive indicators of maternity services' improvement (like better mortality rates) should be looked at carefully, considering that the registration of mortality causes may become an object of manipulation' (Shishkin et al. 2016: 16; Starodubov, Suhanova 2013). In addition, 'the productivity and effectiveness of healthcare services is being considerably reduced due to the lack of cooperation between different branches of the system: diagnostic centres, outpatient clinics, hospitals, and rehabilitation services' (Shishkin et al. 2017: 15-16; for more detail, see Section 2.3).

Another important feature of the regulatory framework of healthcare in Russia is the crucial role of various controlling state bodies, which are not directly involved in healthcare provision. In particular, the MHI federal and regional funds which operate through the system of smaller private health insurance companies, can have controlling power over the healthcare practitioners' work. In addition, the Russian Federal Service for Surveillance

on Consumer Rights Protection and Human Wellbeing (Rospotrebnadzor), Federal Service for Surveillance in Healthcare (Roszdravnadzor), Federal and regional authorities and even the Investigating committee appear to be those institutions, which routinely control and sanction healthcare organisations and professionals. An additional challenge for medical workers and health managers is to fit the requirements of all these controlling bodies, since they often contradict with each other, but are obligatory to fulfil.

Small Russian towns differ little from other parts of the country in terms of regulation. First- and second-level maternity facilities are subject to the same orders and laws, and are controlled by the same state bodies. However, some features are not designed institutionally, but emerge owing to particular spatial and societal conditions. In particular, the small number of healthcare practitioners working in small towns leads to the amalgamation of different regulatory lines: the same health practitioner may serve as head of a maternity unit, the main specialist in a district and a representative of the professional association. Another aspect of this social setting is that small maternity wards in remote areas are not easily accessed by the various controlling institutions (see more in Chapter 7).

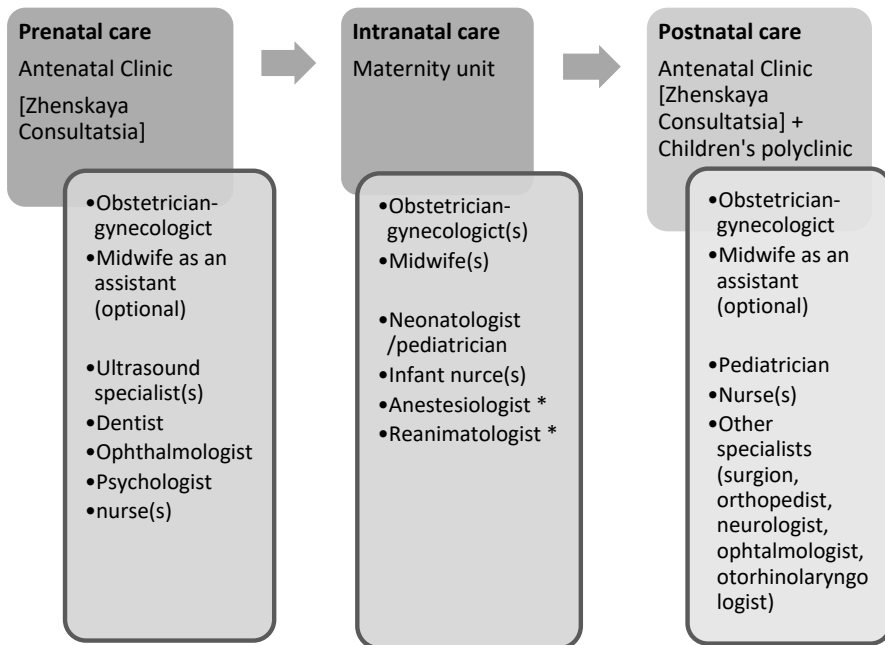
## **2.5 HEALTHCARE PROFESSIONALS IN RUSSIAN MATERNITY CARE**

There are various ways to organize and provide maternity care, depending on the state policy, way of financing and regulation, but more importantly – on the model of care, which places at the core different ideals and principles (Benoit et al. 2005). In particular, social scientists and experts in healthcare describe at least four models of care: midwife-led, obstetrician-provided, family doctor-provided and shared models of care (Sandall et al. 2016: 7). In this classification Russian system of maternity care relates to the shared model, since both doctors and midwives are considered responsible for the delivery. This subchapter examines the key features of professionals' responsibilities, autonomy and ideals as well as inter-professional relations in the field of maternity care and introduces those social actors, which are at the focus of the research.

According to the orders of the Ministry of Health, any pregnancy should be observed and any delivery attended by an obstetrician-gynaecologist, while a midwife takes the role of a doctor's assistant. By the law a midwife cannot provide maternity care without a doctor – only in some urgent cases, when a woman with contractions cannot be transported to the maternity facility (and, for example, gives birth at FAP or in an ambulance car). Non-facility-based childbirth, as was mentioned above, is prohibited to attend for any health practitioner, although women and their families can opt to home birth, referring to the Federal law 'On the basis of the protection of public health in

the Russian Federation' (2011), which allows Russian citizens avoiding hospitalization voluntary.

Officially there is only one medical specialty 'obstetrician-gynecologist', although doctors educated on it can practice or as obstetricians, either as gynecologists, and in some cases as both. To get the degree a doctor-to-be should study for six years at the medical university and after to have a one-year internship in a medical organisation. On practice, the place of internship and the type of the medical organisation, in which a doctor starts his or her professional trajectory in many ways shapes the further professional path and trajectories. As a result, doctors titled and educated in a standardised and similar way can practice completely different approaches to childbirth and have various ideals of maternity care (Novkunskaya 2018). For pregnant and labouring women such a model results in fragmentation of care, since on different stages of gestation she should communicate with multiple health practitioners. The figure 5 illustrates this multiplicity of care providers, which are almost unavoidable, if a woman follows the formally prescribed track of maternity care.



\*Specialists, involved in maternity care provision in case of complications

**Figure 5** Key healthcare professionals involved in maternity care provision in Russia

Midwives represent another professional group responsible for maternity care provision on all the stages of the system. Although in some other contexts they can practice independently and form autonomous and powerful profession (Sandall et al. 2016) in Russia they can not attend childbirth without a doctor, neither to propose a strategy of delivery (for example, estimating the process of labour as pathological). Hence, on practice the relations between obstetrician-gynaecologists and midwives are hierarchical rather than collaborative. In general, the system of maternity care represents a professional jurisdiction comprising differing healthcare practitioners – obstetrician-gynaecologists, other doctors during pregnancy and in case of complications in childbirth, midwives, nurses – which also raises issues of professional competition and gendered professions (Riska 2011, 2014; Witz 1992). I propose that this competition between different professionals' knowledge, approaches to childbirth and the relation to women's experience (as well as the ability to share it) constitute a particular condition of both, patients' and professional agency.

The risk-oriented model of maternity care positions doctors at the top of professional hierarchy and shapes the general approach to childbirth. The dominance of medical knowledge results in quite high medicalisation of the Russian system of maternity care (Temkina 2015) Although there are some ways to avoid being observed and hospitalised during pregnancy and childbirth (Novkunskaya 2014), or at least to reduce the number of medical interventions (Borozdina 2014) in Russia, the power to determine the conditions of childbirth still derives from obstetrician-gynaecologists and their notions of normality and pathology. However, this power is constantly being challenged by various societal factors.

Previous researches show that even in the contexts with historically autonomous professions, new policy measures lead to the challenges for the professional autonomy and lead to the 'hybridisation' of professional role (conceptually the issue of an 'institutional hybrid' will be elaborated in the Chapter 3). Some tendencies and reforms, analysed in the subchapter 2.1, such as policy, driven by the neoliberal principles is a world-wide phenomenon. For example, for health practitioners within the National Health Service (NHS) in the UK, these challenges come from managerial government policy, introducing private sector-style management, measurement, top-down targets, and 'quasi-markets' (McGivern et al. 2015: 413). The structural reorganisation of healthcare services, described in sections 2.1 and 2.2 is not exceptional for Russia as well, as the same case of English NHS demonstrates, hospitals may be taken over or closed down following poor performance and/or financial deficit (Currie, Spyridonidis 2016: 80-81; Fulop et al. 2012).

However, these macro-level institutional changes shape in different ways health professionals' positions, attitudes and relations to how health services are to be provided, organised and regulated. Doctors may oppose both bureaucratisation and marketisation of healthcare, seeking to retain ethical

ideals at the core of professionalism, although these ideals are exposed to change as well. Ekaterina Borozdina (2011) has described the shift in ethics from the Soviet model of 'deontology' to a 'professional ethic' that is more services- and consumer-oriented. In other words, the ethics of Soviet physicians was coherent and, in terms of the values of public health and professional integrity, was valued much more than economic benefits, whereas post-Soviet social transformations have produced multiple ethical norms and standards, including acceptance of the marketisation of medical services (Rivkin-Fish 2005; Borozdina 2011; Temkina, Rivkin-Fish 2019). However, as other researchers demonstrate, these new norms and values are still problematic for many healthcare providers and are not widely accepted (Nikolaev 2015), while the 'ideology of altruism' is still important for Russian healthcare practitioners (Mansurov, Yurchenko 2011). Thus, in the context of perpetual institutional change, the value of professionalism itself is a complex issue to investigate.

This chapter has built up the context of facility-based and state-founded childbirth in Russia. It has discussed details and features of the structure of maternity services, their financing and regulation, and stages in their reform since the Soviet collapse. In particular, it has explained that several stages and trends in reforms have proceeded over the last three decades: liberalisation during the 1990s, which caused considerable commercialisation of health services in general; a 'statist' turn in welfare policy after 2006, which led to increases in state financing and attention to the sphere; and 'modernisation' and 'optimisation' of healthcare of 2010s.

As a result of these regulatory and institutional changes, the particular structure of obstetrics in Russia has been formed. Nowadays, maternity services within each region operate under a three-level system, headed by perinatal centres or large independent maternity homes in regional centres, with multiple small healthcare institutions (maternity departments in district hospitals) located in remote districts and areas. Other important structural features of this sphere include the distinction between outpatient (antenatal) and stationary services, insufficient coordination between facilities of different profiles, and the inner complexity of maternity institutions, which consist of many departments, units and wards.

The main problem caused by modernising reforms for institutional work in the field of obstetrics at the first and second levels is that while healthcare services improve as a result of the development of, and considerable investments in perinatal centres, small medical institutions must reduce their bed space and personnel, or even eliminate maternity services altogether. At the same time, the majority of births actually occur in first-level (67% of annual births) and second-level (27.8%) organisations. This means that access to high-quality medical services for the majority of Russian women has dramatically decreased (Starodubov, Suhanova 2012: 267-269). Moreover, the logic of 'pregnancy monitoring' and 'routing' entails that all risky cases are

designated to perinatal centres in advance, but childbirth complications may occur unpredictably during delivery.

This chapter has also covered various features and problems linked with healthcare and maternity services, particularly financing. This is predominantly a public system, with just a few private maternity clinics in large cities (some of the regional centres). Since 2015, all healthcare services have been financed through a single channel, the federal and regional Mandatory Health Insurance (MHI) funds. Prices for services are fixed for each institution, but vary considerably across districts and regions; moreover, in some cases justifications for tariffs appear not to be pragmatic but based on costly expenses. This gives rise to several problems with the material provision of facilities, particularly its insufficiency and a growth in financial and statistical reporting.

The means of financing also determines the regulation of maternity services in Russia, which depends mostly on managerial authority. There are several parallel regulatory hierarchies within maternity care – an administrative one headed by the Ministry of Health and its regional representatives; professional one headed by obstetrician-gynaecologists' federal and regional associations (or 'societies'); and a set of various state bodies controlling the health services provision and the work of health practitioners. Thus, in terms of regulation, the field of maternity care in Russia appears to be quite bureaucratised, while the autonomy of healthcare professionals is challenged by managerial principles of regulation and controlling institutions.

The last section of the chapter has introduced key actors, addressed in this research – healthcare professionals, working providing maternity care in Russia. It also examined, how economic, structural and geographical conditions have led to a lack of material and social resources for medical work, insufficient infrastructure and the threat of units' closure in the context of small-town Russia. The key point of this chapter is that maternity care services in Russia are currently run through a quite centralised and state-led system, with top-down regulation that institutionally leaves little space for the agency of healthcare practitioners. The outlined macro-level features of the system also correlate with the organisational arrangement of the investigated institutional field, which is the main focus of the research.

As some scholars argue, organisational studies quite often ignore the role of politics 'in designing and implementing change and creating hybridity in public services organizations' (Denis et al. 2015: 285). In my research I aim to address the multiplicity and interdependency of different institutional levels, and the next chapter will elaborate the conceptual framework used to consider this correlation. Based on sociological discussion of professionals and their role in institutional change, Chapter 3 proposes a neo-institutionalist approach to analyse the space for professional agency in the organisational and institutional settings described above.



### **3 STUDYING PROFESSIONALS' AGENCY: CONCEPTUAL FRAMEWORK FOR THE RESEARCH**

The key research question of this thesis is: *what is the role of health professionals in the local organisation and provision of maternity care in the context of top-down led institutional change?* This inevitably places the analysis of this research at the centre of discussions within the sociology of professions regarding relations between agency and structure, and the mutual influence of professionals and the contexts in which they work. Many different frameworks are available to allow thorough investigation of these issues, and many approaches focus on the role of professionals in the process of institutional change. This chapter aims to elaborate the conceptual framework, which provides instruments for further analysis attuned to both the context of this study and the key research question.

In order to put the elaborated framework in a broader theoretical context, the chapter begins by describing theories and approaches that somehow address the issue of professionals' agency and its relationship with structural conditions. Section 3.1 outlines concepts and models presented within the sociology of professions, which examines the agency and autonomy as one of the key elements of professionalism, and introduces the neo-institutionalist framework as the one, which forms the basis for this study. The section also presents the key arguments proposed by the neo-institutionalist approach to sociological investigations of professions and organisations enabling to address both multiplicity of the levels of the social order, and agency-structure interrelation.

Subchapter 3.2 discusses variability of the levels of analysis in studying institutional change and professional agency. In particular, it highlights the importance of the meso-level of analysis in investigation of the institutional change and introduces the concept of institutional work, applied in this study to examine the issue of professional agency. The next subchapter 3.3 is devoted to the competing institutional logics, shaping the field of professional care. Following the arguments of neo-Weberian approach it examines three key organisational principles: managerial, market and professional ones, and supplement the model with the fourth institutional logic of informality.

The last subchapter 3.4 describes the key analytical concepts applied in the study, and attunes them to the key research question of the project, allowing conceptualisation of healthcare practitioners as agents of institutional change. In particular, it elaborates the conceptual model, which allows to address multiplicity of institutional logics, shaping the investigated field, different levels of the latter, and probable directions of the institutional change. It

introduces key concepts applied in the study, which together form the core of the conceptual framework, applied in this study.

### **3.1 PROFESSIONALS' AGENCY IN SOCIAL THEORY: THE LIMITS OF THE ANALYSIS**

In social theory the agency usually refers to the ability of human action (Giddens 1979: 49), which conceptually employed to oppose the structuralist explanation of social change (ibid.). However, broader conceptualisation of agency as 'a temporally embedded process of social engagement and capacity to contextualize past habits and future projects within the contingencies of the moment' (Emirbayer, Mische 1998) enables to analyse agentic actions and institutional change as interconnected. In particular, defined as interest-driven behaviour employed as coordinating mechanism in the organisational context (Beckert 1999: 778) agency in a very generalised way can be assigned to any type of social actors. I proceed with the review of sociological approaches, which in different ways conceptualise the agency of health professionals.

This section presents the major debate on professionals and their role in institutional change, through which I position myself within the discussion and substantiate the proposed conceptual model. Understanding of professionals as social actors responsible for the rational organisation of social relationships (Ritzer 1975: 628) appeared at the dawn of sociology as a discipline. The very distinction of professionals from other types of occupation, introduced by Weber, refers to the ideas of agentic potential, specialist knowledge and power to shape social reality (ibid.). However, there are various ways to describe this interrelationship between professional agency and social structures, each having its own pros and cons. In order to prove the analytical capacity of my conceptual framework, in this section I briefly outline key approaches in the sociology of professions and delineate their limits of analysis.

Various analytical approaches have been taken to sociological debate on the role of professionals in social change, and conversely the effects of the latter on professional practice. The borderline between different approaches is sometimes quite conditional – the same authors outline between five and eight main theories or perspectives in the sociology of professions, addressing the phenomenon of professions in general and professional agency in particular (Saks 2015, 2016). Without considering taxonomic and functionalist approaches that neglect the volatile and changeable character of this complex agency–structure interrelationship, at least four approaches compete for conceptual leadership in this field.

Conflicting approaches to the sociology of professions emerged as a critique of the functionalist theory, dominating sociology of professions during the first

half of the XX century. Two main points of complaint gave rise to interactionist, micro-level analysis of professional work (Becker et al. 1961; Strauss et al. 1963; Svensson 1996; Allen 1997; Evetts 2003) on the one hand, and to neo-Weberian (Freidson 1970, Abbot 1988) and neo-Marxist (Larson 1977, Johnson 1972) historical and 'ecological' approaches on the other. Subsequently, based on Foucault's works, discourse and Foucauldian traditions in the sociology of professions emerged, elaborating on both structural and historical conditions for the rise of professionalism, in terms of governmentality (Johnson 1995) and its effects on daily practices and professional identities as a disciplinary logic (Fournier 1999).

Interactionist approach has been criticised for its neglect of structural constraints affecting both the organisational and professional culture and it does not explain interrelationships between organisational and macro-level structures. This particular problem has been thoroughly elaborated in the neo-Weberian and neo-Marxist approaches. Neo-Weberians have approached professionalisation as a process shaping the daily practices of healthcare professionals, with competition for the 'jurisdiction' transmitted in their relations with both patients and healthcare managers. This idea of competing ways of shaping medical practice has become central to this approach, and has evolved into a model of the different *logics of regulation* of professional practice: managerial, market and professional (Freidson 2001). This model is quite relevant to my study of professional agency in the process of social change, as well as for capturing different directions of institutional change itself. It is partially incorporated into the conceptual framework of this study.

Thinkers in the Marxist tradition have participated in debate about professionals in a similar way to neo-Weberians, determining structural conditions for realisation of the professional project (Larson 1977). They provide a mainly macro-structural and historical perspective on the development of professions and their position within capitalist society. The key concept describing the altered status of professionals in this tradition is '*proletarianisation*', meaning the loss or curtailment of professional prerogatives (McKinlay, Stoeckle 1988: 201). This idea of decreasing professional autonomy and authority in modern societies correlates closely with the notion of '*deprofessionalisation*' (Haug 1972; Brown 1992). Both terms are important for this study, since they may also denote the limitation of professional agency. However, both perspectives have been criticised for similar shortcomings. For example, some scholars question these explanatory models for their inattention to micro-level relations and processes. Annandale (1989: 612) points out that both neo-Marxists and neo-Weberians explicitly distinguish the macro level of medicine, as a corporate body, from the micro level of medical practitioners' everyday work, but their theoretical and methodological assumptions do not allow them to determine practitioners' actual dispositions toward their professional organisation and regulation.

To sum up there is an analytical gap in the outlined debate, which is the lack of a comprehensive model to describe all dimensions of the effects of

professional agency. In particular, interactionist and discursive approaches narrow the scope of investigation to micro-level interactions and fail to recognise the possibility of institutional change caused by professionals' actions. Conversely, both neo-Marxist and neo-Weberian perspectives tend to focus on the structural conditions of change rather than on professional agency itself, and to neglect the organisational order. This research addresses this gap and re-examines the interrelationship between professionals, the organisations in which they work, the state and other social actors shaping the transformation of maternity care. I further introduce the neo-institutionalist framework, which represents another solution to analysing professional agency in correlation with all the other levels of institutional field.

This research in general address the issue of professional agency in a way, which efforts 'to bring the individual into institutional theory and 'inhabit' institutions with people, their work activities and social interactions' (Bévort, Suddaby 2016: 20). While all the previously mentioned approaches enable analysis of either the institutional change with attention to the macro-level social structures, or the professionals acting as individuals on the micro-level interactions, the neo-institutionalist perspective consider all the levels of the social order (ibid.: 18). In addition, professionals are conceptualised in the neo-institutionalist approach as 'not the only, but the most influential, contemporary crafters of institutions' (Scott 2008: 223). Whereas their **agency** refers to 'practical, effortful, sometimes partial and not always successful activities directed at institutional change' (Cloutier et al. 2015: 262). The following subchapter examines this analytical framework in details and highlights its key assumptions of the different levels of the social order and multiplicity of institutional logics, shaping it.

### **3.2 DIFFERENT LEVELS OF INSTITUTIONAL CHANGE AND PROFESSIONAL AGENCY**

As emphasised in the previous subchapter, neo-institutionalist approach elaborates professional agency as 'both the purposeful and the everyday mundane actions through which individual and collective actors – such as professionals and professions – attempt to disrupt, maintain, or create institutions' (Muzio et al. 2013: 700). This section discusses the analytical advantages of merging the neo-institutionalist approach with studies of professionals, and focuses on particular dimensions of institutional change, which are shaped through the professional agency. It starts with a brief outline of the process of coupling organisational with professional studies, proceeds with an introduction to key terms in the field, and concludes by substantiating the terms chosen for the further analysis of professional agency.

First, the notion of organisation adopted by the discipline of the sociology of professions is not its key aspect, but rather the idea that particular social

actors should be incorporated into the study of institutions and organisations. Thus, the concept of '*institutional entrepreneurship*' was introduced by DiMaggio (1991). Based on a quite exceptional case, at least in terms of the scale of institutional changes, the author demonstrated that professionals may initiate institutional changes not only at the intra-organisational level, but also at the level of the organisational field through the mechanism of constructing the environment that they are able to control (DiMaggio 1991: 287-288). DiMaggio's idea of the 'institutional entrepreneur' allows the identification of 'goal-oriented elite intervention at critical points in a field's development and illustration of the construction of fieldwide organizations. With professionals playing leading roles, that exerted an autonomous impact on ideology and behavior' (DiMaggio, Powell 1991: 31).

This attention to the role of professionals in institutional change has been further developed by William Richard Scott, who conceptualises professionals' formation and elaboration of institutions as 'lords of the dance'. From this perspective, institutions 'are comprised of regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life' (Scott 2008: 222). This framework also includes a double proposition concerning social institutions: institutional elements (i.e. rules, norms and beliefs) are considered to be symbolic in nature, and at the same time, as symbols, they are expected to be reflected in social activities, relations and resources (ibid.). In this model, professionals are seen as the primary and most influential institutional agents, who are able to define, interpret and apply these institutional elements (ibid.: 224), and this focus of attention on professionals as key actors shaping institutions fosters the analysis on the organisational level.

Subsequent management studies scholars, including Roy Suddaby and Thierry Viale, have followed Scott's argument and redefined professionals as actors who play a key role in institutional processes. They witness the powerful influence of professionals and professional organisations, acting as triggers for profound social change (Suddaby, Viale 2011: 424), and propose that the interrelationship between institutional work and the process of professionalisation occurs simultaneously and cohesively (ibid.: 426). These authors and their colleagues have also begun to elaborate the concept of *institutional work* as allowing both the study of organisational or institutional change, and concern for the role of professionals within it (see, for example, Lawrence, Suddaby 2006; Lawrence et al. 2009).

The novelty and topicality of this approach lies in the detection of an analytical gap in addressing professional agency. It recognises that the previous studies were focused on the field-level actors, which affect the domination of one of the institutional logics, but gave little attention to those, which act inside organisations (Reay, Hinings 2009: 632). The framework applies a neo-institutional lens to understand professionals and processes of institutional change on different levels (Muzio et al. 2013: 704, 714) and elaborates particular tools for analysis. The terms *institutional work* and

*institutional entrepreneurship*, can be considered as interchangeable, although in some studies, the latter is referred as a case of more formal and macro-level change, and the former as a synonym for informal, micro-level professional actions that cause change in institutions (McCann et al. 2013).

In general, this approach is particularly useful for the study of professionals' agency, as it addresses issues relating to both, the micro-foundations of institutional change and the meso-level of organisational context. Scholars emphasise the importance of research on micro-organisational issues affecting the management of professional workforces. They operationalise this micro-level order as a complex of 'leadership practices and styles, changing career structures and employment patterns, the development of new control and accountability regimes' (Brock et al. 2014: 7-8). As they highlight, it is important not to prioritise structure, but rather to recover the agency of professionals, their colleagues, clients and employers in the various processes of institutional change (ibid.).

Thus, the neo-institutionalist framework enables analysis of the multiple levels of the social order, and the way, professionals act on them to accomplish different tasks. For example, Girts Racko in his research considers the micro, mezzo, and macro levels to analyse, how medical professionals act to pursue autonomy, and how their occupational values shape various societal processes. In particular, the research describes how professional autonomy at the micro level is maintained to control the diagnosis of illness, prescription of treatments, evaluation of appropriateness of patient care, and specification of the character and extent of practitioner tasks and priorities. At the mezzo level, health practitioners seek self-regulation that protects medical profession against governmental intervention, and at the macro-level, they maintain autonomy to legitimise the normative assumptions of the 'bio-medical model' (Racko 2017: 81).

In conclusion, various approaches are applied in current theoretical debate on professions and organisations/institutions to analyse their mutual influence. This brief and partial outline of existing debate over the merging of institutional analysis and the study of professionals provides evidence of quite extensive discussion in this field, while various applied models address several conceptual and empirical aspects of the issue. All these assumptions seem reasonable for inclusion in the conceptual framework of this project, as they 'bring individuals back in to the conceptualization and empirical investigation of institutions' (Bévort, Suddaby 2016: 18) and highlight the role of professionals as agents of the creation, maintenance and disruption of institutions (Muzio et al. 2013: 699).

The multiplicity of the levels of analysis is not the only assumption of the institutionalist approach, applied in this study. Another dimension of the examination is that of institutional logics, which are enacted as organisational principles on different levels. Following the proposition that the rivalry of different logics can result in the hybridity, which, at the same time, can vary across the multiple levels (Denis et al. 2015: 284). The next subchapter focuses

on this issue and addresses probable interference of ‘hybrid structures’ and ‘hybrid practices’ (ibid).

### **3.3 THE COMPETING INSTITUTIONAL LOGICS IN THE FIELD OF PROFESSIONAL CARE**

As I proposed in the previous subchapter, institutionalist approach allows investigation of institutional change on different levels. However, the pattern of this change is shaped by the definite organisational principle, conceptualised in terms of institutional logic. Another important assumption of this study is that these organisational principles can vary considerably and, in some cases, even compete with each other for the domination over an institution or a field. As Graeme Currie and Dimitrios Spyridonidis (2016) argue ‘organizational fields are characterized by institutional complexity, comprising multiple logics, as opposed to being dominated by a single logic. In addition, these multiple logics may be competitive, but their relationship may also be co-operative, orthogonal or blurred’ (Currie, Spyridonidis 2016: 78).

In Eliot Freidson’s (2001) classic work, he challenges the notion of professional autonomy and power, which used to be conceptualised in sociological debate as a core part of professionalism, and questions whether professionals working in modern hospitals and clinics are as powerful as we tend to believe. He proposes at least two alternative regulatory logics that challenge the very idea of autonomous professional practice: market and managerial ones (Freidson 2001). Why is it important to consider these logics in this research? The domination of any of these logics presumably shapes the space for professional agency in the particular social context. In other words, the study questions, whether Russian doctors, nurses and midwives, act mainly as state employees (managerial logic), service providers (market logic) or professionals? Additionally, it addresses the power balance in the field of healthcare and the structural conditions, which affect (inspire or restrict) the scope of professional agency.

Here and further the concept of regulatory logic will be used interchangeably with the category of institutional logic (Reay, Hinings 2009; Hinings 2012) and organisational principle (Noordegraaf 2015), and refer to the ‘*assumptions and values which guide actors in how to interpret organizational reality, what constitutes appropriate behaviour*’ (Entwistle, Matthews 2015: 1142). Although there are different ways to define the set of leading regulatory logics in a particular field, I will start with the conceptualisation by E. Freidson: the professional, the market and managerial ones. In particular, the professional logic refers to the autonomy in terms of decision-making and control over the healthcare based on the professional expertise and ethical standards (Mangen, Brivot 2015); market – to the logic

oriented on consumers' choice, and enacted through the competitive mechanisms and cost-efficiency principles of regulation; while managerial or bureaucratic – to the regulation by managers and in particular case – by state bodies (Freidson 2001; Blomgren, Waks 2015: 80).

The concept of institutional logics presupposes the possibility of their co-existence and simultaneous effects on both individual and organisational behaviour (Thornton et al. 2015: 1). Such a conceptual framework enables consideration of the possibility of 'copenetration, sedimentation, and hybridization of different institutional, managerial, occupational, and organizational logics' (Muzio et al. 2013: 703). Thus, both professional groups and organisations can form hybrids in term of combination and sedimentation of various institutional logics in the long run (Mangen, Brivot 2015: 660). Equally importantly, such approach enables reflection on the influence of the state as a social actor, challenging and changing existing institutional fields: 'governmental intervention is particularly important as it has often facilitated change from one dominant logic to another – for example, from medical professionalism to business-like healthcare' (Brock et al. 2014: 5-6). The model also suggests that professional organisations are a kind of hybrid combining different logics, such as managerial, commercial and professional (ibid.). A key assumption behind the concept of institutional logics is that one logic dominates any given institutional field, but that that domination may shift. Thus, the institutional change occurs when one prevalent logic substitutes for another (Scott et al. 2000; Reay, Jones 2016).

As other scholars argue, the alterations in the balance of different institutional logics affects both the macro-level of the reforms' design and the micro-level of professional work (Entwistle, Matthews 2015: 1143), hence, analysis of the institutional field should address all these levels as well as be sensitive to the institutional complexity. This subchapter focuses on different forms of competition of institutional logics and reviews those theoretical works, which address this issue. In particular, it examines, how managerial and market logics can challenge professionalism and how, on the contrary, these various organisational principles can produce a hybrid.

Managerial regulation represents one of the topics in the literature on professions and professionals' work nowadays, examined as a key challenge for the enactment of the professionalism within the organisational context. As Girts Racko articulated in his recent study, domination of the managerial logic in the medical field manifests itself through the enforcement of administrative and economic efficiency and is likely to weaken medical professionals' concern with common good (Racko 2017: 78-79). He continues that professionalism reveals as the pursuit of openness to change values, emphasizing autonomy of the medical professionals and indeterminate and untestable aspects of their knowledge (ibid.: 80), but all these occupational values are likely to be undermined by bureaucratization 'as a process of the transformation of work in accordance with the values of instrumentally rational administration' (ibid.: 82). In the research Racko concludes that more bureaucratized systems of



governance results in the decrease of the openness to change, autonomy, creativity and self-transcendence values (ibid.: 97).

Some other researches demonstrated that the market logic of regulations challenges professional values as well, although in some cases results in the organisational conditions, which promote self-interest of medical professionals (Entwistle, Matthews 2015: 1152). Importantly for this research project, in those contexts, where commercialisation of healthcare services and consumerisation of patients' behavior develop inconsistently, informal institutions can evolve. Researchers addressing the post-Soviet context analyse them in terms of informality as the fourth leading regulatory logic, which is enacted as an organisational principle in bureaucratic, state-controlled environments, in which 'professional practices are incorporated in the hierarchical structures of the state', and there is no so developed inter-professional competition of jurisdiction in a market-based economy (Riska, Noveiskaite 2011: 83).

Maternity care in Russia is usually state-funded and provided free for patients, with some limited consumerisation of patients' behaviour and commercialisation of services, mainly in the capitals and regional centres (Temkina 2016, 2017; Temkina, Rivkin-Fish 2019). Conceptually, this means that the market logic of regulation in the field of Russian maternity care can dominate only particular segments and organisations, and the logic of informality supplements this through the spread of out-of-pocket payments and a system of personal referrals. This specificity of the context also means that the state should be considered as one of the key social actors shaping both arrangements for and alterations to healthcare institutions, and directly affecting the possibility for professional agency.

Other authors examine informality as a policy issue, and highlight the set of challenges, which emerge in healthcare due to the spread of informal payments: 'they can impede efficiency and affect quality of care, jeopardize equality and equity in access to health care services, impose 'cream-skimming', affect the solidarity principle of insurance-based health care systems, and even threaten democratic and inclusion values' (Gordeev et al. 2013: 25). Another problem with informal practices in healthcare arises in comparison with the market logic of regulation and, in particular, with the patients' satisfactions of the medical services (Habibov 2016). However, as other researches demonstrate, in some cases, informality remains the only one available option for changing the current state of affairs.

Peter Gaal and Martin McKee suggested that there are at least three possible options to change the situation, when both patient and medical staff are dissatisfied with the declining performance of healthcare. Both actors can 'exit' – leave the organization and satisfy wants elsewhere, openly complain using available formal channels or organise informal mechanisms to solve the problem (Gaal, McKee 2004). Authors argue that informality is activated when two former mechanisms fail to work or are not available (ibid.: 172), which some other scholars find to be a particular case of Russia, in which health care

system is still characterized by not having an ability to leave and seek elsewhere and complain system is blocked (Gordeev et al. 2013: 40).

Another conceptualisation of the informality as an institutional logic comes with explanation that 'informal payments will arise when the norms, practices and values of the informal institutions are not in symmetry with the formal rules of the game (Williams, Horodnic 2017: 1). As Tatiana Stepurko and her colleagues propose, informality affect the healthcare system at both levels – macro one, by impediment of healthcare reforms and micro one – by creating barriers to desirable care (Stepurko et al. 2015). Thus, in this research informality will be referred to as a fourth institutional logic, supplementing the three others mentioned above. Importantly for this research this competition of different institutional logics can be analysed not only on different levels, but within the same institutional level, though in different forms or 'hybrids'.

The neo-institutionalist approach suggests that competing institutional logics can result in different hybrids within an organisational context, hence, a hybrid can be considered to be one of the key mechanisms of managing the rivalry of institutional logics (Reay, Hinings 2009; Thornton et al. 2015). In particular, 'hybridity is considered as a form of accommodation to coercive pressures, without becoming totally absorbed by them' and it opens up new ways to analyse 'the consequences of macro- and meso-level changes in public services for individuals and groups, including their perceptions, adaption, or resistance to hybrid roles and demands' (Denis et al. 2015: 280).

To conclude, conceptual framework of institutional logics and their hybridisation is very useful for this study, since it allows addressing both multiplicity of the organisational principles, enacted in given institutional field, and its effects on macro-level of health care structures as well as on the micro-level of professional practices and interactions. It also enables to examine professionalism itself as 'ambiguous, plural, dynamic, and complex', which is 'affected by changing organizational contexts and cases' and undergoing hybridisation (McGivern et al. 2015: 412). Several studies have been carried out on hybridity of health professionals addressing, in particular, the 'interplay between managerialism and medical professionalism in hospital organisations' (Correia 2013), as an enactment of professionals' agency (Currie, Spyridonidis 2016: 78-79), and as one of the responses in relation to managerial expectations (Noordegraaf 2013: 264).

Chapter 6 will elaborate this rivalry of competing institutional logics, affecting the organisational conditions and professional practices of healthcare practitioners. It will also address possible hybrid forms of institutional logics enacted in the organisational context, which emerge in maternity units in small-town Russia. The further subchapter elaborates the conceptual framework of the research in order to analyse all the dimensions of the institutional field, mentioned previously.

### 3.4 PROPOSED CONCEPTUAL MODEL AND ITS LIMITS

The overall framework of the sociology of professions and the neo-institutionalist approach as a particular optic allows professional agency to be placed at the centre of analysis. This section outlines the conceptual framework used to answer the key research question of the study. In order to address the role of professionals acting in the context of structural/top-down change in the organisation of maternity services in Russia, I elaborate a complex analytical model, adopting both a neo-institutionalist approach to study professionals' agency and a neo-Weberian perspective to analyse particular dimensions of the change it may cause. In particular, the model enables analysis of the following assumptions, crucial for the study.

Firstly, it considers the wider societal context of maternity care in terms of the effects of health and economic reforms and some other macro-structural processes. Secondly, it emphasises the multiplicity of the institutional logics, which shape this field and compete with each other for the domination. It, thirdly, introduces the institutional field as multi-layered and composed of different social actors on the organisational level, and the one of interpersonal interactions. Finally, the conceptual model of the research presupposes that institutional change can occur on different levels of the institutional field and be analysed as a two-sided process: in a top-down led form and in a form of agentic alterations – the latter is achieved through a process conceptualised as institutional work, accomplished by professionals.

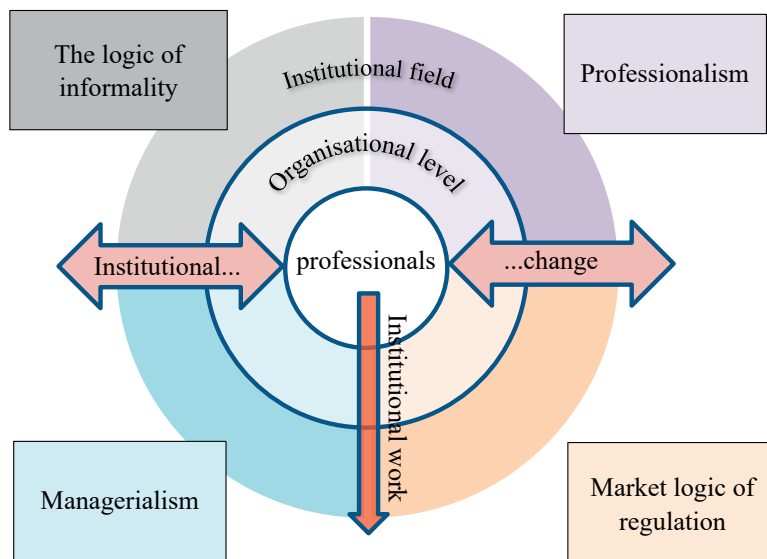


Figure 6 Conceptual model of the research

Following the arguments of some previous researches, I assume that the field of healthcare is being changed under the influence of wider societal-level changes, shaped by the co-existing and competing institutional logics (Martin et al. 2015: 379). In particular, neo-institutionalists have articulated 'how logics can form and evolve at multiple social levels and in multiple fields of organization, interacting and mutually shaping as they do so' (ibid: 380). Thus, the visualisation of the conceptual model (figure 6) is composed to reflect both co-presence of the leading institutional logics, affecting the field of maternity care in Russia, and the interconnection of the different levels of the social order: institutional and organisational ones, as well as micro-level of professionals' work.

Mutual permeability of different social orders is represented by bilateral arrows denoting the process of institutional change. In this way, professional practices can be analysed as the activity, which is shaped by both organisational settings and wider societal processes including 'socioeconomic, cultural, and technological reordering of labor markets, service models, preference formation, action spaces, and career structures, all produce service contexts that have little to do with neo-liberal policies, managerialist politics, and organizational performance system' (Noordegraaf 2013: 785). Thus, behaviour of individual actors must be located in both organisational and institutional contexts, which can constrain or enable agency and change (Thornton, Ocasio 2008: 102).

In order to conduct a comprehensive investigation of the institutional context of maternity care services in Russia, the model includes the concept of *institutional field*. A neo-institutionalist approach is taken to allow consideration of different levels of social order shaping and shaped by professional work. The notion of a field enables interactions between different actors, which are usually treated as incoherent in social theory, to be addressed simultaneously: 'the idea of thinking of fields as orders means that they might reasonably be used to describe very different kinds of social actors who interact, individuals, groups, divisions of an organization, firms, universities, nonprofits, social movement organizations, departments or ministries in governments, states, and intergovernmental organizations' (Fligstein 2008: 6-7). In particular, this model proposes that neither structural conditions nor micro-social processes alone affect the micro-level interactions that build institutions, but rather any of the levels, including the meso- one, reflect both the underlying structural logic and the social actors inhabiting it (ibid.). As I propose for the further analysis, the institutional field is shaped by processes of institutional change from 'outside' by structures imposing different regulatory logics, and from 'inside' through institutional work, that can (or cannot) be accomplished by healthcare professionals.

The notion of *institutional change* is applied to analyse both top-down macro-level structural shifts occurring in the investigated field, and micro-level actions performed by healthcare professionals aiming to reorganise the field, challenge current rules and adopt new practices and approaches. There

is wide debate on the changing role(s) of healthcare professionals themselves in the context of transforming medical institutions. To cover these dimensions of change arising from macro-level social structures down to daily practices, the analytical model for this research includes the concept of *institutional (or regulatory) logics*, which defines how practices, organisations and institutions are designed and regulated (see Freidson 2001; Noordergraaf 2007; Blomgren, Waks 2015).

In general, the concept of institutional logics enables analysis of social processes across micro-, meso-, and macro- social levels and 'highlights the integration of structure and agency' (Zilber 2016: 140). Additionally, as other researchers proposed, the change in the configuration of the key logics, affects both the macro-level of the reforms design and the micro-level of professional work (Entwistle, Matthews 2015: 1143). This once again confirms the necessity to address all these orders, and shapes the structure of the empirical part of this project. In particular, Chapter 5 will be devoted to the examination of the macro-structural processes, affecting the field of maternity care, while Chapter 6 will focus on the competition between different institutional logics within the organisational context.

Agency is the core issue for this study, and the neo-institutionalist approach defines it as 'an actor's ability to have some effect on the social world – altering the rules, relational ties, or distribution of resources' (Scott 2013: 94). The key concept applied in the project to analyse professional agency is '*institutional work*' (red downward arrow in the figure 6), which refers to the professionals' ability to the change institutions in the field of maternity services in small Russian towns. Defined in general as 'the purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions' (Lawrence, Suddaby, 2006: 215), the category of institutional work highlights both intentional, prospective, imaginative and creative activities as well non-purposive, more routine-based and routine-reproducing activities (Scott 2008: 223; Lawrence et al. 2009; Entwistle, Matthews 2015: 1146). Such institutional work need not necessarily result in structural change, but may still reveal itself in other small-scale changes that are also worth analysing and are within the scope of this study. Moreover, as previous researches have shown in non-democratic contexts (and the one of post-Soviet Russia, particularly), where engagement of the civil society is quite complicated, local working practices can serve as an evidence of institutional change (Kulmala 2013).

Neo-institutionalists have developed the category to examine several forms of institutional change that may be mediated by professionals. The first refers to professionals' efforts to widen their jurisdiction by constructing classifications and principles that establish new practices and organisational fields. The second considers actions that result in the establishment of new relations between actors and institutions. The third form of institutional change caused by institutional work reveals itself through alterations to the formal rules regulating the field (Suddaby, Viale, 2011: 428). Another

important dimension of the analysis embedded into the model is that institutional change happens in the context, characterised by the institutional complexity – the multiplicity of the institutional logics, shaping the field as competing organisational principles. Thus, in some cases, institutional work is accomplished to ‘reconcile and hybridize institutional logics or maintain their independent coexistence’ (McGivern 2015: 414).

In this way ‘hybridisation’ of professional activities and organisational principles appears to be another important issue to analyse in the research. The notions of regulatory hybridisation and the ‘hybrid professional’ allow professionals to be treated not only as ‘institutional entrepreneurs’ (DiMaggio 1991), intentionally forcing their project and led by a single coherent logic, but rather as ‘practical people doing practical work’ (Blomgren, Waks 2015: 99), operating in complex and changing institutional settings. At the same time, in the neo-institutionalist approach, this is a reversible process of influence between the institutional work accomplished by professionals, and the organisations and social contexts in which they work. In a recent study, Noordegraaf (2015: 187) addresses how organisations affect professionals’ work to show ‘what hybridization is about and which types of hybridization are identified, and the importance of hybridization, against the background of (changing) organizational and societal contexts’.

In order to attune this conceptual model directly to the object of study, I propose the following definitions. In this study, *institutional field* refers to the complex of healthcare organisations and other social actors, including state bodies and professionals providing maternity care services, to accomplish its regulation and design reforms aimed at its restructuring. *Institutional change* refers to any alteration of maternity services’ provision, regulation or definition in this field, caused by structural processes and individual initiatives. *Institutional work* denotes a particular kind of change of the field, initiated as a bottom-up process and implementing professional agency. *Institutional logic* refers to the three key modes of regulating the field of healthcare, each with a different set of values at their core: the professional logic is associated with the principle of quality of care and professional commitment; the managerial logic with efficiency and accountability; the market logic with the principle of economic profit and cost-efficiency (Scott et al. 2000: 166-235; Borozdina, Novkunskaia 2019). Since this research addresses the rather particular social context of Russian maternity services which, like any other post-socialist society, are experiencing transformation, with widespread informal practices and institutions (Rivkin-Fish 2005), it is important also to introduce a fourth logic of regulation, that of informality (Riska, Novelskaite 2011).

I argue that cross-national research may reveal extensive variability in the work of the institutional field of maternity services and the parties acting within it. Important structural differences may emerge within the same state in apparently similar circumstances, but may lead to differing conditions for professionals’ work and institutional change. In this respect, locality appears

to be a key point worthy of both analytical and methodological reflection. Health professionals are integrated within wider social and organisational contexts (Noordegraaf 2007). Hence, locality and contextual specificity should affect both the design of the conceptual model and the instruments applied in the analysis. Methodologically, my research is designed as a multiple case study to provide data on various potential institutional paths within the same regulatory and social conditions. These insights will be described in more detail in Chapter 4. Conceptually, the research will provide contextuality to the analysis to reveal how professionals are incorporated into organisations, and how this organisational specificity affects the scope for professional agency (ibid.).

## **4 MULTIPLE CASE STUDY OF MATERNITY SERVICES IN SMALL-TOWN RUSSIA**

My research addresses the transformation of the obstetric institutional field in contemporary Russia, with a focus on the perspectives and agency of healthcare professionals, working in small towns. The project is designed as a multiple case study: each case (n = 4) investigates a complex of antenatal and maternity care facilities located in one small Russian town. This chapter describes the methodology, research strategy, methods of data collection and analysis applied in the project. It also describes the cases investigated, and outlines their organisational structure, and how access to the field was (or was not) obtained. The concluding sections of the chapter comprise reflections on the researcher's role during the fieldwork, and on some of the failures and challenges which, I suggest, formed an additional source of data. In particular, the chapter analyses how a researcher and his or her position in the field and personal characteristics (age, gender, education, etc.) affect the quality of data collected.

This chapter is structured as follows. Section 4.1 introduces the research design and strategy which is the multiple case study. Section 4.2 describes the cases investigated in terms of their organisational structure, location and the number of healthcare professionals, providing maternity care. Subchapter 4.3 discusses on the way the access to the fieldwork was gained in some cases and denied in others. Section 4.4 presents the methods used to collect empirical data, in particular – in-depth semi-structured interviews, expert interviews and participant observation. The further part of the chapter 4.5 I explain, how the empirical data was analysed. Section 4.6 is devoted to the ethical issues of the research, and the chapter concludes with some reflections made after the empirical work was completed on how sensitive fields have been elaborated, and which social roles of the researcher were actualised during the fieldwork.

### **4.1 RESEARCH DESIGN AND STRATEGY: MULTIPLE CASE STUDY**

The Russian obstetric institutional field is undergoing considerable changes (for details, see Chapter 2). The causes of these changes are at different structural levels and include both concrete state social reforms, and the more general processes of the commercialisation of healthcare services and consumerisation of patients' behaviour. These processes give rise to changes in the rules and practices of interactions in the field of social support for Russian families, protection of reproductive health, and the provision of childbirth and maternity services.



Despite the centralised (Cook 2011, 2014) character of state social reforms, their consequences appear to be inconsistent and heterogeneous in different social contexts. Thus, in different cases the field of maternity care is being transformed in various ways. In this research, I am interested in how the system of obstetric care is changing and transforming in small Russian towns from health professionals' point of view. As other studies have shown, fieldwork-based case study as a methodological strategy allows consideration of both the structural level and changes occurring at the micro level, thus allowing to investigate the agency in the process of institutional transformation (Jäppinen et al. 2011: 5).

In this research, I analyse the obstetric institutional field as a set of organisations and institutions taking regulatory, preventive and healing measures directed toward the protection of mothers' and children's health during pregnancy, childbirth and puerperium (postpartum period). In general, this field in Russia is a system of both state-funded and private medical organisations, including maternity homes and antenatal clinics and women's consultations ('roddom' and 'zhenskaya konsultatsia', providing medical assistance for pregnant women, women in labour and new-born babies. However, the context addressed in my research quite often lack opportunity for choice, and the options available to women and their families are limited.

The number of healthcare practitioners vary across the maternity units and depend on the specialists available in a district, the level of maternity care provided and relationships with other hospital departments. Order 572n of the Ministry of Health prescribes a minimum set of specialists and the basic services to be provided at the first and second levels of care (Ministry of Health 2012). For example, in the smallest facilities, at least one neonatologist should be employed, but may work from home during night shifts and holidays and be on call to the maternity ward. Children's nurses may be absent from such facilities, in which case a midwife provides newborn care, and in cases of urgent caesarean sections, anesthesiologists are usually drawn from other departments of the hospital (while pregnant women prescribed for planned caesarean sections should be routed to better equipped facilities). Such small facilities usually employ insufficient numbers of obstetrician-gynaecologists, and doctors from other units (antenatal clinic) may cover the night shifts (for more details see chapter 2).

In addressing the perspectives of obstetrician-gynaecologists, neonatologists, midwives and nurses working in first- and second-level maternity wards (for more details on the levelling see section 2.1) and situated at a distance from economic, social and cultural centres, I aim to discover the specificity of such institutions' work and conditions. In particular, the scope of analysis will include the restrictions and impediments faced by doctors in their professional practices and how they cope with them.

To analyse potential variability in the structural transformation and emergence of different forms of professional agency, my research is designed

as a multiple case study (Stake 2006; Yin 2009). A case study strategy is applied in qualitative research to provide ‘in-depth understanding of a single or small number of “cases” set in their real-world contexts’ (Yin 2012: 4). This allows maternity care to be studied in relation to the social context of small towns and social restructuring, which I believe are relevant to the phenomenon under investigation. Through this approach, each case is examined in its complexity, assuming that ‘boundaries are not always clear between the phenomenon and context’ (Baxter, Jack 2008: 545). In addition, as previous researches demonstrate, particularly in the study of institutional change in healthcare and hospital reconfiguration, using multiple longitudinal cases enables to uncover not only contextual factors, but also the way they interrelate with organisational settings and professional work (Fulop et al. 2008: 134).

Robert Stake, a key author on the qualitative methodology of social research, formulates a general rule of three main criteria for selecting cases: *Is the case relevant to the quintain? Do the cases provide diversity across contexts? Do the cases provide good opportunities to learn about complexity and contexts?* (ibid.). I build up the case selection of my cases basing on these criteria, although all the studied institutions work in similar legislative and administrative circumstances (macro-level structural constraints), making the detected diversity more interesting and thick in terms of theoretical increment. It is worth noting that the sample of cases was considerably restricted by access to the field. In summary, the selection of cases was a multistage process, with the *a priori* criteria of first- or second-level maternity care and relative remoteness from the regional centre. The case selection was also considerably shaped by the accessibility of the medical organisations, on which I reflect in the following sections of this chapter.

Although case study as research strategy has a range of limitations, including limited generalisability, following Flyvbjerg’s (2006) argument, I suggest that there are several benefits of using it in my research. In particular, case-study research produces context-dependent knowledge, which is ‘important for the development of a nuanced view of reality, including the view that human behaviour cannot be meaningfully understood as simply the rule-governed acts’ (Flyvbjerg 2006: 223). First, this allows detailed investigation of any issue, even those not envisaged previously. Second, the evidence collected in each case may not obviously contribute to epistemic theoretical construction, but nevertheless may actually do so.

Since ‘binding the case is an important part of its definition’ (Baxter, Jack 2008: 546), it is also important to mention again that my study refers to the specific context of small Russian towns. Thus, the research results may not be applicable to the work of similar medical institutions in cultural or economic centres, in terms of both maternity services’ arrangement and patients’ demands and strategies (Temkina 2017). I also expect that evidence from other regions may differ significantly from my cases; however, this supports my argument that differing social contexts lead to the formation of different

organisational arrangements and professional practices. The following subchapter reconstructs organisational specificity of the cases investigated in the research.

## 4.2 DESCRIPTION OF THE CASES INVESTIGATED

I consider my fieldwork to have started with a previous research project on the distribution of responsibility for reproductive health between doctors, patients and the state (Master's thesis, European University at Saint Petersburg; see Novkunskaya 2016), since some informants who participated in that project were recruited for the new project. In order to show how I approached different cases in the current research, I first outline all stages of my fieldwork, including prior ones, which enabled new data to be collected.

The following four cases were elaborated at different levels of depth, and approached at different times. Cases that did not object to data collection were approached multiple times, enabling the collection of a broader range of data:

**Case 1 (A)** (2011–2012, 2015–2016) Central District Hospital V. (Central Federal Area):

- Volunteering in the office of the head of an antenatal clinic (for 2 weeks);
- 20 in-depth interviews with all available obstetrician-gynaecologists of the district, two neonatologists, and four midwives, including the senior one;
- Series of participant observations in antenatal clinic (about 60 hours).

**Case 2** (2015) Central District Hospital T. (North-Western Federal Area):

- One semi-structured interview with the head of maternity and gynaecological departments; limited access for further fieldwork.

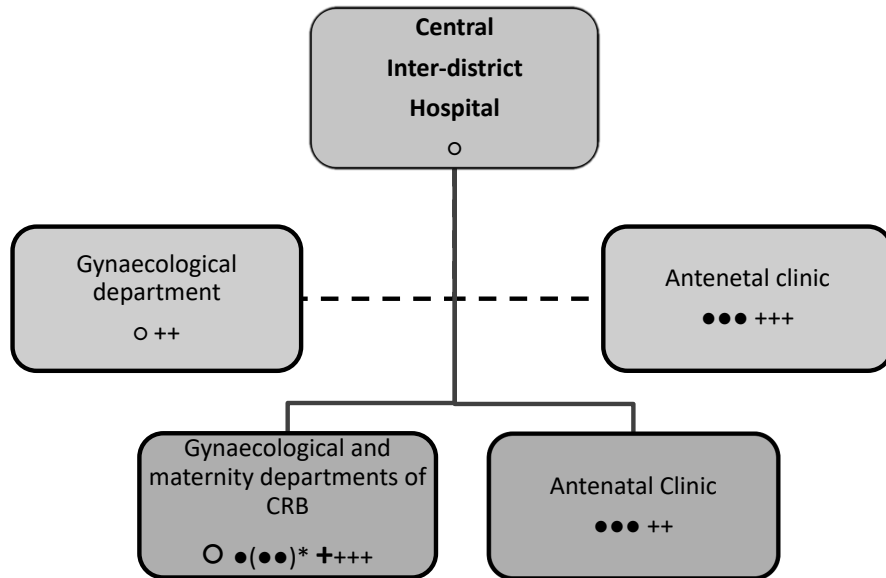
**Case 3 (B)** (2015–2017) Central District Hospital B. (North-Western Federal Area):

- Three in-depth interviews with obstetrician-gynaecologists (including the head of the hospital and the head of the ward); three interviews with midwives (including the senior one); one interview with a nurse;
- Series of participant observations in maternity and gynaecological wards of the central district hospital (25 hours).

**Case 4** (2015) Central District Hospital P. (North-Western Federal Area):

- One interview with the head of the gynaecological department and private antenatal clinic; no access for further fieldwork.

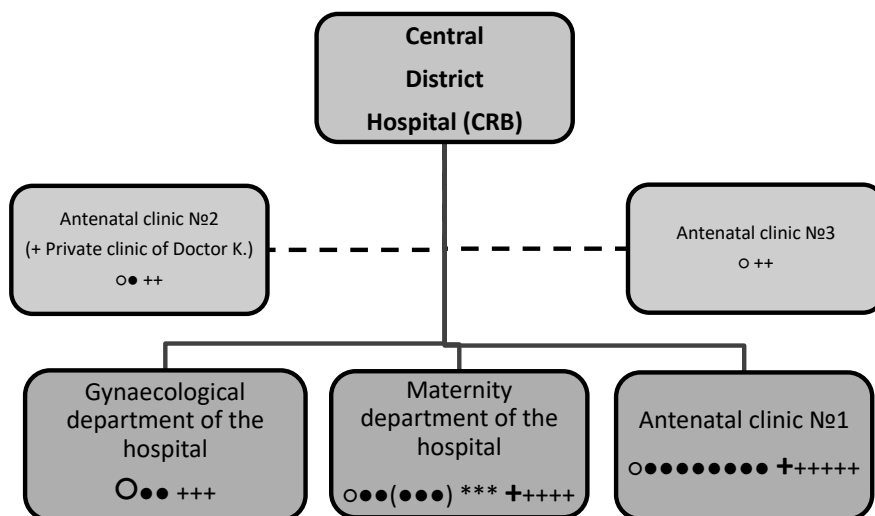
Figure 7 illustrates the organisational structure and number of available specialists in the first-level maternity unit (Case B).



- obstetrician-gynaecologist (10 doctors in total)
- (●) obstetrician-gynaecologist working in maternity department on night shifts only
- head of the department/hospital
- main obstetrician-gynaecologist of the district
- \* neonatologist
- + midwife (11 midwives in total)
- + senior midwife of the unit(s)
- - - - facility located at a distance from the central hospital/in another urban district

**Figure 7** Organisational structure of Case B (first-level maternity services) in 2016

The next scheme (Figure 8) illustrates the organisational structure of the second-level case investigated (Case A) in 2017. It consists of three antenatal clinics, and maternity and gynaecological departments employing 18 obstetrician-gynaecologists, 18 midwives, three neonatologists and other personnel.



- obstetrician-gynaecologist (18 doctors in total)
- (●) obstetrician-gynaecologist working in maternity department on night shifts only
- head of the department/hospital
- the main obstetrician-gynaecologist of the district
- \* neonatologist
- + midwife (18 midwives in total)
- + senior midwife of the unit
- - - - facility located at a distance from the central hospital/in another urban district

**Figure 8** Organisational structure of Case A (second-level maternity services) in 2017

In each case, I examined the history of the obstetric institutional field (how it was established and how it had changed), the organisational arrangements (administrative arrangements for each facility and the units within it), and professionals' evaluations and interpretations of recent changes in practices. I was also interested in the dominant organisational principle (market, managerial, professional or informal) in each case, gleaned by studying decision-making processes concerning the organisation's work, its provision and the work of professionals themselves, and its resources and allocation of actors. I used several methods to collect these data, the next section describes all methods of data collection and analysis used in this project.

### **4.3 ACCESS TO THE FIELD**

The key issues on which I reflect further in this chapter are the influence of the way in which access to the field was gained (or denied), and the role of the researcher's position within the field. I argue that how I obtained access to the field and my social role, appreciated by informants, may also be treated as additional sources of information concerning the structure and social specificity of the studied institutions. In addition, methodological reflections on the path of my fieldwork allow consideration of the researcher as someone who inevitably affects the quality and amount of data collected, and hence should be described alongside other methods used for data collection.

To start my fieldwork (case 1), I decided first to involve my personal social networks, and particularly close family relations. As a relative was head of the neonatological department in a central district hospital in a small Russian town (Central Federal Okrug), I was given an opportunity to meet the head of the maternity department of the same facility. After a lengthy interview, I asked him about the possibility of continuing my work and talking to his colleagues. He did not provide me with a chance to talk to doctors working in the same department, but he called the head of the antenatal clinic in the same town and asked them to accept me.

I was initially met with restraint, since my role as a sociologist was less clear in this context, and all the doctors assumed that 'they have nothing to be investigated here'. Recognising the need to establish trust with my proposed informants, I offered my help as an office worker, assisting with time-consuming documentation and bureaucratic reports. This decision to help participants served not only as a way to establish mutual trust, but also as a basis for becoming a truly participant observer (Kawulich 2011). This form of collaboration appeared to be efficient in at least two ways. First, my help released some time for the clinic's doctors, who would otherwise have had to spend time on this documentation, to talk to me. Second, while working in the office of the head of the antenatal clinic, I was involved in various kinds of professional interactions and was able to conduct participant observation. This kind of involvement also served to legitimise my position: by the end of the office work, all the doctors knew me personally and recognised me as a 'colleague' at a relatively high administrative level, since I was working with the head of the clinic. Moreover, my assistance could be considered as a form of reciprocity, problematised by many other social researchers (Chege 2015; Kawulich 2011). As a result, at the end of my work (about 60 hours over two weeks spent in the unit), all obstetrician-gynaecologists thanked me for the help, which had saved them some time.

I reflect on two additional factors in my successful entry to and development in the field, also articulated by my informants. In a small town, all doctors know each other very well. All obstetrician-gynaecologists constantly and explicitly emphasised my family connection with their colleague (although he was in a different speciality) as a basis for our good

relationships. In addition, I was recognised by the doctors as a potential patient: my young gendered and pregnant body was often referred to during interviews as an example of doctor–patient relations or in discussing reproductive experiences. Our interactions were sometimes facilitated by the fact that I personally was a potential patient.

Based on my relative success with entry to the first case, I decided to use the same strategy in approaching the Case 2. It appeared that the head of the obstetric and gynaecological departments in one of the district centres of another region (North-Western Federal Okrug) was an acquaintance of a friend of my in-laws. I wrote a letter introducing myself and explaining the goals of my current research, since neither my relatives nor their friend could explain why a sociologist needed to interview a doctor. After a while, I received verbal consent for the interview and my informant's contact details, and we arranged an interview at his workplace.

I thought that the high administrative position of my informant and my personal reference from an acquaintance would help me to gain access and continue my fieldwork. In addition, I knew that two medical organisations (Cases 2 and 3) collaborated with each other and were strongly connected owing to the routing system within maternity services, so I expected that the head of this unit would further advance my fieldwork. However, my expectation was not met. During the interview, he reproduced all the formal rules of the institution and professional codes that could be read in state laws or ethical codes. At the end of the interview, my informant recognised that our conversation had been possible only because of a personal reference from our mutual friend, and did not think that his colleagues would wish to talk to me.

At that stage, I realised that I had failed to gain access to the second case. There was also little chance of gaining access to the Case 3, since I did not even have any acquaintance or recommendation for it. All I could do was to make a formal request to the hospital's administration by calling the head of the hospital's work number, available on the hospital's official website. Such a request seemed unlikely to be effective, since sociology, and especially qualitative methods, are less institutionalised in Russia, and thus less widespread, understandable and acceptable. For example, there are no sociological institutions or research centres in the region approached.

However, this approach appeared to be successful for me, since the head of the hospital agreed to give me an interview. After the interview, I talked about the work I had done in my first case and asked whether I could help with any paperwork in the maternity department. He answered that I would have to contact and consult the senior midwife of the maternity department, and gave me her phone number. He also provided consent for my fieldwork (observing the hospital and interviewing doctors, nurses and midwives) if the health professionals themselves were willing to talk to me. From that interview, my intensive and 'thick' fieldwork in Geertz's terms (Geertz 2008) began in the obstetric and gynaecological departments, located together under the same head, in a central district hospital in a small Russian town.

It is worth noting that some administrative changes had been made to medical institutions as a result of so-called 'optimisation', requiring reductions in financing, personnel and beds in Russian hospitals and clinics (for more details, see Chapter 2). Consequently, hospitals in two nearby towns were administratively united. Geographically separated by 30 kilometres, the two systems of hospitals, clinics and dispensaries had a single head, a single source of financing and the same administrative procedures. In accordance with this structure, I expected easy access to the former maternity department in the fourth case, which was now working only as a gynaecological unit within the new inter-district hospital system. I obtained the contact details of the head of this unit from the head of the hospital, and conducted a prolonged and intense interview with the head of the fourth case institution, who had formerly been the main obstetrician-gynaecologist of the district prior to unification. During the interview, I figured out that there were only four doctors, including the head of the department, of that specialty in the fourth case. At the end of our talk, my informant gave consent for my continued work in the organisation and promised to call her subordinates to notify them of my arrival. However, every other obstetrician-gynaecologist in this institution refused to grant me an interview.

In summary, I tried to gain entry to four obstetric institutional fields in small Russian towns and was successful in only two of them, while the others remained closed following interviews with their heads. I realise that this sample is too small to make any generalisation; nevertheless, I argue that cases of both granted and denied access are worth analytical reflection. Moreover, I aim to show that how access was gained or refused provides an important characterisation of the medical institutions I sought to study.

My entry to the first case was obtained through family connections with one of the doctors. This tie was articulated by almost all informants in the case, and obviously helped me to advance my fieldwork. I was not the only one in that field who used social networks to advance their 'careers' as patients (or in my case, interviewer), as I could see during my observation. The choice of doctor and opportunities to receive better-quality services were often gained through acquaintances in that organisational context.

There were additional points of reference that facilitated successful entry into this field. Nobody refused to be interviewed, although some potential informants were unavailable for reasons such as vacations or maternity leave. My gender and age served for some doctors as additional 'legitimation' of our talk. It is worth noting that for residents of a small Russian town, the status of a sociologist and the method of interviewing in a medical institution are less clear or comprehensible. My other social roles helped my informants to establish a more understandable and acceptable communication setting in the form of a doctor and his/her 'curious' patient. In my interviews, for example, obstetrician-gynaecologists often referred to my own experience as a 'young lady', and later as a 'pregnant woman', to explain social specificities of their own work or of the medical organisation. Interestingly, this manipulation of



my personal social identity was not intentional, as it might be in some research settings (see, for example, Kawulich 2011), but was activated and adopted by the informants themselves through the actualisation of different aspects of my own background.

My successful entry into the third case was enabled by other circumstances. First, it was initially obtained through a formal telephone request, and the head of the hospital was not surprised or confused either by my speciality as a sociologist or by my request to conduct an interview. Our communication occurred as one between two professionals (although of different specialities), and neither my gender nor my age were articulated as important characteristics for our interaction. My further advancement in this field was also enabled mainly by my technical assistance in helping with documents and their delivery between different departments, rather than by my gender, age, status or acquaintances. As I observed during my fieldwork there, the professional culture in that organisation was shared by almost all medical practitioners, and shaped communications between the health professionals and their patients.

Another important characteristic of this third case was its relative openness. Medical organisations in general, and those relating to obstetrics and gynaecology in particular, are considered to be somewhat closed to 'outsiders'. Deriving from the Soviet healthcare system, Russian maternity homes and antenatal clinics tend to be institutionally unapproachable, even for prospective patients and their relatives. The former often get to know the rules only after admission (for example, when the labour has already started), while the latter often cannot even accompany women in labour or visit them afterwards. In the case under investigation, the doctors organised special weekly free excursions for pregnant women and their relatives to show them all the units, explain the principles of their work, meet personally with medical workers in the maternity department, and ask them any questions. Moreover, during these excursions, the main midwife and her colleagues encouraged pregnant women to give birth with a partner. In the interviews, among other reasons such as women's physical and psychological comfort, the same medical practitioners substantiated this position with the need to make their work transparent:

*We invite fathers [to attend the labour process] because they can watch us – women in labour seldom ask anything, but their husbands always check what we do, what injections we administer, how we work... in this way, they are sure that we are not doing anything bad to the patients. We have nothing to hide (I.S., senior midwife of maternity and gynaecological departments, Case B).*

In other words, relatively easy access to this case initially surprised me, but can be explained by the institutional specificity of that maternity department, which at every stage and in every communication sought to be transparent and

open in their work. The head of the hospital's consent for the interview and for my research was only one action among many others that provided the openness and transparency considered by the health professionals to be an important part of their professionalism.

As mentioned above, some of my attempted entries into the field were unsuccessful in terms of further fieldwork. My research experience shows that even for apparently similar institutions, the same strategy for gaining access may not work. In two cases described in the previous section, two different strategies were adopted – involvement of a social (family) network, and a formal request. However, the fieldwork conducted in two other cases presents evidence that the same strategies may appear to be irrelevant or may not work in other circumstances, but may nevertheless provide important data on how this medical unit is arranged and how it works.

## **4.4 METHODS OF DATA COLLECTION**

Overall 28 in-depth interviews with medical professionals (obstetrician-gynaecologists, neonatologists, midwives, nurses and healthcare managers) were the primary source of data. In addition, in cases where sufficient access was granted, observations were conducted. This method allowed me to detect informal practices and those not articulated in the interviews. For example, in the first case, attendance at a regular weekly meeting of health professionals to coordinate the doctors' work allowed me to understand how new formal regulations were transmitted and how the logic of state or managerial regulation was realised.

To uncover the history and structure of each case, document analysis was undertaken of both governmental regulations, and local paperwork and notices used in the medical organisations. In addition, in 2016 I conducted several expert interviews with the ex-chief obstetrician-gynaecologist of a region (2016). This helped me to study how maternity care was organised administratively, the system of coordination and regulation between districts, and the state's involvement in the work of medical institutions, through federal, regional and district administration.

### **4.4.1 IN-DEPTH SEMI-STRUCTURED INTERVIEWS**

I elaborated guides for different professional groups of informants, adapted to their positions and duties within maternity units (see Appendix 2). All interviews were conducted in my informants' workplaces, usually immediately after work or during night shifts, but in some cases during working time if suggested by the informant as the most convenient. The interviews lasted between 40 minutes and 2.5 hours, with an average of 1.5 hours. On several occasions, other informants joined the conversation, in which case I notified

them that I was conducting the research. I obtained verbal informed consent and digitally recorded almost all the interviews. The single exception was an interview with the head of a gynaecological department and a private clinic (Case 4), for which all notes were handwritten and expanded shortly afterwards. Probable explanations for this refusal are given in the following sections of this chapter. The recorded interviews were later transcribed verbatim and anonymised by the researcher, replacing all personal names. For more details on the informants, see Appendix 1.

Several research participants were identified as key informants, who helped to proceed with the fieldwork were re-interviewed twice or even several times. In one case the key informant was the head of the neonatological department of the central district hospital, who negotiated the possibility to conduct the research with his colleagues, and, in addition, helped to navigate both formal and informal professional hierarchies in the facility. In another case the key informant was a senior midwife of the maternity and gynecological departments, who willingly helped me to arrange the interviews with other practitioners and gave additional interview, focused on the particular approach to maternity care, introduced in the facility (see Appendix 2).

#### **4.4.2 EXPERT INTERVIEW(S)**

In 2015 I attended an annual meeting reporting on the work of maternity services in one of the regions (North-Western Federal Area) in which several cases were conducted. The region's main obstetrician-gynaecologist occupies a non-staff position within a regional system of maternity care, with a duty to coordinate different levels of services and collect aggregated statistical data. I obtained contact details for this specialist, who appeared to be also a professor in the medical university and a gynaecologist in a private clinic. I called the reception of the private clinic, introduced myself and the topic of the research, and asked whether the doctor would be willing to participate in my research. Several days later, an administrator at the clinic called me back and told that the informant agreed, but had a tight schedule so I should contact them later. Three months after the annual report, the position of the main obstetrician-gynaecologist of the region had been taken up by another doctor, but I was finally able to arrange an appointment with the former specialist.

I was only able to conduct the interview during the informant's working time and had to sign up through the clinic's administration, taking a 40-minute slot allocated to patients. To complete the interview and cover all the issues in the guide, I registered for three appointments over two weeks (as proposed by the informant). I consider this to be a series of expert interviews, since the informant, as the former main obstetrician-gynaecologist of the region, talked about various organisational, administrative and even legal aspects of the regulation and provision of maternity services. The information collected from these interviews contributed to my understanding of the field,

and also helped me to formulate key dimensions of the tension between different logics of its regulation.

#### **4.4.3 PARTICIPANT OBSERVATION**

The time spent in maternity, antenatal and gynaecological units was not limited to the duration of the interviews with healthcare practitioners. In some cases, after the interview had been conducted, I asked whether I personally might be useful or help the informant in order to compensate for the working time spent on participating in the research. In the first case investigated (Case A, 2012), the start of my fieldwork occurred simultaneously with a new requirement for regional authorities to duplicate all information on patients' medical history electronically. Some informants working in the antenatal clinic viewed this as a time-consuming and pointless task, since they had recorded all the information on paper and there was actually only one computer in the whole facility, so they would have to spend extra time after working hours to cope with filling in the forms. The head of the antenatal clinic therefore asked whether I could assist with this task, and I agreed. The only computer was in her office, so I was able to observe all communications with patients and staff members. To process all the patients' histories (around 700 pregnant women monitored in the unit), I spent around five to six hours each working day for two weeks, with some further work after a short break.

In the next case (B), the senior midwife of the maternity and gynaecological departments asked me to help her with a similar task, completing forms for pregnant women who had been routed to second- or third-level maternity facilities. The computer was in the office of the unit's senior midwife, but the door was left open almost all the time, and healthcare practitioners working in the facility, as well as patients who needed to communicate with her, freely entered the room. The volume of this task was much smaller than in the previous case, so I accomplished it in 20 hours (four to five hours per day for a week).

Data from the observations were collected in the form of handwritten notes, and were supplemented with analytical memos immediately after the fieldwork (Holloway, Wheeler 2010: 284-285). I consider these series of observations to be participatory, since I accomplished not only the research goals, but also tasks relating to the work of the maternity services themselves. Conducting observations allowed me to collect data on informal practices and interactions not articulated in the interview narratives, and hence provided methodological triangulation (Flick 2004: 178). It also helped shape the ensuing interviews.

#### **4.4.4 DOCUMENTARY SOURCES**

As a supplementary source of data, document analysis was applied in the study. It enhanced the collection of the 'background' information on the investigated institutional field (Green, Thorogood 2018: 156), and enabled the examination of its arrangement. In particular, documentary data were collected from three key sources:

1. To allow analysis of the key stages and actual arrangements of healthcare services reform in Russian state orders, I examined laws and programmes issued since 2006 by the Ministry of Health and other executive authorities.

2. To learn about the history and organisational structure of each case under investigation, I examined all publicly available online information, including the official sites of the regional administration, regional healthcare committees/ministries and medical organisations (local orders and regulations). In addition, I collected all media publications that covered any news relating to maternity services, maternity units or health practitioners in the districts and regions investigated.

3. To detail particularities of both the social contexts of the cases studied and the more informal rules of micro-level interactions (between healthcare practitioners and patients, and amongst medical staff and others), I investigated parents' forums and posts in social networks devoted to the experiences of women who had given birth in the studied maternity units. During the fieldwork I also collected local documents, such as information lists, notifications and announcements, available in the maternity units.

#### **4.5 DATA ANALYSIS**

To analyse the data, each interview and fieldnote from observations was coded (open coding) separately, then similar codes or themes were built into categories (Holloway, Wheeler 2010: 282). All the written data (transcripts of the in-depth interviews and fieldnotes from the observations) underwent a common thematic content analysis. As some other researchers, investigating institutional field and multiplicity of the organisational principles, shaping its arrangement and change, emphasised, it is not a direct and one-way process to identify theoretical categories in the narratives. In particular, they recognised that 'data analysis progressed in three stages, during which the level of analytical generalization was raised step by step' (Currie, Spyridonidis 2016: 83). I followed quite a similar strategy of the data analysis and introduce it further.

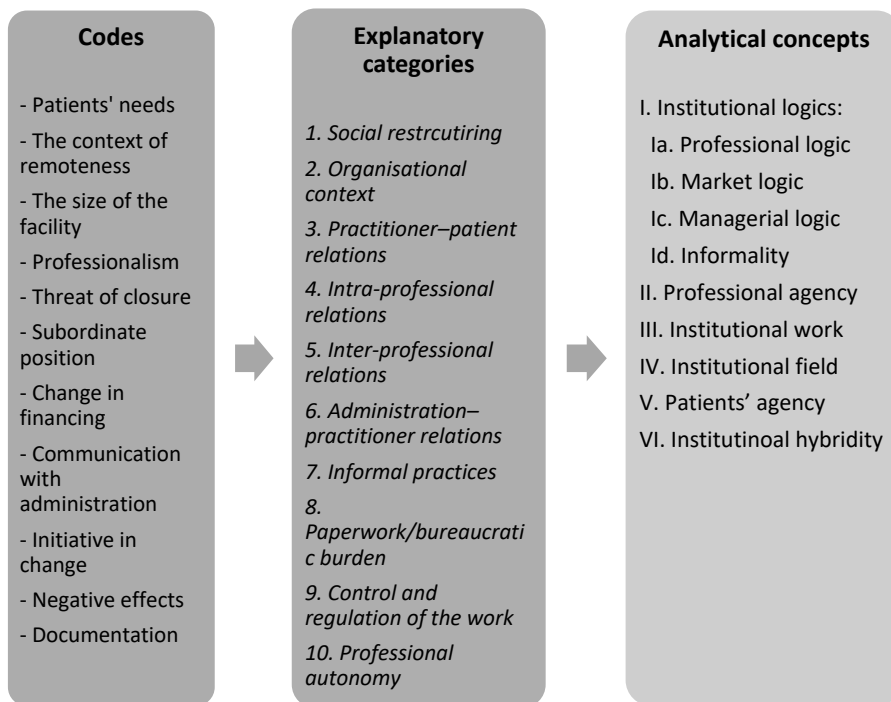
In the first step of the analysis, after transcribing each interview verbatim, transcripts were read closely to identify interpretation of changing social position of healthcare practitioners, their relations with patients, with other colleagues, organisational context and other problems. The fragments of

transcript were assigned with codes, relating to the key problems of the research. Both descriptive and interpretive codes were used on the first stage of analysis (Miles & Huberman, 1994).

Further, the codes were aggregated to the explanatory categories or abstract labels to summarise different perspectives, topics and storylines into key conceptual dimensions (Green, Thorogood 2018: 258-259). All the themes extracted from the interviews were revised, discussed with colleagues at research seminars and in consultations with supervisors, and redefined into more abstract categories, correlated with the conceptual framework of the research (Forrest Keenan et al. 2005). Examples of coding of the interviews' fragments, extracted themes (1–9) and analytical concepts (I–VII) are given below:

***They [patients] need** a full complement of staff. Full equipment. So that the maternity hospitals are clean, nice and cozy. So that a woman **would want** to give birth **in a small ward**. Without going to a big city. So that **everyone is a professional**. So that she wouldn't need to call anywhere, no ride anywhere, just like that. She comes to the maternity ward, a small one, she gets all the help, and they have all the equipment. But **small maternity wards are closing**, and the woman has to go to the world's end...*

*So, the fact that **we were made subordinate** to the state had an overall **negative impact on the jobs** (...) Because, first of all, there is only **one source of financing** – it's what they buy and get for us through various programs, from the Ministry, well, the Committee on Health. Before, **we could go to the head of the district administration** and say, "**Let's adopt this program** and do this and that, or buy this and that..."*



The data collected from the observations was analysed in a similar way, and the further analytical steps, proposed by Gina M. A. Higginbottom and her colleagues for the focused ethnographies in healthcare research, were taken: (a) coding for descriptive labels (b) sorting for patterns or explanatory categories (c) generalising with constructs and theories, and (optionally) memoing including reflective remarks (Higginbottom et al. 2013: 6). The following extract from the field notes, made during a single observation in Case B, illustrates the first step of the analysis – coding for descriptive labels ‘documentation’ and ‘communication’:

***It takes about 40 minutes to fill out one card [form of pregnancy monitoring]: the text itself is only one column on two pages, but interpretation the data of analyses and diagnoses takes a lot of time. Several times I clarify completely incomprehensible records from the I.S. [The senior midwife of maternity unit] - with some of them even she goes to G.L., the head of the department, or another doctor obstetrician-gynaecologists to ask for help. Most of all problems arise with cards filled in the antenatal clinic in P. [Case 3] (according to G.L, because they have an unfamiliar handwriting). But once G.L. commented that all the records from P. needed to be checked additionally, “because they confuse everything all the time” (observation on 27.07.15).***

Multiplicity of the methods applied (semi-structured interviews, observations, expert interviews and document analysis) enabled methodological triangulation (Flick 2004) to compare data and confirm the findings, to contextualise adequately and accurately the participants of the research in their local environments and to enhance understanding (Higginbottom et al. 2013: 6) of the analysed institutional change. In some cases, data, collected from the observations allowed not only to deepen and detail the analysis of the semi-structured interviews, but to reveal some inconsistencies between professionals' self-representations and practices as well.

## **4.6 ETHICAL ISSUES OF THE RESEARCH**

Following the arguments by Nigel King and his colleagues, any qualitative interview-based study deals with the following ethical issues: informed consent, confidentiality, right to withdrawal, assessing risk of harm, avoidance of deception, debriefing, limitations to the researcher's role, honesty and integrity in the research process (King et al. 2018: 33-35). All of these ethical principles I realise as my personal responsibility to follow, however, some of them appeared to be more challenging to implement, than others. This subchapter reflects on these ethical dilemmas and challenges, which emerged during my fieldwork.

Among other issues, I consider the necessity to keep the confidentiality and anonymity of my informants (Green, Thorogood 2018: 60) to be the key ethical challenge in the research, boosted additionally by the specificity of the object studied. Worth noticing, that my cases relate to the settings of small towns in which the number of health professionals is limited and the density of social networks is more intense. Thus, knowing the position of the informant, his or her name could be easily identified. In order to protect the anonymity and confidentiality of the data provided by my informants, I must conceal not only their names, but also the place names and administrative titles.

Another ethical issue, which I tried to control during the fieldwork was the openness of my research position within organisational context – I tried to inform all visitors of the facility during observation on my research and keep my position overt (Green, Thorogood 2018: 138). In addition, although no one asked me to sign any document relating to the maintenance of medical confidentiality (Kaiser 2009), I consider it to be my personal responsibility, as a researcher, not to discuss or transmit any information relating to patients, and I did not make any notes on their personal information. Potential vulnerability of both patients and healthcare practitioners themselves appeared another unexpected issue to be reflexive on.

The sensitivity of the research comprises another set of ethical issues, I needed to be reflexive on, since healthcare research can be sensitive in many aspects (Dickson-Swift et al. 2008; McGarry 2010). Although I did not initially



consider my research to be particularly sensitive, several episodes during the fieldwork revealed the relative vulnerability of my informants and the sensitivity of the whole field. As discussed in Chapter 4, my initial notion of potential sensitivity pertained to practices of the shadow economy, such as informal payments and privileges through acquaintance. However, in only one case (Case 4, see Section 4.5) did discussion of this issue seem challenging. In all other cases, the informants were quite comfortable with telling me about out-of-pocket payments they received from patients. As my fieldwork has shown, some tensions present in an organisational context may be hidden from outsiders and absent from formally similar settings. Reflecting on these tensions, I argue that the detection of sensitivity relating to a particular field, topic or setting is one of the methodological results of the research.

One of the key sensitive issues in one of the investigated cases appeared to be relations with the hospital administration, with controlling institutions and with other colleagues. As one informant complained, *'We always work under control – all our lives we work for the prosecutor!'* This appeared to be a leitmotif in almost every narrative, although it was not directly within the scope of my analysis. As evaluation of the data collected from observations has shown, much time and administrative resources were spent on preparing for expected inspections. The probability of a controlling institution's arrival created a constant feeling of a military situation, and during the interviews this atmosphere of tension and anxiety prevailed. An example of such a worry is the description below from the head of the antenatal clinic of a city hospital:

*Whoever is controlling us! It is easier to say, who do not – they have been controlling us constantly! And crossover inspections are conducted, first of all. We are asked to check the K.M. [neighbour district] antenatal clinic – crossover inspection, they come from T. [regional centre] to inspect us regularly and check all the documentation. Rospotrebnadzor [Federal Service for Oversight of Consumer Protection] has just inspected us, very tightly, they had planned inspection and have checked everything absolutely: all the licenses, all the documentation, at the staff office, whether everyone possesses proper certificate, proper ranks – all these documents, all medications in accordance with documentation. They have checked all the equipment, technical passports, expiration dates (...) they control us constantly! Foundation of Compulsory Medical Insurance is inspecting us constantly! (V.V., female, born 1947, case A.).*

Another dimension of professional sensitivity revealed in my study was the lack of proper and adequate communication between the hospital administration and healthcare practitioners. The doctors and midwives felt divorced from decision making on economic, administrative and even professional issues. The informants often described themselves as dependent

on the hospital authorities and dissatisfied with the policies and decisions made. The doctors also claimed that there were no opportunities for feedback or reverse influence – such an evaluation was given by even administratively privileged doctors, like the head of maternity ward of Central District Hospital, also acting as the main obstetrician-gynaecologist of the district:

*Well, a brave man appeared, who came [to public prosecutor] and was not afraid of such pressure! To be honest, they can oppress for such actions, you probably understand. We have signed recently a document, titled 'ethical codex of service behaviour of V. Central District hospital's personnel'. Do You know, what I liked there? Which sentence? What we have to comply with? Look [reading a document] 'staff members have to avoid statements and public judgements or evaluation regarding Central District Hospital's activity and its administration, if this is not official duties of the employee'. But, first of all, there is no such employee [in the hospital], whose duty is to judge the administration! (D.P., Male, 1952 year of birth, case A).*

As a sociologist who guaranteed the anonymity of the data collected, I felt myself to be the only other person to whom these complaints could be reported. At the same time, I also suspect that some refusals to participate in the research were caused by distrust and suspicion that I might be a 'secret controller'. This occurred in facilities where I had no prior acquaintances, and where access was provided downward from the hospital's top administration. In such cases, midwives and doctors without administrative duties might interpret my presence in the facility as an 'order' by the hospital or the regional authorities. Such distrust took months to dispel. It may also have been a manifestation of the intra-hospital mistrust that arose following the amalgamation of two separate organisations located in two different towns.

Another sensitivity that I revealed and experienced personally in my research field was the quite vulnerable position of patients. Although I did not conduct interviews with patients of maternity care services in this project, as a young woman interacting with healthcare practitioners, I was able to determine some traces of the power imbalance present in doctor–patient relations in reproductive healthcare facilities in small Russian towns. My age and gender allowed some informants to talk with me as with a potential patient, as one gynaecologist, working in antenatal clinic, explicitly articulated:

*Doctor: "You too... as our probable patient, will go through this [maternity care] (...) 'Do You use contraception? Do You use the contraceptive pill? Which particular medication they [interviewer's gynaecologist] offered to You? ... I will teach You, when You come to a doctor, when You, a young woman, come to a gynaecologist. In*

*order to let him well respond – it does not matter, how you look like. It is right when You come being cultured and educated, BUT! When a normal doctor starts to talk to You, You have to speak with him the same language, I mean, You have to know exactly, and tell without hesitation the days, that You had your period at these exact dates – precisely, without hesitation, report on your period. You have to know, let's say, your biography, your sexual life's start, how it proceeded, which illnesses You had, which hadn't...' (S.A., male, born 1964; case A.)*

Feeling uncomfortable and embarrassed, I felt the power imbalance in doctor–patient relations since I was unable to manage the direction of the conversation. Importantly, the longer my research lasted, the fewer cases of such ‘patientisation’ occurred. However, with male informants, this gender asymmetry continued to emerge, especially during expert interviews, where the power imbalance seemed to be more acute.

## **4.7 REFLECTIONS AND DISCUSSION**

In this section, I summarise some advantages and disadvantages of particular strategies to gain access to the field. I then outline some findings derived from my fieldwork experience, and particularly the empirical data that it was possible to collect from cases that remained closed to subsequent fieldwork. As other social empiricists mention, any social position taken in the field (as either ‘insider’ or ‘outsider’) has advantages and disadvantages, enabling access to information in some cases and preventing it in others (Enguix 2014: 88).

In the context of small Russian towns, the position of a social scientist is generally vague for potential informants, while the interview method seems strange and irrelevant to their professional experience. However, when entry to the field was successful and the informants agreed to our communication, they often tried to redefine my status, to establish a comfortable way for them to interact and use familiar patterns. Sometimes the informants preferred to actualise my personal social roles rather than that of a sociologist (although they were always aware of it), and each of these roles affected the trajectory of my advancement in the field in different ways.

Two main strategies were used to gain initial access to the field. The first, drawing on personal networks, has particular advantages, such as relative trust in the researchers and more easy communication by means of redefining their social roles. In my case, the social roles actualised by the doctors included:

- a junior colleague (because I assisted with medical documents)
- a patient (because of my age and gender)

- a newcomer from a cultural centre who had information in which they were interested (system of higher education or cultural events which are absent in small towns)
- a student needing help with a thesis
- a relative of a colleague (when the doctors interviewed were interested in information about my family).

However, this way of gaining access also had disadvantages. Among these, the most obvious was the limited information I was able to collect. When informants were interacting with me as with a patient or simply an acquaintance, they avoided discussing specific medical issues, and did not use medical terms, but talked about more about abstract issues rather than professional experience.

The second strategy of making an official request also had some benefits and restrictions. On the one hand, it provided more professional interaction, and my position as a social researcher was not redefined or ignored. Health practitioners used medical terms and built our interaction as with another professional in a different speciality. On the other hand, this kind of relationship does not necessarily presuppose mutual trust, and I expected that informants might 'filter' the information they provided. Moreover, little knowledge was gained concerning informal rules and practices. In addition, as my experience with the fourth case demonstrates, this strategy for fieldwork does not work if there is internal conflict between doctors, which tends not to be articulated by the informants beforehand.

There are also two types of trajectory for sampling informants, both using a snowball technique, which can be applied to an organisational case study. These also have particular benefits and limitations. It is possible to move further within a medical organisation from bottom to top – initially attracting, for example, midwives or nurses, proceeding with doctors and concluding with the administration. Such a trajectory helps to prevent bias in the data collected from nursing staff who know that their supervisors are also participating in the research. At the same time, as my several efforts to apply a bottom-up strategy demonstrate, in Russian public healthcare services, midwives and nurses are often situated at the very bottom of the professional and administrative hierarchy, which prevents them from participating in any but professional activity without the consent of a doctor or an administrator. In other words, the arrangement of post-Soviet medical institutions maintains midwives and nurses in a quite disempowered position, and they are unlikely to be gatekeepers to medical units.

An opposite, top-down strategy also has obvious disadvantages. First, researchers should be aware of possible bias in the data, such as inconsistency between formal rules and informal practices, conflicts between different types of worker, and so on. In addition, potential participants (or organisational members) may refuse to participate in research simply because they are in conflict with the administration.

**Table 1** Scheme of strategies and trajectories of the fieldwork elaboration

<b>Strategy</b>	<b>Benefits</b>	<b>Restrictions</b>
Official request	More ‘professional’ interactions	Does not allow detection of informal rules and practices
Social networks (personal acquaintances)	Relative trust in the researcher, making communication easier	Limits to the information I could ask for
<b>Trajectories in the field</b>		
Top-down	Wider coverage	‘Filtered’ information provided by subordinates
Bottom-up	Access to informal practices	Limited progress and difficult entry

This chapter has presented some methodological insights from my fieldwork conducted within the framework of the research project on changing maternity services and healthcare professionals’ perspectives. It precedes the empirical chapters with analysis of aspects revealed in the investigated cases through research reflection. In particular, it has discussed the dimension of power relations in which the researcher becomes integrated during data collection and analysis.

In addition, the extent to which maternity units appeared to be ‘open’ and easier to approach can be analysed in terms of manifestations of their intrinsic arrangements and shared notions of professionalism. For example, the openness of a particular field correlated with a more inclusive way of approaching all visitors, including patients, their relatives and the researcher. Relatively easy entry provided by an acquaintance or relative may partially be explained by the prevalence of informal networks and services rendered in the logic of *‘blat’*, a form of cronyism widespread in Russian healthcare in general, and in obstetric services in particular (see Rivkin-Fish 2005). The access that allowed the fieldwork in my third case to proceed, initially through a formal request, may be considered to be a ‘symptom’ of the openness of this institution, which had intentionally reorganised its structure to establish patient-friendly conditions for childbirth and make the professional culture more egalitarian. In other words, institutions promoting openness in their activities to patients appear also to be open to social researchers, since they ‘have nothing to hide’.

However, I argue that even in cases where a gatekeeper did not allow me to proceed with data collection, or where all the informants simply refused to participate in the research, some important data could be extracted and

analysed. In redefining the question ‘what did we not learn because of who would not talk to us?’ (Groger et al. 1999), I seek to answer ‘what did I learn because of who would not talk to me?’ and propose that all cases of gained or denied access to the field can be included within the scope of analysis.

For example, in Case 2, the head of the maternity and gynaecological departments appeared to be the actual ‘gatekeeper’, who decided to keep this gate closed. This probably occurred due to the relative rigidity of the institution itself. If an organisation is ‘closed’, reproducing paternalistic relations with patients and impeding access to their relatives, it will not tend to accept newcomers such as sociologists. Another case of refusal to participate can be interpreted in a different manner: I gained formal access since the gatekeeper (head of the department) gave me permission to continue my work, but all other doctors in that organisation refused to participate in the research. This might also be interpreted as a form of protest against their supervisor. The lack of egalitarian or partner relationships between colleagues led to fragmentation of the field, and hindered collaboration.

Some methodological limitations of the study should be mentioned here. I conducted my research in 2011–2013 and 2014–2017, but I include in my scope of analysis institutional changes that have occurred since 2006, when the most extensive reforms to healthcare and obstetric services were issued and implemented. For example, the introduction of the ‘childbirth vouchers’ programme (for more details, see Chapter 2) caused an important change to the material provisions of obstetric institutions. Thus, some narratives included descriptions of historical processes and were analysed differently from representations of ongoing changes.

An important problem which I tried to be reflexive on, was that the cases investigated differed not only structurally, in terms of the level of maternity services provided, the number of healthcare practitioners employed, etc., but also methodologically, since access to the field and the methods of data collection differed. In addition, since the focus of this research is on small towns in regions in the Central and North-Western federal areas, the data collected and conclusions drawn cannot be generalised to the whole country. I propose that other federal areas, such as the North-Caucasus, Siberia and the Far-East, have very different societal, economic and spatial characteristics.

## 5 HEALTH PRACTITIONERS' PERSPECTIVES ON RUSSIAN MATERNITY CARE

This is the first of three chapters that analyse the empirical data collected in the multiple case study of healthcare practitioners' perspectives relating to the path and effects of institutional changes in the field of Russian maternity care. Each of these empirical chapters focuses on a particular aspect of the key research question: **what is the role of health professionals in the local organisation and provision of maternity care in the context of top-down led institutional change?**

The following chapter 5 addresses the field-level changes and investigates, how doctors, nurses and midwives narrated features of the organisational structure, financing and regulation of the investigated institutional field. The chapter aims to address the mismatch of national level reforms (and its formal goals) with the micro-level reality of professionals' expectations, practices and ideals. In particular, it investigates those conditions for professional agency which are shaped by the perpetual institutional change. Subsequent Chapter 6 directs the attention into the organisational setting of maternity care and analyses the multiplicity and variability of institutional logics in the field of maternity services in Russia. Chapter 7 focuses on the scope of professional agency, analysed in terms of the institutional work accomplished by healthcare practitioners in one of the maternity wards under investigation.

According to the conceptual framework elaborated in Chapter 3, the central research issues are investigated through the concepts proposed within the frame of the neo-institutionalist approach to organisational studies and the neo-Weberian perspective on the sociology of professions. The object of study, maternity care services in Russia, is conceptualised in terms of the **institutional field**, which is being changed in a top-down manner. To examine how this structural change occurs in the field, I apply the concept of **institutional logics**, which reflect the underlying organisational principles of healthcare management and determine the design of service provision. Finally, in order to address the role of healthcare professionals in this institutional change, and the potential scope for their agency in small Russian towns, I use the concept of institutional work.

Chapter 2 outlined features of general healthcare, and particularly maternity services reform, financing, organisational structure and regulation in Russia over the last decade since 2006. It claimed that this institutional field is being changed predominantly in a top-down manner, and in a contradictory way that combines both neoliberal and statist policy rationales. The current chapter addresses the same issues of institutional change in the field and its

structural features, but analyses these through the lens of healthcare practitioners' attitudes and evaluations. Based on the empirical data collected from the multiple case study, it explores in detail aspects of the practical effects of state reforms enforced in the field of state-funded maternity services in small Russian towns. It argues that this context diverts the intended aims of social policy, with unexpected and sometimes negative consequences for the work of healthcare institutions and practitioners.

Section 5.1 focuses on specific institutional changes to maternity services caused by state reforms that have directly affected the organisational arrangement of healthcare facilities. In particular, it highlights the general neoliberal tendency for departments and units to considerably reduce their staff and dismiss personnel, which has led to a redistribution of professionals' functions, changed their practices, and aggravated patients' access to services.

Subsequent sections address changes that have occurred to how maternity services are funded and regulated. Some recent reforms, such as the move to single-channel financing and medical insurance companies' empowerment, are described and evaluated from the healthcare professionals' perspective. This provides evidence that recent and current institutional changes in the sphere of financing have appreciably restricted professionals' scope for making decisions and influencing their own working conditions.

Section 5.5 analyses maternity services' contextual specificity. It emphasises that the settings of small Russian towns shape the trajectory of state reforms and sometimes have unexpected practical consequences. The case of the routing law is outlined as a complex of structural, financial and regulatory alterations that significantly affect the work of first-level maternity facilities.

## **5.1 CHANGING ORGANISATIONAL ARRANGEMENTS**

In this section, I analyse the changes that macro-level reforms brought to the local level of the organisational arrangement of maternity care facilities. These were examined more generally in Chapter 2, which revealed that at least two main recent trends in healthcare reorganisation have caused large-scale alterations to the institutional field. The first is the introduction of levels of maternity facilities according to the principles of the risk-oriented model initiated by the 2012 routing law. The second major trend in structural reorganisation is a reduction in the number of medical departments, personnel and services, which is generally framed as a process of so-called 'optimisation', leading to considerable redistribution of administrative, social and even medical functions among the remaining units and practitioners. Some features and paths of the routing will be described in detail in the last section of the chapter as a case of unpredicted structural, regulatory and financial transformations that have occurred in small Russian towns.



Several important organisational changes were brought about by the implementation of the ‘routing law’. These included the allocation of maternity units to specific levels, which led unintendedly to the restriction of services in the regional periphery and even the closure of some facilities, as well as the obligatory routing of pregnant women at risk of complications, which brought another set of organisational challenges. Moreover, other important institutional shifts have occurred recently in the field of maternity services that have considerably influenced patient provision and professional practices. In particular, the process of so-called ‘optimisation’, which is not inscribed in any state order or programme but has occurred as a result of various administrative measures, has led to appreciable changes. The logic of optimisation has given rise to reorganisation and reductions in healthcare services and personnel in accordance with profitability measures and facilities’ formal demands for equipment. Standards of equipment and capacity have noticeably declined in facilities assigned to the first level, located in sparsely populated districts or that are unprofitable. Healthcare managers have had to close or reduce some units, personnel and services to fulfil budgets.

One of the most appreciable structural conditions for obstetrician-gynaecologists and midwives working in maternity departments (in contrast to independent maternity homes) is the outsourcing of some services to other units and organisations. For example, such facilities often lack their own anaesthesiology and reanimation (intensive care) units and specialists in obstetrics. In the case of operations (such as caesarean sections)<sup>4</sup> and other complications, maternity department personnel must call a hospital anaesthesiologist who works in all departments and does not necessarily have the necessary qualifications to carry out epidural anaesthesia. This considerably restricts the possibilities for pain management during childbirth – obstetrician-gynecologists of antenatal clinic and maternity department describes it as following:

*I believe that an anesthesiologist who works full-time in obstetrics should inject [anesthetic](...) an experienced doctor, who knows exactly how to do it!’ (N.V., female, born 1966, midwife of maternity department in B. district).*

*And we have situation, when the same anesthesiologists come to us from the intensive care unit. Even for our operations. That is, even if we make a cesarean section, we do not provide women with an epidural anesthesia, in fact we have a C-section under the general anesthesia... [it is necessary that an anesthesiologist] knows the*

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<sup>4</sup> The proportion of caesarean sections is increasing each year. In 2014, they amounted to 26.4 per cent of all on-term childbirths in Russia (Ministry of Health 2015). This proportion varies between regions and between maternity facilities, depending on their level or specialisation.

*consequences for a child and a woman, can estimate all the outcomes. We don't have such (A.R., Female, born 1991; case B)<sup>5</sup>*

Another structural complication for professional work in small maternity units is the scarcity of adjacent pediatric services. These small, first-level facilities often lack a pediatrician-reanimatologist (by law, such a specialist is prescribed to work only in perinatal centres) or a round-the-clock neonatologist and infant nurse, owing both to a scarcity of personnel, and the process of 'optimisation' if there are fewer childbirth cases per year in a district. In the quote below the head of gynecological and maternity departments of Central District Hospital complains:

*Concerning the personnel - well, with children's, with neonatologists we have a big problem. There is only one now - on duty around the clock, it's hard to imagine, she is already 60 years. Who does not spend the nights here - the night after night. It's hard. So now it turned out that we do not have now. There used to be four specialists, then somehow everything collapsed, everyone went somewhere ... (G.L., female, born 1965; case B)*

Staff dismissals may affect more than one specialty and organisational level. For example, infant nurses, a nightwatch neonatologist and medical attendants (junior medical staff) were dismissed simultaneously from the same maternity facility. This led to a considerable increase in midwives' workloads, who are now required to perform the functions of all these specialists, as well as coordinating with doctors if childbirth occurs during at night. The following long and emotional narrative of a midwife, working in the first-level maternity unit vividly describes the difficulty of working under the new structural conditions:

*And now here we have to call, a woman starts to push, you run, grab the phone, call an ambulance, [in order to call the neonatologist] "dress up, we now a childbirth is supposed to happen". Then you run like a fool again to the delivery room. You prepare a woman on the table [obstetric bed], in fact... it is a clusterfunk [laughing]! And especially since there is no infant nurse. That is all, and you do not know what to seize. And you can call the pediatrician too early, yes, you do not know when exactly it happens, then you can just stand there for an hour, maybe two there, maybe, well, there's eight centimeters [of the opening of the cervix], yeah, okay, we'll wait there for twenty minutes until the head goes down, the cervix opens, and we call her [a neonatologist]. Five minutes later you come, and*

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<sup>5</sup> Some of the narratives quoted in the thesis, which deserved a particular linguistic expertise, have been translated by Anastasia Daur.

*she [a woman] is already starting to push, and a scurry begins, you are like a fool. (...) It is a duty of a midwife to prepare a delivery room, and prepare everything for the baby, and prepare for resuscitation, you never know what can happen, because the tight period is tight, that is. You never know what will happen next, yes. Childbirth is a childbirth, it is never predictable. And you are like a shavka [mongrel]: a tongue on your shoulder, and you run like a fool, you don't know what to grab for. Well, we still have medical attendants, they somehow know where and how to help ... but, well, what can they provide actually? They can serve something, bring something. But on the other hand, yes, this reduction, it, of course, affects a lot the work. I believe that it is wrong, that they have dismissed nurses (N.V., female, born 1966, case B).*

Importantly, optimisation of healthcare may increase and may also result in maternity facilities closing down completely. The midwife quoted in the previous paragraph used to work in another maternity department in a nearby district, which was closed in 2007. The head of the remaining hospital explained why this had happened in terms of economic profitability. In particular, he mentioned that a decline in the number of childbirths and the new principle of maternity care financing (per capita) had made it unmanageably expensive to keep both units open.

Ironically, after my fieldwork in one of the empirical cases had finished, the head of the hospital quoted above was dismissed, and the maternity department was subsequently closed for the formal reason that it lacked a paediatrician, the previous one having retired. Shortly before this, the same midwife quoted above claimed that personnel shortages are the main reason for maternity facilities' closure, which also considerably worsens pregnant women's access to obstetric services:

*They need a full complement of staff. Full equipment. So that the maternity hospitals are clean, nice and cozy. So that a woman would want to give birth in a small ward. Without going to a big city. So that everyone is a professional. So that she wouldn't need to call anywhere, no ride anywhere, just like that. She comes to the maternity ward, a small one, she gets all the help, and they have all the equipment. But small maternity wards are closing, and the woman has to go to the world's end (N.V., Female, born 1966; case B).*

In addition, this midwife argued that she would prohibit her own daughter from giving birth in the facility where she worked, owing to a lack of constantly available neonatologists and other specialists. This, I suggest, is an important marker of poor professional commitment caused by structural change in the field.

The data analysis demonstrates a mismatch between the formal goals of state reforms, articulated as the improvement of the accessibility and the quality of maternity care, and reasons for structural change in the maternity care field, and the actual outcomes of the reorganisation. The new organisational design of maternity care elaborated by federal-level state bodies appears to lack sensitivity to the local specificities of maternity facilities. This results in unwanted 'side-effects' of reorganisation, which actually both aggravate the working conditions of medical personnel, and ultimately result in patients' limited access to maternity services.

## **5.2 UNINTENDED CONSEQUENCES OF CHANGES IN FINANCING**

Changes in maternity services financing appear to be quite ambivalent for professional work and organisational structure. As outlined in Chapter 2, since 2006 there have been two major national projects ('Health' since 2006, and 'Modernisation of healthcare' in 2011–2013), which have entailed considerable budgetary transfers to healthcare institutions in general, and maternity ones in particular. Since 2006, a system of 'childbirth vouchers' has served as an additional means to improve maternity services. At the same time, health professionals (like other experts, see Chapter 2) indicate a general insufficiency of healthcare financing owing to single-channel funding since 2015 (only through MHI), inadequate tariffs for MHI payments (compulsory medical insurance), and inability to predict or influence the amount of services provided. This section addresses all these issues, and provides evidence of ambivalence in the material provision of maternity services.

One-off injections of resources through the federal 'modernisation' programme and the 'Health' national foreground project have undoubtedly improved the material conditions of maternity services, allowing them to engage in at least partial renovation, and to buy specific equipment or develop facilities, although even this was considered to be insufficient. An example is the story narrated by the head of a hospital:

*But, unfortunately, the amount of money [provided within the federal program 'modernisation'], to my mind was two million three hundred thousand rubles, not so large. So, it was not possible to make everything [needed], so, outside, we did not have enough money to make beautiful building outside. But inside everything was done okay: have changed the floors, changed the electrics, changed the windows, that is, that's all what we did, that's all the money have been spent for (A.V., male, born 1964; case B).*

Doctors deem the system of childbirth vouchers to be one of the most positive recent reforms and state programmes for the work of maternity facilities. The

head of gynecological and maternity departments of B. Central District Hospital, who also works as the chief obstetrician-gynecologists of the B. district sums it up in the following quote:

*Additional payments [through the system of childbirth vouchers] - is that bad? It is very good. We can buy some medicines, which we could not do before, because a budget did not allow. Some equipment, and in addition - salary to the staff. This is essential. When there were many childbirths, it [payments] was more (G.L., female, born 1965; case B).*

Yet there are important restrictions. For example, money received through the system of childbirth vouchers cannot be used to improve gynaecological departments, although in some cases of complication pregnant women are actually hospitalised in such facilities. Such a mismatch between the formal goals of the Federal and Regional policies and actual local circumstances has been investigated as intrinsic characteristic of the social restructuring in Russia (Kulmala 2014: 93-94). In addition, money from childbirth vouchers cannot be used for renovation or some types of equipment, as it outlined by the head of the entire hospital:

*This is a good measure actually, but again, unfortunately, a list of what medical organisations can buy for the money received through the childbirth vouchers (...) is limited by law, yes ... There you can buy various medications, you can buy equipment, medical tools, but for some reason you cannot buy medical furniture, for some reason you cannot do renovation using this money, in obstetrics facilities, antenatal consultations. Therefore, there are some little restrictions (A.V., Male, born 1964; case B).*

However, such 'statist' measures, highlighting particular forms of state support and its explicit claim to be responsible for healthcare improvement, is not the only trend in changes to healthcare financing. Another important tendency is a turn toward a neoliberal logic of healthcare provision. Despite extensive federal and regional transfers to hospitals and clinics, their personnel testify to a lack of economic resources and inability to influence their increase. The most appreciable institutional change in this field has been the shift to single-channel financing, which prohibits the devotion of additional resources from district or regional administrations to supplement the provision of maternity services. The head of a central district hospital describes it in the following way:

*So, the fact that we were made subordinate to the state had an overall negative impact on the jobs (...) Because, first of all, there is only one source of financing – it's what they buy and get for us*

*through various programs, from the Ministry, well, the Committee on Health. Before, we could go to the head of the district administration and say, "Let's issue this program and do this and that, or buy this and that..." We went to the council of deputies, proved the importance of it, the deputies approved it and included in the district budget, and we got it (A.V., Male, born 1964; case B).*

This new scheme of funding has not only restricted the number of different sources available for healthcare facilities, but has also complicated how resources are obtained. In particular, it means that each institution (hospital or department) must calculate its needs exactly in advance, and must estimate which particular medicines will be used over the whole of the next year, since the possibility to add resources during the current financial period is limited. A negative evaluation of the economic situation can be identified in the quote by the main midwife of gynecological and maternity departments of B. Central District Hospital:

*Right now I do not like our economic situation - I do not like anything. If before... well, now I cannot say how many births exactly I will have this month, how many the next one - I cannot even predict closely. They closed [maternity hospital of the second level] for emergency - we had 100 childbirths that month. That is, when I make an application [for material and medical provision] for the next year, I cannot calculate it. That how difficult it is. That is, this unrealistically. But, if I make an order, and I will not have enough, no one will provide me with it additionally! Medicines change, requirements change - that is, a year is a large interval [for calculation] (I.S., female, born 1972; case B).*

Consequently, this situation brings additional complications to medical management, and new tasks for health practitioners, how the head of maternity and gynaecological departments sums it up:

*Frankly, our money situation is not too good right now; yeah, because we've got a kind of single-channel funding, the procurement is weak, there are tendering procedures and competitions. You order in the beginning of the year - heaven forbid you need anything in emergency - to get this medication, you have to walk through hell knows how much you will get [sic]. If only there were [medications] to treat [people]... (G.L., female, born 1965; case B)*

Moreover, healthcare practitioners cannot order particular medications and instruments that they consider to be appropriate and necessary. They must justify their necessity, prove that the cheapest ones are not always the best, and make a formal tender, according to Federal Law №44 (2013). Doctors and

midwives criticise this regulation, since it demands a particular economic qualification which they lack, even being at the administrative position, like the main midwife of gynecological and maternity departments:

*...we have money from the childbirth vouchers, but I have to call the accounting office, find out how much money left on the childbirth vouchers, found out, then I have to find this medicine, that I need, on the Internet, to find its international denomination, I found it, then I have to make a technical assignment for this drug (...) But I have to make it up the way, that this particular company, that I need, will win. Do you understand? (I.S., female, born 1972; case B)*

In addition, this law considerably complicates negotiation and approval within medical organisations. It requires the personal commitment and enthusiasm of professionals responsible for purchasing and provision, as the same informant narrates:

*This is my interest. Let's say so. I am interested in this. Then I take it to the contract department. Oh, I have the chief doctor sign it, that he doesn't mind, then I take it to the contract department. See, this is idiotic. (...) Yeah, these are completely different structures. I will also have the economist and the accountant sign this paper, that they don't mind. The chief of the facilities also, the engineer, that she doesn't mind. Then I take it to the contract... And then they tell me: look, we've got a lot of work, we have to participate in tenders for three months, and so this drug I have ordered in early June, I hope to God I will see it in November. You see? (I.S., female, born 1972; case B)<sup>6</sup>*

The mechanism of tenders leads to a qualitative deterioration in the medicines and equipment ordered, since it applies market mechanisms which, in healthcare practitioners' opinion, are inapplicable to healthcare in general. Health practitioners argue that the cheapest instruments and drugs, which are procured if additional efforts are not taken, complicate their practice, while it becomes more and more difficult to justify their need for more expensive ones. An example is the description below from interview with the head of a hospital:

*Yeah, and of course the notorious Law 44 on public procurement, when you can't do anything, can't really purchase anything, which, in my opinion, shouldn't be applied in healthcare at all. At least when it comes to the procurement of pharmaceuticals. (...) [But this law is applied] to everything in general. From business trips to*

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<sup>6</sup> This and some other fragments of interviews further, which required specific linguistic qualification, were translated by Anastasia Daur

*pencils. ... This is the difficulty. The main difficulty (A.V., Male, born 1964; case B).*

As a result of such changes to how maternity services are financed and provided, health practitioners may find themselves in situations where they cannot meet the requirements of medical protocols and orders, owing to a lack of equipment or medication. The head of gynecological and maternity departments and the main obstetrician-gynecologists of the B. district complains of such a situation:

*For instance, Rho(D) immune globulin, okay? This is an expensive medication, and we are supposed to administer it during pregnancy and after delivery. The point is, excuse me, how do you afford it? We scraped the bottom of the barrel, we ordered it – and that's it: for how many women will it last? So, these are the problems (G.L., female, born 1965; case B).*

In summary, analysis of the data in this section shows that federal-level initiatives designed to change the financing of healthcare organisations have had unintended consequences at the level of the smallest and poorest facilities. The changed method of provision has aggravated the material resources they possess and can obtain. In addition, new rules for the procurement of medical equipment and medicines have impeded the flexibility and variability of necessary supplies. As a result, healthcare practitioners have to spend more time and effort on overcoming all these impediments, but still find the system unpromising in terms of developing and improving services. Moreover, conditions are being made riskier for services provision, since the new model of financing causes outages of essential and vitally important medications.

### **5.3 CHANGES IN REGULATION OF MATERNITY CARE AT THE STRUCTURAL LEVEL**

In Chapter 2, it was concluded that the recent federal reforms in the field of healthcare have centralised its regulation and increased both the marketisation and bureaucratisation of state-funded services. This section addresses the effects of these macro-level shifts on how maternity services are regulated by design. At the same time, I argue that regulations in terms of the dominance of any institutional logic may differ across different levels of the field. Chapter 6 will focus on the organisational settings and principles which favour or constrain professional agency, and address the various ways in which they compete and merge, resulting in different hybrid forms.

The neo-Weberian framework proposes three ideal logics of regulation (Freidson 2001), although it is quite challenging to establish empirically which



of these is dominant in the institutional field of maternity care. Healthcare services in Russia are rather a 'hybrid' model (Field 1991), meaning that professional, managerial/bureaucratic and market logics of regulation co-exist. Recent reforms have complicated this interlacing, leading to the strengthening and predominance of both administrative power and market mechanisms. Particular neoliberal measures and the practical consequences of their implementation have already been described in this chapter. This section examines some cases that illustrate changes to regulation of the institutional field.

One of the most appreciable manifestations of the dominance of the managerial logic is the hospital head's complete administrative dependence on representatives of regional authorities and the Ministry of Health. Sometimes informants testified that such recruitment is intentional, with the aim of optimising healthcare provision, which in practice means reducing services and personnel. Therefore, the regional administration hires the head of a central district hospital from another district, in order not to promote personal connections and sympathy. The ensuing structural restrictions in the field described in the previous section often occur as a result of the regional administration's decisions, rather than in accordance with the institution's particular needs and notions. As the head of neonatological department describes it:

*Poof – and he's appointed, that's it. And everyone there is happy with him, he even had a nickname – Andrey the Liquidator. Because, at first, he liquidated the children's hospital – under his rule, he was the chief doctor when it was gone. And he's not going to argue with anyone or protect anybody's interests before his superiors, right? If he is ordered to do something, he will do that. He doesn't argue much with his subordinates, either (B.I., Male, born 1971; case A).*

This state of affairs substantiates the general tendency for top-down regulation and structural change in the institutional field. This principle, in particular, aims to centralise regulation on the one hand, and to decrease the autonomy of facilities and healthcare professionals on the other. The sequence of administrative decisions taken in one of the studied cases<sup>7</sup> emphasises this dependency, where the maternity unit was closed after the regional authorities

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<sup>7</sup> The maternity department was closed after the fieldwork (February 2017). After this, I contacted the informants in summer 2018 to investigate what had happened to the obstetrician-gynaecologists and midwives of the unit. Some had retired after the maternity unit's closure, while others, including the senior midwife and the ex-head of the maternity ward, continued to work in the same hospital, providing only gynaecological services. They also said that two more heads of the hospital had been appointed by the regional authorities during this period (2017–2018), and that each time it had led to a redistribution of administrative and material resources between different units and professionals.

appointed a new head of the central hospital, who came from another district and was not personally involved in professional networks. The formal reason for closure was the lack of a neonatologist, since the previous one had retired in 2017 and it was allegedly impossible to find another specialist. However, even before this measure was taken, personnel in the department were discussing the threat of closure, which no one could stand up to owing to the hospital head's dismissal.

The dominance of the managerial over the professional logic of regulation was also appreciable in the mechanism of control of the maternity care, which influence the routine working practices, which will be analysed in more details in the next chapter. What I aim to emphasise here is that regulation and control of maternity care in Russia is evaluated by healthcare practitioners as irrational and incompatible with the ideals of professional autonomy. Every time a new law or state programme is implemented, it inevitably adds to the list of obligatory reports, records and other documentation required as part of the work.

As informants reported, the increasing documentation also leads to a situation of broken communication between different hospital units, and, as a consequence, impede the coordination and control of the quality of care provided. Every unit is regulated by its inner logic of provision, and does not function in accordance with other departments and wards. Thus, each hospital represents a multiplicity of different regulatory frameworks, which complicates coordination between different units. That is how the senior midwife of gynecological and maternity departments of a central district hospital puts it:

*That is, I say, we have a lot of problems. It's interesting to work here, but you get stuck in these papers. That is, here the [hospital] pharmacy gives me medicines I do not need, which I do not use. She [pharmacist] has nowhere to spend it! (...) but what we need actually, what I order, it does not come, I do not know (I.S., female, born 1972; case B.).*

This increase in the volume of documentation and multiplicity of logics occurs owing to both the large number of institutions controlling hospital work, and the various fines and sanctions they can enforce. Among other controlling authorities, insurance companies were complained about most as being unfair and wrongful. An example comes from the head of maternity ward of a central district hospital:

*This...this, how to say, this outgrowth on the body of medicine, which in the form of insurance companies, blood-sucking one, I would call it so – for what do we need it?... You see, they inspect medical records and authorize their inadequacy, I mean, they check*

*whether they are drafted correctly. And [then] they impose fines, oh yes they do” (D.P., Male, born 1952; case A)*

Doctors criticised the authority of insurance companies as not only unreasonable and unnecessary, but even harmful to healthcare services, since it reduces the already insufficient resources and takes a lot of doctors’ time, and the companies perform like raiders. In the quote below the head of a central district hospital explains it:

*This is an absolutely unnecessary buffer – insurance companies. What’s interesting, it is the insurance companies who fine us. So, a private entity, an insurance company is a private entity... [they] fine a public-sector entity and put the money in their pocket. You see what’s illegal here, right? <...> so private entities, in fact, steal money from the government. Whitewashing it in medical institutions. So that’s the state of things. (A.V., Male, born 1964; case B).*

It is noteworthy that the authority of the health insurance companies was recognised by the healthcare practitioners as the dominance of a managerial rather than market logic of regulation, since it functions as just another controlling body, and not actually as a market mediator. Its formal status as a non-state (private) organisation only increases the feeling of injustice and illegitimacy over insurance companies’ performance. As the same informant proceeds:

*Well, first, there is always a lack of money, [our] financing is rather scarce, so we have to patch up many holes. Based off of our not very big resources. We ourselves earn money. Nobody gives us anything. There are certain tariffs established by... these are the tariffs by which we receive money from insurance companies. Which is also wrong, in my opinion (A.V., Male, born 1964; case B).*

Some regulatory changes in healthcare have nevertheless alleviated the burden of professional practice, allowing the introduction of new approaches and practices. For instance, a technical amendment to sanitary norms has allowed patients’ relatives to come into healthcare facilities. In the particular sphere of maternity services, this has enabled the introduction of a family-oriented approach to childbirth with a partner as the preferable model. An example comes from the same interview with the chief doctor of the hospital:

*The legislation has changed towards simplification at that moment exactly [means the period of organisational transformation – from 2007 till 2013], Sanitary norms, all these orders, yes (...) normative, which allowed to organize the [pregnant women’s] relatives’*

*presence [during childbirth]. Before there was a prohibition to let anyone into maternity home. Well, it all used to be a closed premise completely. But now it is possible (A.V., Male, born 1964; case B).*

Further details of the changed model of maternity and childcare in this case will be discussed in Chapter 7 as an example of institutional work accomplished by healthcare practitioners. It is referred to here just to show that regulation of the institutional field of maternity care is quite uneven, but in general is characterised by the domination of market and managerial logics of regulation. This tendency, when public employees are suffering from both growing managerialism and market pressure, is less specific to Russia in comparison with other contexts (Evetts 2012; Noordegraaf 2015). As research on Western systems of healthcare demonstrates, healthcare professionals have become vulnerable in the face of managerial control and market mechanisms, both of which transform the core of medical professionalism (Numerato et al. 2012: 626).

In this regard, the institutional field of Russian healthcare is distinctive owing to its lack of professional autonomy even before the growth of managerialisation and marketisation (Field 1991:58; Saks 2015). During the Soviet period, professional groups experienced neither professional autonomy in defining the content of their work, nor authority to affect healthcare regulation. Consequently, no professional group has been able to withstand the neoliberal transformation of the public sector and the strengthening of managerial control in post-Soviet Russia (Matveev, Novkunskaya 2019).

## **5.4 MATERNITY SERVICES IN THE CONTEXT OF REMOTENESS**

This section examines the remoteness of the maternity care in small Russian towns as a crucial factor that may considerably shape the path of institutional change in the field. The geographical dimension of healthcare arrangements is often not considered in the design of state reforms. These do not take account of actual distances from one level of maternity facilities to another, the area of the region or district which affects how long it might take to transport women in labour, and other aspects. As a result, some unpredictable consequences of reform may emerge, affecting all dimensions of maternity facilities' work. Although the borders between different types of structural, regulatory and funding alterations are not always clearly defined, since one process may affect another and vice versa, in this section I describe institutional changes that have been caused by the implementation of the 'routing law' (Ministry of health 2012). Based on the data collected from interviews with healthcare professionals working in a first-level facility, I provide a detailed description of some of the problems that emerged after its implementation.

Formally, this measure aimed to improve the quality and accessibility of technologically advanced maternity services. In particular, it entailed the introduction of a perinatal risk-oriented model to reduce maternal and infant mortality rates in the regions through precise monitoring of each pregnancy, risk scoring for each case, and planned routing of pregnant women to a facility sufficiently equipped to assist with potential complications. According to the latest statistics, the goals of this model have actually been achieved: maternal and infant mortality rates have reduced in most Russian regions (Ministry of Health 2015; Shishkin et al. 2016). Health professionals working in first-level maternity facilities also welcome the stated intention of this measure, as they appreciate the positive effects of delegating complicated and pathological pregnancy and childbirth cases to suitably equipped and technically developed maternity homes or perinatal centres. One of the obstetrician-gynaecologists working in the maternity department sums it up in the following quote:

*Well, first of all, everything has to be done in advance. This is why they introduced these registers where we manage medium- and high-risk women. Here, we diagnose them, we have to hospitalize them in advance in higher-level medical facilities (...) This is how we prevent possible complications. Because there are specialists there working with these complications (...) Consequently, there is a decrease in infant mortality, perinatal mortality, and maternal mortality. (...) Well, routing is generally a good thing, I think it takes place everywhere in the world (A.V., Male, born 1964; case B)*

However, healthcare managers and practitioners testified that there is always a difference between planned and actually implemented models, and that the very useful idea of routing, as well as the formally articulated goals, have produced a new set of unintended consequences. In particular, redistributing patients across the region has led to a scarcity of childbirths in peripheral areas served by first-level maternity units, which now have insufficient workloads. The head of gynecological and maternity departments argues:

*That is, this system [of the routing of pregnant women with complications] is good, the idea is excellent, but it must be improved and adopted! To provide everyone with their own work everywhere [on all levels]. (G.L., female, born 1965; case B)*

The implemented order was not accompanied by additional financial transfers to the regions, which has led to a lack of equipment, personnel and facilities sufficient to carry out all planned schemes of the routing. Another example comes from the head of the central district hospital:

*But another thing is, that, as it often happens, many things are not completely finished. Here, the routing was announced, so there*

*should be, among other things, an obstetric reanimation brigade, so-called mobile one, which has to, if necessary, let's say... if I have revealed that I have in Z. [remote area within the district] a woman with complications, yes, pregnant. We need this team from T. [second-level medical institution] to the Z., so that it could take her and, if necessary, along the way, provide her with all the necessary assistance. And since there is no such brigade, unfortunately, all these measures are taken by paramedics of the ambulance... (A.V., Male, born 1964; case B)*

Besides the planned effects of the law's implementation, some unintended institutional changes have emerged, which in practice have caused practical obstacles to the provision of maternity services. The formal obligation to delegate some pregnancy cases, coupled with the mechanism for financing healthcare services through fixed per capita payments, have considerably reduced the number of childbirths in first-level facilities, and consequently the amount of economic resources transferred through the single-channel system (MHI). This has caused a deterioration in the provision of maternity facilities, and a lack of material resources and unprofitability have emerged as new problems. This difficulty is aggravated by the additional expenses arising from the necessity to transport pregnant women and women in labour, which rests on individual patients and first-level hospitals rather than on the regional administration. The main midwife of gynecological and maternity departments of a central district hospital sums it up in the following quote:

*Everything is at their [patients'] own expense. We have, you see, a remote district - the worst thing we have, is that we are far away, and that we have a scattered area, that is, we reside an awesome area! Of course, this is difficult in terms of funding - there are a lot of transportation costs, taken by the hospital account. We deliver them [pregnant women with complications] ourselves, well, sometimes we call "sanaviation"<sup>8</sup> (I.S., female, born 1972; case B)*

As the head of the same departments put it, the routing model appears to be ambivalent in terms of regulation and financing, since it prescribes delegation of complicated cases, leading to a decrease in childbirth rates at a facility, but is simultaneously a reason for growing unprofitability:

*Routing. It's all because of routing. I mean, we lose a third of our deliveries <...> A third. This is the problem of all first-level [facilities]; many of them will probably close - [the number of deliveries] has reduced to a minimum. You see, there are few*

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<sup>8</sup> There is one ambulance car per region, as informants reported, which is not always available to use.

*deliveries, the hospital cannot financially support us – the service is very expensive. Very [expensive]! That’s why we’ve been always frowned upon, because a lot of money is invested in us, and there is little return when there are few deliveries. So that’s it... (G.L., female, born 1965; case B).*

Another difficulty with the implementation of the perinatal risk-oriented model is its orientation toward pathological and complicated childbirths rather than physiological ones. This has led to a deterioration in access to healthcare services for medically normal cases. In addition, the model presupposes only planned pregnant women’s hospitalisation, and does not take into account the specificity of this sphere. Childbirth is sometimes unpredictable in terms of dates and time frames, but when urgent labour starts, it does not allow the woman to be transported, as the main midwife of maternity department argued:

*The point is that she was to give birth in the Almazov’s center [Federal perinatal center, specialized on cardio-pathologies], and they wrote there: ‘come at thirty eight weeks and four days’ [of gestation], but at the thirty eight weeks and three days her water breaks and she starts laboring. Where could we transport her? Nowhere! That is a peculiarity of our small maternity home. I mean there are levels, yes, when there is planned transportation, of course, it is much easier for us. But part of this level [childbirths with complications], anyway anytime can appear here. (I.S., female, born 1972; case B)*

Furthermore, some general features of maternity services were not considered in the design. In addition to unpredictable timings, there are challenges in terms of transportation, which is not easy for pregnant women considering the quality of roads and cars and distances within a region, especially late in pregnancy. These conditions are worsened in some cases by women’s reluctance to move far from home, refusing to go the regional centre planned according to the risk rate assigned during their pregnancy monitoring. In the quote below the main obstetrician-gynaecologist of the district describes such situation:

*This is just an awful problem [convince a woman to move to another institution]! An awful problem. We can do nothing with them. Just now we have assisted a woman with a high risk, with sugar diabetes – she was to give birth in a specialized institution, and could do it in T. [second level institution]. I swore, I begged, I, there, asked-begged-persuaded her. The only thing I succeeded was to direct her to the T. (...) Many women resist “No, I won’t go, won’t do it” – that’s all. It is a trouble actually. (G.L., female, born 1965; case B)*

The decrease in the number of assisted childbirth cases has had unintended consequences, such as loss of professional competence and qualifications. Because they assist with only uncomplicated childbirths, at least according to the plan, doctors and midwives affirmed their lack of practice with pathologies and obstetric challenges, leading to discouragement in professional practice. The main midwife of maternity department explains, how it can happen:

*They have implemented this three-level system – and this destroyed everything on the vine [the growing popularity of this small facility, when women from other cities used to come to give birth here]. I mean a woman comes, and we tell her “you know, you cannot give birth here!”. I mean we started to redirect even ours [women of the same district]. I mean it is quite offensive for us, and... how to say, there is no any development, you become dull. We used to deal with urgent pathological cases, with a complicated pathology, all doctors were training all the time, developing... but now – I don't know... it has become so... of course any childbirth can become [difficult] But when you have a half of all cases urgent, and another – planned, it is one situation, and when you have urgent childbirth only once a year, it is scary. I mean, if we used to be on the alert all the time, we always used to be in tonus, but now we have become relaxed. We know that complicated cases we will forward there [to facility of the second or third level] (I.S., female, born 1972; case B)*

The above quote highlights how the managerial rationale for the maternity care reorganisation is enacted and challenges the professionalism in terms of inability to practice in the desired way and loss of professional qualifications. Her colleague, a midwife of the same department continues this claim:

*It is not interesting at all, not at all. You see, because, what we are skilled to do, it will be forgotten slightly. Because we are not allowed to work the way we are used to. It is not interesting at all! (N.V., Female, born 1966; case B)*

In conclusion, there have been many unintended consequences of the institutional changes resulting from implementation of the routing law. Although the introduction of a risk-oriented model has undeniable benefits, for the smallest first-level facilities it has resulted in a deterioration in financing, working conditions, and even healthcare practitioners' proficiency. Hence, it represents an example of a top-down institutional change which, in practice, considerably limits the possibility for professional agency.

In conclusion, this chapter has examined structural-, regulatory- and financial-level institutional changes to maternity services in small Russian



towns during the implementation of state reforms. It has outlined the leading principle of changes to the institutional field, which is a top-down form of regulation. In addition, a finding of the research is that this centralised approach to institutional change and the national government's ideas do not correspond with local arrangements for maternity care services, in terms of their remoteness and economic profitability. In practice, this mismatch has unintended consequences, with unintentional 'side-effects' arising from the reforms.

Analysis of the empirical data reveals the emergence of crucial challenges for the work of maternity facilities under the influence of recent reforms. Specifically, doctors and midwives recognise significant reductions in some units and departments, dismissals of some personnel, and in some cases closure of whole maternity units. Empirical data from the interviews confirm that these processes are aggravated by a lack of material resources, scarcity of service provision and altered ways of funding. Healthcare managers and practitioners criticise the shift to single-channel financing and the growing authority of medical insurance companies, which have led to increased bureaucratisation of the work and dominance of the managerial logic of regulation.

The 'routing law' implemented in 2012 has been analysed as a particular case that affects all dimensions of maternity services' arrangement. This case provides evidence that the spatial dimension and the specificity of the social context (remote small towns) were not considered in designing the law, which has had unintended consequences. Although designed to reduce maternal and infant mortality rates and improve the quality of healthcare services for pregnant women, women in labour and newborns, in practice the routing law has led to the emergence of new forms of social inequality and impediments to medical professionals' practice. Specifically, for first-level facilities, which are the most remote and least equipped, it has given rise to several problems and risks. It has reduced the number of assistances with childbirth, thus worsening these institutions' material provisions and conditions, and also leading to a threat of closure. Several risks have also emerged for patients who are not categorised as being at risk of complications and are not 'routed', since such units may lack necessary medications or equipment. At the same time, health professionals may lose practical skills and proficiency, while pathological deliveries still occur at this level, since some patients with complicated pregnancies may refuse routing or may not give birth on their expected delivery dates, so emergency births also occur at the first level.

## **6 CO-EXISTING AND COMPETING INSTITUTIONAL LOGICS AT THE ORGANISATIONAL LEVEL OF MATERNITY CARE**

In the previous chapter I have analysed, how the institutional change on the local level of studied organisations is shaped by the top-down led state reforms and, which consequences it causes for the provision and organisation of maternity services. In particular, I examined, how professional logic is dominated by the managerial and market ones in the way maternity services are designed and regulated. According to the analysis of the empirical data, health professionals in Russia have not been acting on the structural level as independent and autonomous social group during the last decades. Some previous researches only confirm this statement (Brown 1987; Saks 2015) and provide scarce evidence of professional agency revealed on the macro level of institutional changes.

Conceptual framework of my research proposes that institutional change can occur on at least three levels: the one of the entire institutional field, organisational one and on the micro-level of professionals' practices and interactions. I also argue that it is important to consider not only different social orders of the institutional field but different institutional logics, which dominate or blurry on each of the levels.

In this chapter I aim to answer the following sub-questions of the research: *which institutional logics do appear to be dominating the institutional field of maternity care in small-town Russia? How do healthcare practitioners manage the rivalry of different organisational principles, and which mechanisms do they elaborate to maintain their professionalism?* Following the arguments of neo-institutionalist scholars, I assume, that institutional logics itself are not static, and some of the components of one logic can blend into another or even combine dimensions of diverse logics (Martin et al. 2015: 393). Although this distinction of different ways in which institutional logics can blend or assimilate in particular cases is 'empirically slippery' (ibid), this chapter addresses the perspective of health practitioners in order to elaborate how these different principles manifest itself within organisational contexts.

Several previous studies have shown that to fully understand the institutional change, an examination of the actors' interpretation of multiple logics on the ground is needed (Currie, Spyridonidis 2016: 78; Bévort, Suddaby 2016). This chapter focuses on the ground level of organisational settings, and examines how street-level professionals, i.e. doctors, midwives and nurses, working in maternity units in small Russian towns reflect on the institutional logics that frame both the content of their work and their ability to affect it. It aims to analyse the perspective of health professionals and calls

into question, what is professionalism as both an ideal of professional practices and an organizing principle for healthcare practitioners working in maternity units in small-town Russia? The chapter also examines, how do other institutional logics manifest itself in the same institutional field, in what way do they challenge professionalism and what kind of social mechanisms are elaborated to overcome these challenges. In order to answer these questions, the chapter is organised as follows. The first subchapter focuses on those professional practices and narrated ideals, which can be analysed as the efforts to enact the professional institutional logic. The next subchapters examine the managerial and market organizing principles, present in the context of maternity care, and how they affect the possibility to follow the professional ideals and principles. The last subchapter introduces the fourth organizing principle relevant to the investigated field, which is the institutional logic of informality.

## **6.1 PROFESSIONALISM: THE FIRST LOGIC**

Rephrasing the definition introduced by Eliot Freidson (2001), I consider professionalism to be not only one of three other key organising principles in the field of healthcare, distinguished in the classical theory, but as the primary one for the medical professionals in terms of self-identification and shared professional ideals. Although this chapter in general addresses the rivalry of different institutional logics in the organisational context of maternity care in small-town Russia, I start with the analysis of those health professionals' practices and outlooks, in which they enact professional institutional logic as a leading organisational principle.

This section examines the healthcare practitioners' perspective on their own professional status, the content, ethics and standards of their work, and conditions that help or impede their fulfilment. What part of their professional role do doctors assign to the process of education and the implementation of new recommendations? How do they take responsibility for health, establish their professional standards and expectations and fulfil them as a sign of integrity? These questions are observed through the positions of obstetrician-gynaecologists, nurses and midwives, working in the maternity departments of the first and second levels of care.

As the evidence from the semi-structured interviews demonstrate, healthcare practitioners defined the issue of professional knowledge and experience as the core part of medical professionalism. They considered continued self-education to be a key feature of professionalism in general, and of their own professional integrity in particular. Second, they appeared to be ready to reconsider some of their existing notions and knowledge (they expressed open-mindedness), and to be reflexive and critical with regard to shared norms and rules, which they reconceptualised as volatile and challengeable. Doctors and midwives recognised that knowledge and expertise

had changed, and that in order to develop both their professionalism and maternity services, they needed to learn continuously. As the main midwife of maternity and gynecological departments put it:

*We try to attend as much conferences as possible, we participate, we do presentations at the conferences as well (...) Yes, she [the head of the department] is very literate, educated, and competent, she is learning all the time, always studies something. I mean she is interested in all these issues. And she has an interest in woman's deals. I mean, she wants to get satisfaction from the childbirth. I mean, she is so, she reads a lot, participates at conferences as well, and makes some videos [informational and educational] regularly. That is why, we do it [implement innovations] together steadily (I.S., female, 47 years old. Case B).*

This data correlates with some results of the previous researches, which emphasise that the new practices can emerge through the influence of the new knowledge (Entwistle, Matthews 2015: 1149). As other scholars point out, the complex of new expertise and practices, or the 'new professionalism' comprises of such features as evidence-based practice, active rather than passive patients, and wider networks of accountability and regulation' (Martin et al. 2015: 381). Another example of such an 'openness to change values' which is conceptualised by social scholars as one of the key components of the new professionalism (Racko 2017), comes from the head of the same maternity and gynaecological departments, mentioned above:

*This [transition to the program "mother and child", initially founded by UNESCO] was, let's say, my initiative and our senior midwife, I.S.. How it happened? We came to... led by this international organisation, as I understand, to this "mother and child", we were invited for studying. Well, how invited? We were forced by the committee's order to go there, for two weeks of study. Well, we went there. Of course, we were wary going there with such, let's say, with mistrust - how can it be, that suddenly we do not know, how to take delivery, and, in general, what would they teach us there? A little bit, with skepticism we concerned. And the first days we generally thought that this was a kind of American propaganda, and we were being zombified, that it is impossible, it is prohibited. That is, that each manipulation should be discussed with a woman, obligatorily, all pros and cons. (...) That is, we used to intervene actively, aggressively. Although it turned out that everything was unsubstantiated actually – I mean, we believed books, professors, all these, we were taught. But now they trust researches, moreover, those, which are randomized (G.L., female, born 1965; case B).*

This quotation also supplements the discussion on professional agency with new notions of what may enable it. New professional training and knowledge, and opportunities to apply it in an organisational context to actually alter it channel tension between the professional logic and other forms of regulation. This will be discussed in more detail in Chapter 7. The quote above also refers to another component of the professionalism, which was articulated by doctors, working in other facilities – initial scepticism and mistrust of the new recommendations. As evidence from the interviews reveals, obstetrician-gynaecologists considered their own professional experience to be more convincing than any other. They were distrustful of new recommendations and new forms of healthcare, whether these models were suggested by patients or by acknowledged ‘professors’. That is how the head of a maternity ward of central district hospital articulated:

*No, they [the Ministry of Health] recommend that you do not need to use it [concrete medication], but I disagree with them and think that it is necessary, that it is effective, and "oxytocin" is less effective. The same is with perinatal medicine – you never know, who and what can write there! Professor! But maybe he's crazy? Are you sure that they all are judicious people? Where is the guarantee of their sanity? (...) They have hardly substantiated their recommendations by the evidence ... double, randomized and in this way. And the whole West has long been on the evidence [based medicine]. And we are just starting - before that we used to [get information] only from monographs, one institution is working this way, the other – that one (...)*

*And what can you invent in childbirth, tell me? If it is physiological? Well, I can hold her by the hand [ironically] (...) But is it necessary to prepare [women for childbirth]? Hard to say! (...) What can you learn more for physiological births? Anyway, they will give birth the very same way they always do! (D.P., male, born 1952; Case A)*

As the quote above suggests, some doctors are prone to rely on their professional knowledge and experience, which was articulated as the core part of professionalism from the earliest works on sociology of professions (Freidson1970). Thus, such reluctance to adopt new recommendations and approaches, can be also analysed as an example of the institutional work, but the one of the ‘maintenance’ of institutions (Muzio et al. 2013; McGivern et al. 2015).

Doctors’ willingness and enthusiasm to engage in further education are shaped partially by their general attitude toward the Soviet system of healthcare. Health professionals sceptical of new recommendations and sources of information (such as the Internet) described Soviet medical education and healthcare as currently lost ideals. They referred to the Soviet

model of healthcare as a 'golden age' when all necessary medicine and equipment was available, and criticised all practical and regulatory innovations as being imported from 'the West' (meaning Western Europe and North America), probably with harmful intentions. An obstetrician-gynaecologist, who also has the administrative position of the head of the maternity department described the working condition in the Soviet healthcare in the following way:

*There used to be time, we lived in, then later, you know how it was, firstly, there were enough medicines, there was a preventive orientation of medicine, everyone used to be screened, it was completely free of charge, medicine ... Is not it a kind of merit of a certain time, that everything was free. Or they said later, that it was a bluff, this cannot be, everything should be for the money. Well, everything is for money now. Wherever you go, you have to pay everywhere, if not officially then into a pocket. (D.P., male, born 1952; case A)*

Conversely, other doctors, mainly from the maternity facility in Case B, characterised Soviet obstetrics as 'aggressive', harmful to women and even 'terroristic'. They criticised their colleagues for being outdated and 'too Soviet' – implying too authoritarian and domineering – in their attitudes toward patients and their inability to adopt new, scientifically substantiated approaches. Healthcare practitioners in Case B also expressed pride in the changes that had been made to their maternity facility, which met international and up-to-date recommendations.

An obstetrician-gynaecologist, who performs the similar duties of the head of gynecological and maternity departments and the main obstetrician-gynecologists of the district, evaluates the Soviet healthcare in a different manner, and emphasised some 'negative' aspects of the Soviet medicine:

*Well, there are people - the most important point is people, you know. There are [in another gynaecological department of the hospital, former maternity department] doctors, who are even at the age of seventy already, that is, they have such Soviet notions on obstetrics – but now a lot has changed! And they don't have maternity ward for a long time, and they have probably already forgotten what it is, and here they live according these old laws, let's say (G.L., female, born 1965; case B).*

Doctors and midwives in this facility also recognised that they used to practice a 'Soviet' approach, which they now considered to be inapplicable to maternity care, primarily owing to its aggressive and overbearing way of communicating with patients. The same informant admitted:

*We ourselves used to have it differently! There is a fact, for example, they [new recommendations] say to us: "The child born in your ward - is not yours! You cannot dispose him! Take him away from his mother, do some vaccinations. This is not your child!". How it could be? Like this? Everything is ours! Everything that is in our maternity home. I mean we used to behave completely differently! That's a fact, well there are facts of obstetric aggression as well. I mean we [used to] ascribe an infusion – just because we want so, we [used to] make an operation – we want so! We [used to] never ask anyone about anything! And we used to have our own, don't know, by whom invented points, and woman did not used to participate in it actually. Well, with few exceptions. Now, of course, everything has turned upside down. We have thought and decided: "Yes, it [attitude to the patients] should be changed. Yes, we will do something." And as we took an active part, it became more interesting to work, and now, let's say, there are some results [...] You no longer feel yourself a terrorist. You understand that you discuss everything with a woman; she is involved in the process (G.L., female, born 1965; case B)*

Health professionals mentioned openness, in terms of both communication and organisation, as a key feature of this institutional change. For example, they discussed as achievements the introduction of tours of the maternity ward for pregnant women prior to labour and delivery, and the policy for women to have a companion with them during labour. They contrasted these practices with Soviet medical facilities, which they defined as 'closed', in terms of being hostile to women themselves and completely inaccessible to their relatives. The main midwife of the maternity department, who is responsible for the organisation of maternity care describes the way in which they started to provide more openness for their patients:

*Well there are people from S. [the regional centre], from T. [the second-level institution] coming - we invite them in advance, once a week we conduct excursions - we tell everything, we show everything ... Such tours, of course, are only 40 minutes long, but all the questions on the management of childbirth, and on the positions during labour, and on the role of husband, and on feeding - I try to answer here (I.S., female, born 1972; case B).*

Notions of the Soviet past are addressed in this section as a metaphor for strong state authority, which was intrinsic to the Semashko model of healthcare (for more details, see subchapter 2.1; Field 1957). Analysis of healthcare practitioners' narratives in the two investigated maternity units proves that institutionally similar fields, shaped by the same top-down reforms, may differ considerably in terms of professionals' views on the ideal

model of maternity care, and therefore on the necessity to initiate alterations. It also provides evidence of significant differences in professional approaches and practices by representatives of formally similar professions and specialties. Further analysis emphasises this dissimilarity in other aspects of the organisation and provision of maternity care.

At the same time some of the health practitioners appear to be more sensitive to the new social trends like the consumerisation of the patients' behavior (Temkina, Rivkin-Fish 2019). As a result, they create new call for professionalism – in particular, the necessity to perform the emotional work alongside the professional one. As part of their work, obstetrician-gynaecologists and midwives described the labour of managing their emotions (Hochschild 2012), not allowing themselves to express them. That is how a gynaecologist, working in a gynaecological ward articulated the necessity of the emotional work:

*Well, if we have taken this responsibility [take care of people], we are to suppress our own emotions (T.V., Female, born 1949; case A).*

Another example of emotional work as inevitable part of professionalism comes from the head of antenatal clinic of a city hospital, who compared this new task with the psychological expertise:

*Like a psychiatrist, their specifics of communication with patients, so we [communicate] with ours – you have to play the fool all your life. What emotions can you even have? If there's a person sitting in front of you, what are you gonna do? Sometimes people come that make your soul seethe with anger! But you can't, you mustn't do anything like that! You have to swallow, sometimes you do get angry, but you cannot show your emotion – it goes with the job! (V.V., female, born 1947; case A)*

The informants recognised that the sphere of maternity services is linked with emotional and moral experiences. They also narrated that all painful and unwanted outcomes that happened to their patients also affected them. Thus, professional burnout might emerge, requiring additional psychological work. The main midwife of the maternity department emphasised this dimension of the professional work:

*That is, if a child dies, a child is injured, I say, it is very hard for personnel! Who worked with this woman, a midwife takes it as her own grief! I had one such case in my practice, but I still remember it, I still remember this premature baby who died on the second day, but we did not have this medication for the lungs at that time, and I did everything I could. And I do not care what she [a woman, lost her child] says about me - maybe she told someone that they had*



*killed a baby in the hospital, but let God help, it would relieve her. Psychological aspects have a big role! It's harder for her in hundred times – anyway it is a work for us, but for her it is life ... We would [like to] have a psychologist - we support each other, calm down, we cry, sometimes we cheer, on the contrary! That is, we need a psychologist, we all need. Professional burnout - you cannot invent this, it exists actually (I.S., female, born 1972; case B).*

This quotation can be analysed as a ‘symptom’ of the professionals’ exhaustion, caused by efforts to comply with their own notions of professionalism, ethical standards and new approaches to maternity care in social conditions that did not favour their realisation. The next subchapters are focusing on these dimensions of the organisational arrangement and care provision in the field of maternity care and examine those practices and conditions, which enact managerialism and marketisation.

As M. Noordegraaf highlights, not only knowledge, skills, and expertise as well as their application in specific situations are of matter in the definition of professionalism, but the way they are regulated, since the ‘professionalism is a matter of “(self)controlled content’ (Noordegraaf 2013: 784). The previous chapter concluded that, at the structural level of federal reforms, maternity care is regulated rather through managerial and market principles. Following the arguments of the previous researches I propose that on the street level, professionals can successfully integrate both managerialism and professionalism (Bévort, Suddaby 2016: 20). The next subchapter addresses this rivalry of two institutional logics and examines, in which cases it can result in either in conflicting rationales, or in hybridity of a professional role.

## **6.2 MANAGERIAL LOGIC OF REGULATION: DOMINATION OR HYBRIDISATION?**

Russian social and healthcare policy represent quite a bureaucratised context for the work of professionals. As a result, relationships between doctors and the state in Russia are usually described in terms of the bureaucratic system of healthcare services inherited from the Soviet order, with physicians representing a ‘hybrid profession’ (Field 1991; Noordegraaf 2015). This term refers, on the one hand, to the ambivalent position of healthcare professionals, who have little autonomy from state managers, yet simultaneously have considerable authority in the eyes of patients. On the other hand, ‘hybridity’ within institutionalist perspective can be considered as a form of adaptation to the institutional complexity, in which different logics of regulation compete with each other and can dominate differently on different levels of the field (Denis et al. 2015: 280).

Relations with the state (and healthcare managers) remain crucial in defining professionalism and restrictions to its enactment as an organisational

principle. As the recent research conducted by the Levada center demonstrated, the tension between managerial and professional logics of regulation appears to be the most severe for Russian health practitioners. In particular, sociologists argue that some new norms imposed on the field of healthcare go against the established order of care provision, which exacerbates professional choice between conflicting domains: careful examination of a patient vs. proper filling of papers; rationale of economic efficiency vs. professional standards; refusal of treatment vs. falsification of the diagnosis; responsibility to the managerial or controlling body vs. responsibility to a patient (Levada-center 2016: 30).

The management of daily work, and conditions such as relationships between colleagues and how their work was coordinated, were described differently by employees in the two maternity units, although their legislative and administrative frameworks remained similar. I investigate intra-professional relationships as an indicator of different approaches toward the social hierarchy embodied in medical organisations. In particular, I consider willingness for collaboration between obstetricians and midwives and the reproduction of formal hierarchy to be important features of organisational principles, which enact different institutional logics.

Doctors in the first maternity facility mentioned several times that their daily working lives were controlled ‘from above’, or by other bodies such as insurance companies, some controlling state bodies (like ‘*rospotrebnadzor*’ and ‘*roszdravnadzor*’ – for more details see the figure 4. in chapter 2) or the public prosecutor, while they themselves had no opportunities to manage their own practices or initiate changes to them. Obstetrician-gynaecologists working in various maternity units identified themselves as actors in very subordinate positions and with no ability to make changes. Even the administrative position within the field of maternity care does not solve this problem – the head of antenatal clinic of city hospital sums it up in the following quote:

*We always work under control – all life we work for prosecutor! (...) Whoever is controlling us! It is easier to say, who does not – they have been controlling us constantly! And crossover inspections are conducted, first of all. We are asked to check the K.M. [neighbour district] antenatal clinic – crossover inspection, they come from T. [regional centre] to inspect us regularly and check all the documentation. Rospotrebnadzor [Federal Service for Oversight of Consumer Protection] has just inspected us, very tightly, they had planned inspection and have checked everything absolutely: all the licenses, all the documentation, at the staff office, whether everyone possesses proper certificate, proper ranks – all these documents, all medications in accordance with documentation. They have checked all the equipment, technical passports, expiration dates (...) they control us constantly! Foundation of Compulsory Medical*

*Insurance is inspecting us constantly!* (V.V., female, born 1947; case A.).

The quote above emphasise that subordinate position of a healthcare practitioner, who is tightly embedded into the rigid organisation hierarchy. As the further analysis reveals, this administrative hierarchy was reproduced at an inter-professional level, between doctors and midwives, and with nurses as well. Other informants, working in the maternity facilities of the same case insisted that ‘command work’ (collaborative) between doctors and midwives was impossible since they had different responsibilities, and that professional boundaries should remain stable and unchanged. The assumptions for the hierarchical interprofessional relations are outlined by even quite young doctors, like an obstetrician-gynecologists quoted below:

*No, it is not a teamwork [work during childbirth], all decisions are taken calmly. Anyway, we are responsible [for childbirth], not they [midwives]. They just need - to do some injections, to help to give birth. Normal deliveries. If there are any pathological childbirth, a midwife is with a baby only, a doctor manages – all these buttocks [pelvic presentation], forceps ... Well, nobody talks to them [midwives] strictly particularly, but they know their work, they have great experience. They do everything they are told to. Well, there are some midwives, who have little understanding, then you must talk severely and loudly in order to make them start to do, and others themselves know what to do – you just say, and they already know what to do* (E.I., female, born 1979; case A).

Midwives, as representatives of another profession, working in the same facility confirmed this distribution of responsibility in relationships between doctors and midwives. They recognised the accountability of doctors as more powerful and expert professionals, as a quite experiences midwives described it:

*A doctor anyway knows better, and he is responsible for this. So, we decided for them. Everything will be as doctor says. When I do caesarean, I'll say: it's right that we have done it ... Sometimes we think - that's not necessary; but once they have done it - thank God, they did it!* (A.A., female, born 1960; case A)

In contrast, health practitioners in the other maternity unit under investigation represent another way of combination of managerial and professional logics – in particular, they emphasised the necessity for collaboration between different specialties. In that case health managers and doctors recognised not only the necessity of interprofessional collaboration, but the expertise of formally subordinate specialist – a midwife. The role of the

senior midwife was emphasised by doctors and administrators as key to the process of institutional change, that is how the head of the entire hospital evaluate her qualification:

*Well, we have it in this way. We have the level... let's say, all our midwives are of the same high level [of qualification], excepting I.S., the senior midwife – she is, of course, of the higher level! (A.V., male, born 1964, district B)*

This senior midwife was described by her colleagues as a key challenger of the existing order. All informants working in the same unit recognised her authority to influence the path of change in the maternity department. She herself describes this process of change and her role in it in the following way:

*You see, we got it all more home-like in here, we got it all smaller, and we don't have an influx as large as Hospital number 1 [one of the maternity hospitals in St. Petersburg, also working in accordance with the Mother and Child project]. That's why we got it all homely and cozy. Our staff is all – all of my midwives are... I was the... no, I've just hired a young girl, but before, I was the youngest, and all the midwives are elderly women, they all do baby-talk – they talk to them like they're their own daughters. As to being rude – no, they're not rude even off-work. I mean, they all go babbling softly... (I.S., female, born 1972; case B).*

Interactions between doctors and midwives working in this unit and inter-professional communications were described as collaborative and egalitarian. The same main midwife of the maternity department explained it:

*I have not worked in big cities - I have nothing to compare with. I do not know the model of the work in big cities, I have created the model I wanted to see here, I created it. (...) There are maternity hospitals, in which maternity ward and the newborns unit are different structures and they even do not communicate with each other! Here we have it differently, our collective is small, if something somewhere [happens], we are all together! Anyway, I know everyone from our staff members, who is capable for what, who can be lost in an emergency situation - who needs help, who, on the contrary, concentrates, who needs to be called. Also we know our doctors, who can be expected to do what, we have already worked well together... Doctors who are on duty, who come from the consultation [antenatal unit]- they will not interfere in the process. If there is something somewhere [happens], a midwife just informs them with the fact: 'I do not like this or that, let's try to do something like that'. A doctor gives consent. There was not such ... [situation of*

*refusal]* - we have experience for more than 25 years of work experience (I.S., female, born 1972; case B)

The data discussed here allow the conclusion that inter-professional relations in a given unit may in some cases reproduce the hierarchy and symbolic borders between different professionals, while becoming more egalitarian and horizontal in others. The latter model may stimulate institutional change, at least in terms of some organisational alterations. This difference can also be analysed in terms of different ways to combine the managerial and professional institutional logics. Representatives in the first case regarded the professional hierarchy as a stable characteristic, and experienced authority over subordinates and dependence on the administration simultaneously. At the same time, the permeability of intra-professional boundaries in the second case allowed the powerlessness of healthcare practitioners to be challenged, at least partially.

As a specific form of managerial pressure on professionals' work, obstetrician-gynaecologists and midwives in both institutions mentioned overwhelming paperwork and administrative tasks. In particular, they criticised the immense amount of such work as being practically impossible to complete, useless for medical practice, and lacking any value for final assessments of their work. They argued that the amount of medical documentation required nowadays did not allow them to take care of their patients in a way that satisfied their professional ideals and integrity. In both cases, administrative work was defined as a field of struggle, and as a time-consuming and useless process that had nothing to do with their actual medical practice. In this sense, doctors and midwives clearly contrasted themselves with managers and administrators, whom they did not recognise as health professionals.

This particular work dimension in both maternity units studied reveals the dominance of a managerial logic of regulation as a main obstacle to professional development and autonomy. Paperwork takes most of the time, as healthcare practitioners testified, and does not allow them to introduce new practices, educate themselves or communicate with each other adequately. An obstetrician-gynaecologist, who works in different units within the system of maternity care narrated paperwork as being incompatible with healthcare itself:

*Everything is paperwork only! We don't even have time to work with patients – we have to devote ourselves to scribbling: we have to fill in clearly and legibly this form and then to write a report»*  
(S.B., Male, born 1964; case A)

No less importantly, medical professionals claimed that this aspect of their work had lately been getting worse, in terms of time consumption and irrationality. This partially confirms the reduplication of structural features at

the organisational level, which had similarly become a site of managerial dominance, which affected the work of every health practitioners, including a midwife of a maternity department with no administrative duties:

*It's the general [clinical record] that they manage. And we've a ton of paperwork! And somehow there's more and more of it coming every month... Well I don't know [why], they add something new every time – what else is there to add? What else... There was nothing like that before: we didn't write drugs off the inventory, we didn't do clinical records... Now we have to record the woman herself. Besides, to take her in, we have to give her three papers that she has to fill in herself. Despite them being in labour... (A.A., Female, born 1960; case A).*

The overwhelming paperwork was recognised as a problem not only by the doctors, but also by other healthcare practitioners (midwives and nurses), although they are formally not responsible nor for the organisational documentation neither for a patient's history. The senior midwife of the maternity unit emphasised how irrational and useless her work duties had become:

*It might seem that we have to talk to women in labour, discuss breastfeeding, all that... But we don't have enough time! We really don't. And it's become worse over the past few years! Now they made us count vials and pills! This is just idiotic. You're sitting and counting (...) before, we just received the pharmacy and expended by the name. Now you're sitting and counting, how many wooden spatulas, how many syringes, needles, how many [pharmaceuticals] written off the inventory. And this consumes so much time! Plus this is useless work! I mean, it doesn't make the quality of treatment better! We'd better spend this time on staff education and training – the work that no one else can do. But we cannot do that kind of work! I mean, I have no economic education to compute all that staff, cost effectiveness and all, tendering, technical assignments. So, this is the bad, the unpleasant side of things... (I.S., female, born 1972; case B)*

This increasing bureaucratic burden affected all health professionals – not only those with administrative functions, but also every doctor, midwife and nurse, as previously narrated. Previous researches show that such a bureaucratisation of national governance is a global phenomenon, which 'weakens the occupational values of medical professionals' (Racko 2017: 95). However, for practitioners formally accountable for administrative tasks, the amount of medical documentation had increased still further. The head of a

maternity unit, who also held the position of the main obstetrician-gynaecologist of a district, put it as follows:

*There are many official duties as well – ascribing a woman with a particular risk group (...) then if any orders come – from the ministry, Russian, intra-hospital, all of them are coming [to me], I have to transmit it to obstetrician-gynaecologists, working [here]. That I have to investigate all the cases of perinatal mortality, to provide a report to the Region. Report, every three months on the work of our maternity services I have to provide, working plan for the next year, what and how will be – everything related to a paper work, everything I should accomplish. There is a lot of such work, and it is quite difficult. In general, all the bumps, which come, everything what has happened badly – they require me for all of these all the time, I am the ultimate (...) All these duties combine in one person in such small maternity facilities as ours. And [a paper workload] has increased considerable. There are some new orders emerge permanently – or the Ministry issues, either our Committee [regional committee of health], either someone else. Thus, and everyone issues different papers, on which you have to report. But what time? Nobody is interested in what time it takes for us to accomplish! (G.L., female, born 1965; case B)*

Notably, throughout the interview this informant was continuing to deal with reports and other documentation. She had a very short time in which to meet the researcher, although she did not mind research being conducted in the unit. Participant observation confirmed her narrative on the workload: the head of the maternity and gynaecological departments quite often stayed in the facility after her official working time was over in order to complete all the necessary paperwork. The data collected from participant observation demonstrate that healthcare professionals have neither the time nor the skills (for example, to work with special software) to meet all the managerial requirements imposed. As a doctor working in both the maternity department and the antenatal clinic testified, there is an even greater bureaucratic burden in facilities providing ‘primary’ (outpatient) care services:

*It’s too much. Too much, that’s for sure. It’s too much. Sometimes you even deliver a baby and enjoy your work. Then you go and spend an hour, hour and a half on papers only. Writing a report, a statement, all kinds of stuff. And of course, there is a lot of paperwork because now we have to get special waivers from women and whatever else. We are bound up with it. And of course, there is a lot of paperwork in women’s consultations... Indeed, there is a lot of paperwork in a women’s consultation. Lots of it – poor doctors. Not only doctors, but midwives, too. There are all kinds of*

*reports – record here, record there, all kinds of journals... Receipts, too, for statistics – all these statistics. Sometimes you can't even understand what's with the woman while you do all this paperwork*  
(A.R., female, born 1991; case B)

As some previous researches show, some professionals 'reluctantly and others willingly perform hybrid roles' (McGivern et al. 2015: 413). However, the greatest challenge from the managerial logic within the organisational context of maternity care in small-town Russia is that there are almost no institutionalised channels to counteract it. Describing their intra-hospital position in terms of administrative dependence and their inability to criticise, and hence improve, their working conditions. As observations demonstrate, doctors and midwives quite often critically discussed healthcare managers, but always lowered their voices, although the head of the hospital could be in another building.

As the analysis of the data reveals managerial logic of regulation can be enacted in the organisational context of maternity care not only as a challenge to the professionalism in terms of overwhelming bureaucratisation of practices and rules, which are time consuming (Entwistle, Matthews 2015: 1150-51), but can form a hybrid in terms of maintenance of the intra-organisational hierarchies and subordinations. As it was proposed in the conceptual model of the research, both parts of this hybrid can be challenged in the changing institutional field by the consumerisation of patients' behaviour and the emergence of private medical practice and implementation of the market mechanisms in the state-funded healthcare. At the same time, some scholars argue, that market logic can also become a part of this institutional hybrid, for example, when market mechanisms are employed by professionals to pursuit self-interest (Entwistle, Matthews 2015: 1152). The following subchapter addresses particularly this issue.

### **6.3 CHALLENGES FROM THE MARKET INSTITUTIONAL LOGIC**

In addition to the challenges and obstacles raised by the dominance of the managerial logic of regulation outlined in the previous section, healthcare practitioners complained about the growing influence of market mechanisms introduced into maternity services. There are at least two dimensions of this trend: the rising commercialisation of services, and consumerisation of patients' attitudes. Interestingly, in Case A, the first dimension was not criticised as much, and according to data from the observation, the practice of informal payments was quite widespread in this maternity department. Furthermore, the same doctors did not tend to recognise patients' growing autonomy, and regarded their demands, additional requests and efforts to



influence the approach to childbirth, in order to make it more individual and softer, as a challenge to their professional authority.

Healthcare practitioners from another case recognised patients' right to take part in decision making and to demand more personalised maternity care, and welcomed their growing interest in childbirth issues, readiness to learn more about labour and right to choose. At the same time, they argued that patients' responsabilisation should not be achieved through paid-for services. Despite some differences mentioned above, analysis of the interviews reveals crucial similarities between the two case study organisations. It is notable that all informants expressed disapproval of the commercialisation of medicine in general, and the emergence of paid-for services in maternity units in particular.

However, there were some nuances in their arguments. In particular, doctors, whose institutional work is accomplished to maintain already established order, criticised commercialisation as a structural process that had made them economically vulnerable and had aggravated an already demanding situation with additional paperwork. They also lamented that this paperwork now had to be done not for public but for commercial interests, such as insurance companies. Some also condemned the fact that commercialisation had led to a growth in patients' expectations, which the doctors sometimes referred to as 'groundless'. But the key critique of the formally paid services was that it does not lead to the growth of health practitioners' salaries, how the head of the maternity department argued:

*We do not have [payed services] officially we have nothing! All of this is liquidated. They said...well, I even do not know, what they have said (...) And we used to have these paid rooms, now they are used for other things, and other paid services [like payment for chosen doctor of midwife] has started dying out (...) it should be good for personnel, that if there is payment, some banknotes should go to doctors! The state should just rise doctors' wages, I think so!*  
(D.P., male, born 1952; case A)

Healthcare practitioners, who were more prone to the adoption of the new professionalism in terms of openness to change values and orientation towards more active rather than passive patients (see section 6.1) also criticised commercialisation. At the same time, they invoked patients' perspectives, stating that this process had led to a deterioration in access to quality services for those who were already deprived. They also insisted that 'money' always spoils social relations, both between colleagues in the form of the emergence of competition, and with their patients, in terms of commercial rather than professional rationale for the quality of care.

Doctors and midwives in the second case explicitly criticised paid-for services in healthcare in general. They argued that such a measure would worsen relations with patients and between colleagues, and would aggravate

working conditions, since it would require spending more time at the hospital. Both the senior midwife and the head of maternity department highlighted this negative side of the paid services:

*Paid services – I don't want money to be here. It will worsen everything. I don't want it here! (I.S., female, born 1972; case B).*

*I am not sure, that it is legal actually, Well, what we can offer as a payed service? We have, firstly, very poor population, no one will be able to pay. All our delivery rooms are individual ones already, and a choice of a doctor – we just have nobody to work here: can I, after a night shift, come for a payed childbirth? Even now I come home and pray for not to be called back [to the maternity unit] again! (G.L., female, born 1965; case B)*

A striking distinction between the two cases compared in this study emerges in physicians' expectations and attitudes toward patients' autonomy and ability to acquire information and prepare themselves for childbirth, make their own decisions, and choose appropriate courses of action. Doctors working in Case A criticised innovations and preconditions that allowed their patients to read about medical procedures and to try to manage and control their own experiences of pregnancy and childbirth. As shown in the next quotation, obstetrician-gynaecologists considered their patients to be just 'dilettantes', no matter how much they had read or how thoroughly they had prepared.

*We have never made any manipulation, let's say, if any woman said: 'I won't do it'. We didn't do it. But you know, they used to trust a doctor much more. If a doctor says so, it means you need to so. But now, surfing the Internet, looking, reading literature, they come and sometimes even dictate to us methods of their childbirth. Supposedly, 'I don't want this, let's do this, no, let's do so. Finally, you convince such person on your side. I mean, that in general people are just dilettantes, although they have read a lot (D.P., male, born 1952; case B).*

Doctors in the second case (B) related to patients in a completely different way: they expected them to read as much as possible to obtain information on pregnancy and childbirth, and to be able to choose and make their own decisions concerning healthcare and reproduction. Even in cases where women did not aspire to autonomy, obstetricians and midwives in Case B taught them to do so. The structural organisation of this maternity facility also presupposed that patients should be involved in all issues relating to labour and baby care. Moreover, health professionals mentioned that it was important to involve not only women themselves, but also their relatives. They

strove to convince their patients to give birth with a partner, and insisted that this approach to childbirth was best for all parties, including the medical staff. Notably, these healthcare practitioners recognised that the growth in patients' autonomy might challenge professional authority, but they saw it as an additional stimulus for their own development and additional education.

*I think, now mothers have become better and girls have become more educated as there is Internet, there is more information. Now mothers are different! They read more, learn – they are good girls [...] It is difficult for the doctors, because doctors ceased to be an authority. It means that doctors need to learn constantly, to read constantly, to educate constantly. And if a doctor is used to do nothing and just to apply till the retirement the knowledge that he obtained at the university, it's difficult for him. Because a patient has become smarter than a doctor. This is not always pleasant. This hits your self-esteem. When a patient can tell you about breastfeeding more than you know, it's unpleasant, right? (I.S., female, born 1972; case B)*

The quoted above senior midwife of the maternity department explained that they with other colleagues welcomed patients' efforts to learn more about labour, and within the maternity unit tried to educate and teach them how to manage problems with newborns themselves:

*A mommy can learn to change a baby in two steps! You show it once, you show it twice – especially that it's my custom that mommies mostly do everything themselves. I mean, the less... that's what I say on [hospital] tours, "The less often the staff touch your baby, the safer it is for you and for them [the infant]" (...) The less often the baby encounters the staff's hands, the healthier the baby is. That's why we'll tell you and show you all this, and you will do it yourself (I.S., female, born 1972; case B).*

This analysis demonstrates that the same challenges to professionalism as, for example, the process of patients' consumerisation, can be elaborated differently within different organisational contexts. The already mentioned 'new professionalism' considered as openness to change values and orientation towards more active rather than passive patients, allowed to enact increasing demand from the patients as a part of professional organising principle. Noteworthy, that in this case healthcare practitioners were oriented to collaborate not only with a pregnant woman, but also with her family (partner) during childbirth. They even delegated some important functions to partners and regarded them as assistants in maternity care:

*My midwives, they all love childbirth with a partner! Because, if something [wrong happens] a dad is a witness! We have nothing to hide! The more relatives see, the more tranquil situation is for everyone, isn't it?*

*Oh, I haven't seen a single man fall unconscious. Quite the opposite, husbands help a lot. Sometimes the dad is bossing around more than us. I mean, he can, he knows how to talk [to her], I mean, they've lived together for years, so the woman comes to us, and you start to approach her, it's good if she is cooperative, but there are tight-lipped ones, she's deep inside her pain, and dare anyone to dig her out of there, so she's sitting there in pain, without sharing, without telling anyone. I mean, she's having a hard time with us, but what a hard time we're having with her! ... So the husband is a go-between. I mean, even if she doesn't communicate, she still talks to him. (...)*

The same quoted senior midwife emphasised not only this emotional work of a patient's partner as the reason for the promotion of partner childbirth. She also highlights their role as a watcher and guarantor of the professionals' best intentions. In other words, she felt herself professional enough not to be scared of an outside observer:

*Second of all, I already tell it on tours, I say, Dad is watching us, he's watching if we've washed our hands, if I've forgotten to wash my hands, Dad will remind me, he won't forget anything. He'll remind us, "Oh, you forgot to wash your hands or something," figuratively speaking. The dad will always ask, "What are you doing to her?" If there are prescriptions or something for the woman... "why? What effect will it have?" Women never ask, they don't care what is done to them (...) I mean, during the labour they're overall... but the husband will inquire [us] inside and out. So, it's more comfortable for us, too, you see. (...) The dad sees that the labour passed, that no one... I mean, that the woman got no injuries (I.S., female, born 1972; case B).*

The quote above can be analysed as an example of a change in professionals' approaches toward doctor-patient relations. It reflects a turn toward a more patient-centred approach in the maternity facility (for more details, see Chapter 7). It is noteworthy that such an approach includes women's relatives as key actors involved in the institutional field of maternity care, and emphasised the trustworthy relations with them. In this way health practitioners themselves in this case promoted the agency of patients and their relatives, as the obstetrician gynaecologist explained:

*Childbirth with a partner – it is a beauty actually! We used to fear it wildly, that someone would be watching us, an outsider, would*

*see what we are doing here, yes? Probably there would be a swearing, or conflicts with relatives. But it appeared to be conversely, that a husband supports us, that he takes our side, that he trusts us the same way, a woman does (G.L., female, born 1965; case B).*

This patient-centred approach practised in Case B seems to be contrast to the notions of professionalism, shared by healthcare practitioners in Case A. This again confirms rivalry between the institutional logics competing in the field of maternity services, which results in different hybrid forms of practices and coordination. As it was proposed in the conceptual framework of the research (see subchapter 3.4), hybridity can be considered ‘as a form of accommodation to coercive pressures, without becoming totally absorbed by them’ (Denis et al. 2015: 280). It also helps to detect some inconsistencies between different levels of the institutional field in terms of domination of managerialism or market logic of regulation.

As the previous chapter concluded, on the macro level of state reforms and arrangement of the whole field, the system of maternity care in small-town Russia appear to be quite unfavorable for the professionalism as leading organisational principle. The structural arrangement of maternity services and the working conditions of health professionals have changed considerably under the implementation of recent state reforms. In addition, market mechanisms introduced into the institutional field have symbolically transformed patients into consumers. Both tendencies have resulted in ‘hybridisation’ of the medical profession, with altered notions of professional ethics. In this chapter, I aimed to show that emerging challenges of managerialism and marketisation, range of professional practices and ideas are directed to maintaining professional integrity and authority.

Doctors and midwives in their narratives defined themselves as deprived of administrative and economic resources, stating that this considerably decreased their professional autonomy and threatened their authority. They mentioned that they felt pressurised not only by representatives of state and commercial bodies, such as insurance companies and prosecutors (see Section 6.2), but also by their superiors, such as the head of the hospital and patients. Interpersonal relations have become almost the only resource available to doctors and midwives, while all other resources, such as economic and administrative ones, are being eroded by the dominance of managerial and market logics on the organisational level. In the following subsection I aim to address, which particular social mechanisms are employed by healthcare practitioners to enact the logic of professionalism and analyse it in terms of informal rules and practices present in the field.

## **6.4 INFORMALITY: THE FOURTH INSTITUTIONAL LOGIC?**

With the long history of professional logic being challenged by managerial and market ones in Russia, there cannot be clear repetition of the loss-of-power argument, applicable for the western professions (Davies 2003). As social scholars argue, Russian doctors and midwives in that sense cannot be nor de-professionalised neither re-professionalised as a professional group which never had this professional autonomy and power (Brown 1987). However, as analysis in the previous subchapters demonstrated, health care practitioners, working in maternity care in small-town Russia, enact professionalism in different forms. They also try to manage the rivalry of different institutional logics, which compete in this institutional field and in this way different hybrids emerge. In this subchapter I address informality as one more part of this institutional hybrid.

As the research by C.C. Williams and A.V. Horodnic (2017) has revealed, informal payments in healthcare can emerge in those institutional conditions, where 'formal institutional imperfections are present'. In particular, the propensity to make informal payments is higher in those healthcare systems, which are characterised by greater formal institutional imperfections, such as formal institutional voids or inefficiencies, lack of financial resources, poor quality of government and health system performance (Williams, Horodnic 2017: 2). The previous chapters of the thesis devoted to the analysis of healthcare reforms in post-Soviet Russia provided the evidence of quite rigid institutional arrangement and diverse, often contradictory, changes. Hence, the case of maternity care in small-town Russia can be defined as favorable for the informality's presence and proliferation.

Some attempts have been made in order to describe the role of informality in the coordination of professional work in post-socialist context. The research by E. Riska and A. Novelskaite (2011) showed that health practitioners perceived nor the state, neither the market mechanisms to be effective regulatory principles, and concluded that we should consider the informal economy of peer referrals, gift giving, and extra payments as the fourth institutional logic (Riska, Novelskaite 2011: 82). I proceed further with the analysis of some informal practices revealed in the empirical data and aim to analyse its role in the professional management of different institutional logics.

Unofficial payments in Russian state-funded healthcare legally is a law-breaking practice, so informants usually were reluctant to report on 'gift-giving' or informal payments in the interviews, which were audio-recorded. Doctors usually showed by hand (rubbing fingers) any mentioning of corruption or related practices. However, during observations and informal communication in some maternity units they were not hiding the informal dimension of their work at all. Finally, in one of the maternity departments, where the system of unofficial payments was quite wide-spread, an

obstetrician-gynaecologist described in details, how patients come to pay for maternity care and how this money is distributed among personnel:

*An acquaintance of mine came and said, "I've been told that it's good [to give birth] with you." They said, let's try. I suggested – alright, D.P. [the head of the department] is on duty, he is an experienced physician. "But we're afraid of him." Alright, alright. Alright. He's not very happy with that, what are you gonna do? Well, he [D.P.] is upset, too – he's on duty, then somebody comes to give birth, and [her] friends are in here. What are you gonna do?... [If a patient asks a doctor to come in advance] Well, then I just give him part of [my] money, so he's happy and keeps quiet. Even if it's not his shift, just because he's the chief (E.I., female, born 1979; case A).*

The quote above identifies that the system of informal payments has introduced the competition between different doctors and a situation of the conflict of interest. On the one hand, this practice was described as an option to meet increasing patients' demand on more personifies and careful approach, to decrease the level of fear and uncertainty during childbirth. On the other, it has also maintained the existing interprofessional hierarchy, since any payment was shared with the head of the department. The latter informally (without audio-record) interpreted this practice as a compensation for low doctors' salaries. In other words, informality in this case can be analysed as a mechanism, which managed the rivalry between organisational constraints and market logic of regulation.

I have not collected any empirical data on informal payments in another case under investigation (case B), though some other informal practices were revealed. In particular, healthcare practitioners of different specialities working in this maternity unit had friend-like relationships:

*But I say, we are a collective, we work together for many years already, and our families are here as well – I mean we communicate with our families too. We spend holidays together, and we do some travel together, to dachas, to somewhere else (...) We live like a one whole family here. (I.S., female, born 1972; case B).*

This way to spend even after hours reinforced inter-professional communication and consequently fostered institutional work, accomplished in this case, which will be analysed in details in the next chapter. In particular, professionals mentioned, that different informal practices strengthened the team of the medical ward. The senior midwife of the maternity and gynecological departments recalled that non-medical activities, such as participation in competitions and creative projects, had occurred within the hospital as additional inspirations for change.

This kind of informal and friendly relations also helped to overcome the challenges, provoked by the managerial and market principles of regulation. For example, the head of maternity and gynecological departments described how good relationship with the head of the hospital helped to obtain those medications they needed, but could not buy due to some formalities:

*I'm talking about what [medication] I would like to have. There are modern drugs, but we are confining ourselves to those ones we do not really want. But I say, 'the main' [the chief doctor of a hospital] in this regard is a good fellow, he helps. If we convince him that it [another medication] is necessary, needed, then I think we will have it (G.L., female, born 1965; case B).*

Such an informal way of communication used to overcome the challenges caused by bureaucratisation within a hospital was also practiced with colleagues working in other maternity units, located in another district. As the same informant continued:

*Well, that happened, for example... surfactant - there is such a medication to accelerate lung maturation of a newborn. And we had 2-3 preterm births in a row. And then a [premature] baby is born - we do not have it [surfactant], but we have to introduce it immediately! Well, we call to T. [second-level maternity unit in a neighboring district], and ask, they give us - while they give. Then [later] we return it (G.L., female, born 1965; case B).*

As this analysis reveals, informality in the context of maternity care in small-town Russia works as a mechanism of management the contradictory institutional logics. It, firstly, works as a tool adopting market logic to the organisational context of maternity unit with no official payments for medical services, like it was presented in the case A. In that case the system of informal payments was also employed to maintain the inter-professional hierarchy within the unit. Secondly, informality revealed in the form of particular way of inter-professional communication and relationship. In this way it helped to tackle with the challenges from managerialism and market institutional logic. It also has become an additional source for the institutional work, accomplished to change the organisational arrangement of the unit, in the contexts characterized by the rigidity of the formal institutions.

This chapter has provided evidence that, even within formally similar structural conditions for maternity services provision, there is a rivalry of different institutional logics can be enacted within organisational context and quite different professional practices and dispositions may emerge. It was aimed to answer the research sub-questions on the institutional logics, dominating the institutional field of maternity care in small-town Russia, and



on the way healthcare practitioners manage their rivalry. The analysis of the empirical data, collected in two cases under investigation has revealed that there is still some space for a professional logic of regulation in the institutional field of maternity services, though the managerial and the market organisational principles can challenge it in different ways.

The analysis has shown that, on some dimensions, organisational settings reproduce organisational principles, set at the federal level and affecting the institutional field of maternity care as a whole. However, on the organisational level maternity care represents a case of complex rivalry of different institutional logics, in which the one of professionalism can be dominated by the market and managerial ones, but can form a 'hybrid' in various constellations.

The empirical evidence shows that some doctors and midwives are able to change the rules of interaction, working conditions and approaches to childbirth in accordance with notions of the 'new professionalism', rather than satisfying managerial rules or market demands. In particular, health professionals can become prone to the 'openness to change values', welcome opportunities for additional education and active, rather than passive patients. Though the chapter also examined an opposite understanding of professionalism, which presupposed maintenance of rigid hierarchy within organisation, and borders between both, different professional groups and patients. To meet the demands of these different notions of professionalism, various forms of institutional hybrids were formed. In particular, such hybrids can help to accomplish different types of institutional work: maintenance of the organisational order in one case and institutional change in other.

The study also provides further evidence for the importance of the informal organising principles, which are employed to overcome unfavourable institutional and organisational conditions for the realisation of professional ideals. Basing on some previous researches I assume that competing logics can not only co-exist and rival within the same organisational context but managed by healthcare professionals as well – in particular, through the development of collaborative inter-professional relationships (Reay, Hinings 2009: 629). The next chapter focuses on these examples of professional agency, and investigates in detail what particular conditions enable its manifestation in the context of small remote towns.

## **7 INSTITUTIONAL WORK IN THE CONTEXT OF MATERNITY WARD IN SMALL-TOWN RUSSIA**

Chapter 6 analysed variability in healthcare professionals' attitudes to and evaluations of institutional logics and their effects in the field of maternity care. In particular, the analysis revealed that almost all doctors and midwives working in small remote towns emphasised the dominance of managerial and market logics, which had caused tensions with their notions of professionalism. However, representatives of the different maternity units navigated this institutional complexity differently, and in one case the organisational principle of informality was enacted to keep the organisational arrangement of the unit, professional hierarchy and paternalistic approach in doctor-patient relations unchanged. Informants from another case, conversely, emphasised that ability to shape the change in maternity care provision and organisation comprises the core part of their professionalism.

Focusing on the perspective of doctors and midwives who recognised themselves as active agents of institutional change (Case B), this chapter aims to investigate their agency and the conditions under which this may occur. In particular, it addresses the following aspects of the key research question: how is healthcare practitioners' agency restricted or enabled by the wider structural constraints, organisational context and the remoteness of the settings? Which professional practices and ground-level alterations of maternity care in small towns do reveal the agency of healthcare practitioners?

The role of these practitioners in the process of institutional change is conceptualised as **institutional work**, accomplished to alter the organisation of maternity services in a way that corresponds with their professional knowledge and ethics. This role of healthcare professionals in the process of institutional change will be examined as a complex of both intentional and routine professional practices that form a basis for shaping and transforming the organisation and provision of maternity services in the facility. Although, analytically, institutional work does not necessarily result in macro-scale structural change, it may reveal itself in other, micro-scale alterations to how the institutional field of maternity care works in one first-level unit.

To analyse the various conditions and forms of institutional work accomplished by the healthcare practitioners in this maternity unit, this chapter is structured as follows. Section 7.1 describes the new model of childbirth, defined as more 'humanised' than the more conservative and 'technocratic' approach generally practised in Russian maternity care services. Based on empirical data from in-depth semi-structured interviews with healthcare practitioners, Section 7.2 focuses on three main domains of change

in the maternity facility: its material reconstruction, structural reorganisation and communicative novelties. Section 7.3 examines the key terms and conditions of this particular case of institutional change, and Section 7.4 considers barriers and impediments that limit further reorganisation of the field.

## **7.1 CHANGED APPROACH TO CHILDBIRTH**

This chapter addresses changes in the professional approach to childbirth in one maternity unit as an example of institutional work accomplished by healthcare practitioners. It does not aim to evaluate what kinds of childbirth practices and approaches are more ‘normal’ or ‘proper’. My task is rather to describe the multiplicity and variability of approaches and practices legitimately co-existing within the same obstetric institutional field. I presume that different situations require different medical attitudes and social patterns recognised by participants as normal and acceptable. As a sociologist, I am interested in how these norms are shaped and compete with each other within the same institutional field. Another goal of this final empirical chapter is to define the key sources of institutional change, provoked by the agency of health professionals, as well as to address the challenges to its realisation.

The turn toward patient-centred, or so-called ‘humanised’ or ‘soft’ approaches, the wholly new paradigm opposed to medicalised childbirth, in the organisational setting of a maternity unit is considered here as an example of changes to working practices and organisational settings in healthcare. Since this transformation was launched as a grassroots initiative by healthcare practitioners, I analyse it as being a result of the institutional work they were able to accomplish in the investigated context. Integrating such approaches into professional practices generally entails an orientation toward the principles of greater attention to and care for pregnant women, less medicalisation in terms of reduced medical interventions, and active involvement by partners. Such principles also involve a specific way of communicating: the woman and her relatives are reconceptualised as active agents in the process of decision making in the context of the medical organisation, with more personal relationships (Borozdina 2017a).

Patient-centredness correlates directly with the recommendations of leading healthcare organisations such as the WHO (2018), although contextual specificity is very important. This approach started to emerge in the 1970s in the USA and some Western European countries, implemented through various methods and movements (Borozdina 2014). In Russia, this model of maternity care emerged in the 1990s and flourished during the 2000s in reaction to the closed and unalterable Soviet approach of childbirth. Such practices have become possible within more general movements toward patients’ consumerisation and the commercialisation of medical services. The

former has led to growing demand for alternative childbirth practices, due to the active involvement of women and their families in the choice of maternity facilities, medical practitioners, and forms and methods of delivery. The latter, in terms of the development of paid-for services, has allowed the provision of patient choice.

Thus, private clinics and maternity centres have emerged mainly in large cities, and paid-for services have arisen mainly in state-funded maternity facilities, forming a particular market for alternative childbirth options (Temkina 2016, 2017). Nevertheless, as the empirical data collected in small Russian towns demonstrate, even in remote areas where neither patient demand nor market-paid maternity services are present, reorganisations and examples of such institutional change are still possible. As I aim to show in this chapter, this possibility has emerged despite the general top-down structural changes shaped by managerial and market domination, by virtue of professional agency.

It is important to mention that the term ‘soft methods’ does not refer to a specific approach to childbirth, but is used to denote any programme or method of delivery that is in some sense alternative or opposed to the medicalised approach to state-funded, hospital-based maternity services. These alternatives may be referred to as ‘natural birth’, ‘active birth’, ‘childbirth oriented to the family’s participation’ or ‘partner birth’, amongst others. The core feature of any humanised approach is patient-centredness, as an organisational and communicative prerequisite for the agency of both healthcare practitioners and their patients.

Anthropological research suggests that, symbolically, such an approach is opposed to the form of medical practice also conceptualised as the ‘technocratic model’ of childbirth (Davis-Floyd 2001). The latter is the most widespread approach to medical encounters, and deals with women’s bodies as if with broken machines, with doctors acting as ‘mechanics’ repairing and fine-tuning them (Davis-Floyd 2001; Martin 1992). The humanistic model of childbirth, both conceptually and in practice, entails acknowledging the patient as a competent and rightful participant in medical interactions, with consequently more partner-like and personalised relationships. In other words, it reconceptualises maternity care not as simply a medical domain, but rather as a complex of social relations. According to WHO experts, ‘positive childbirth experience goes beyond having a healthy baby’ (WHO 2018).

In particular, this model of maternity care emphasises that not only medical manipulations but also social components are important for a ‘positive childbirth’ experience and outcome. In this paradigm, women and their families act as independent participants, responsible for decision making on a par with medical personnel. This presupposes more awareness and information sharing between all interacting actors. The body is no longer considered to be a ‘broken machine’, but is treated as an organism requiring both curing and caring. According to the anthropological argument, these conditions can be met only through medical professionals’ personal interest

and initiative, at least in terms of openness to new recommendations and practices (Davis-Floyd 2001).

American anthropologist, Robbie Davis-Floyd elaborates at least twenty tenets of the 'humanistic' model. I shall outline those that correspond directly with practical and organisational changes that occurred in practice in the investigated maternity facility. First, it is crucial to such an approach that patients are recognised as relational subjects who require real human connections with medical personnel, and that the latter are not scared of such personalised ways of interacting (ibid.: 11). Second, 'whereas the technomedical paradigm is based on the principle of separation, and the holistic model on integration, the principle underlying the humanistic approach is connection'. This means that, even within the setting of a medical organisation, patients are recognised by healthcare practitioners as still connected with a wider spectrum of social relations, including their families and communities (ibid.: 12).

Third, analytically, the humanistic model of childbirth emphasises that it is advisable to 'balance between the needs of the institution and the individual' (ibid.: 11). In practice, this means that the medical personnel must try to customise and 'soften' the organisational and material conditions of the maternity facility in order to provide women with 'flexible spaces in which they have room to move around as much as they like, to be in water if they wish, to labor as they choose' (ibid.). Fourth, the humanistic approach presupposes the sharing of information, decision making, and responsibility between patient and practitioner (ibid.: 13).

Fifth, 'humanistic' healthcare practitioners are expected to make effective choices of scientific and technological inferences and standards. In practice, they are likely to use virtually the same tools and techniques as 'technomedical' doctors, but are able to reflexively manage the timing of their application, and make selective use of the instruments suggested by hospital settings (ibid.:13). Finally, humanistic practitioners tend to be open, in terms of learning alternative healing techniques, tolerating alternative modalities and advocating dietary and lifestyle changes that border on holistic approaches (ibid.: 15).

The next sections, based on empirical data collected in one of the cases under investigation, follows the path of changes that occurred in the maternity facility. These ideational changes, caused by the aspiration of doctors and midwives to 'humanise' the obstetric approach in their maternity ward, have led to the practical alterations as well. The latter are examined in the subsequent subchapter through the lens of 'institutional work' carried out by healthcare practitioners to alter the rigid institutional setting.

## **7.2 OBSERVED INSTITUTIONAL CHANGES IN MATERNITY CARE**

The general frame of institutional change in maternity care includes aspects such as reorganisation of facilities to enable the introduction of new practices, and organisational rearrangement allowing the adoption of the new approach. Conceptually, this change is analysed as an enactment of professionals' agency, manifesting itself in particular as the management, and adjusting 'to the ambiguity, pluralism, and contradiction that major reform gives rise to' (Cloutier et al. 2015: 262). All types of change will be analysed in detail, based on empirical evidence from one of the cases studied, a maternity ward in a central district hospital in a remote area of a region. This small maternity facility in North-Western Okrug provides first-level maternity care, with around 300 births per year. The change in this case consisted of both technical and social reorganisation, under the formal framework of UNICEF's 'Mother and child' initiative and its model of a 'baby-friendly hospital'.

To implement this institutional change, the physical setting of the facility had been reconstructed in order to make three individual birthing rooms, rather than one shared one as is quite common in post-Soviet, state-funded maternity facilities. Each room had also been equipped with devices to support women in labour that were not required under state recommendations, with fit-balls to relieve contractions, music players to provide a relaxed atmosphere, and other equipment. All postpartum beds had been re-equipped to accommodate both mother and child. In addition, a new 'family room' had been organised as a paid-for service, to allow women's partners to stay with them during the entire period of hospitalisation. In the quote below the senior midwife of maternity ward describes:

*This room has been established to make relatives more calm, to make a woman calm. In order to make her not think of loneliness, of how she must stay alone for the night... and here is her husband, her family. Sometimes [women's] mothers stay the night, sometimes a husband, sometimes a best friend (I.S., female, born 1972; Case B).*

The most appreciable changes had occurred in the medical approach to childbirth. According to organisational statistics provided by the senior midwife of the maternity facility, healthcare practitioners had reduced the number of perineotomy<sup>9</sup> from almost 80 per cent in 2007 to six per cent in 2016, and had also reduced the number of planned caesarean sections. Medical personnel had started to practise non-drug methods of pain management, such as particular breathing techniques and different positions

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<sup>9</sup> Perineotomy or episiotomy is a surgical incision of the perineum and the posterior vaginal wall, usually performed during second stage of labor to quickly enlarge the opening for the baby to pass through. (Merriam-Webster dictionary)

during labour, and encouraged skin-to-skin contact between mother and newborn after birth. In addition, all practitioners since that time promoted breastfeeding both in the hospital setting and afterwards.

As obstetricians and midwives themselves said, the model of maternity care had been completely transformed, particularly in terms of relations and communications with patients. The social component of interpersonal interactions was recognised as a no less important part of the humanised approach than the medical one. The core aim of these changes was to create a new relationship with the pregnant woman or woman in labour, her partner and a newborn. For example, almost all healthcare practitioners were oriented toward a partnership model as the most welcome in the medical encounter. According to local statistics, during the fieldwork, about 40 per cent of all childbirths in this case organisation occurred with women's partners present. The role of women's partners during childbirth was articulated by the senior midwife as follows:

*Husbands, on the contrary [to the previous expectations concerning their behavior and uselessness in the maternity unit], help a lot. Sometimes father commands more than we do. I mean, he can, he knows, how to communicate. I mean, they live together for years, but woman comes to us and you only start to adjust communication. It is good, if she is sociable one, but there are some [women], which do not even say anything. She immerses herself into a pain, and it is difficult to withdraw her from it, and she is sitting with her pain, not sharing it, not talking about it. I mean, it is a challenge for her to be with us, but can you imagine, how challenging it is for us?! (...) And husband, he is like an intermediate link. Even if a woman is not talking with us, she does with her husband (I.S., female, born 1972; case B).*

Furthermore, these healthcare professionals instructed mothers on how to care for newborns, and in many ways tried to reduce the number of manipulations made by medical personnel with the babies. The senior midwife in this maternity unit described it as follows:

*We have given babies out to their mother. I mean, these children they are not ours, and we had to explain firstly to personnel, that children are not ours, we have no rights to take them away even for a minute, they are not ours. We should just help mother, explain to her, tell her. But anyway it is her baby. (I.S., female, born 1972; case B)*

In order to acquaint women coming into the maternity facility with its arrangements and personnel and the general process of childbirth, medical practitioners arranged weekly tours of the maternity ward free of charge.

These meetings were available to any women and their partners who were expecting a baby and were able to give birth in a first-level facility according to the calculation of perinatal risk. This confirms the idea that openness is necessary in a medical organisation aiming to integrate a more humanistic approach to maternity care. As already examined in the previous chapter (in comparison with the other case of study), such an attitude will not be adopted by default, but requires particular effort in order to introduce it.

### **7.3 CONDITIONS FAVOURING THE INSTITUTIONAL CHANGE OF MATERNITY CARE**

As described above, the institutional work carried out by the healthcare practitioners in the studied case affected all aspects of maternity care: technical, medical and communicative. The general direction of change was oriented toward a 'more humanistic' model of childbirth, and resembled the analytical framework of the 'humanistic paradigm' of medicine described by American anthropologist, Davis-Floyd (2001). The methods introduced and practised and the conditions of maternity services provision differed considerably from the more widespread 'technocratic' model of childbirth, at least in the post-socialist context, in which a woman is treated only as an object of medical manipulations. This section focuses on the particular conditions and circumstances that enabled this reorganisation in the setting of a state-funded, first-level maternity facility in a remote area, with quite limited material and social resources and no articulated patient demand for the humanisation of childbirth.

#### **7.3.1 CHANGED NOTIONS OF PROFESSIONALISM**

Professional knowledge and expertise are described within the sociology of professions as a core basis for the professional autonomy. The necessity to gain and update this knowledge and be able to apply it to the medical practice are also an important characteristic of professionalism (Freidson 2001). As the evidence from the case investigated allows to examine, how the new knowledge about maternity care caused some changes in the approach and practices, which consequently altered perceptions of what professionalism consists of.

In particular, the turn to the 'new professionalism' (for more details see subchapter 6.1) includes the 'openness to change values' and additional education. The transition to a new 'soft' model of childbirth in the case under investigation took place over a decade from 2006. According to the narratives of the head of department and the senior midwife, an educational 'mother and child' course had been organised for medical personnel by the regional administration, and the Moscow Family Planning Centre appears to have been



a starting point. Both these specialists described in similar terms their initial mistrust of the new approaches to childbirth proposed in the course. However, retrospectively they both evaluated this educational programme as having ‘overturned their views’ and ‘revealed the wrongness of previous practices’, how the head of the department articulated:

*And we went together with the main midwife to the first course, devoted to the breastfeeding’. We were going there and thinking that we already knew everything, we considered ourselves to be aware of all the things related to mothers’ breast. But they have overturned it completely, what we used to do... initially we thought they are zombifying us, but further awareness came, and we realized that we used to harm for twenty years (G.L., female, born 1965; case B)*

This opportunity to attend a new educational course for healthcare professionals, and the participants’ readiness to engage in all the lessons and question their own previous attitudes, formed the first stage of institutional changes, the ideational one. This resembles the ‘open-mindedness toward other modalities’ mentioned by Davis-Floyd as a key component of the humanistic model of childbirth. It can also be analysed as one of the changes in the professional identity, which neo-institutionalists examine as another form of institutional work: ‘institutions and identities are fundamentally interrelated. Identity work is a form of institutional work’ (McGivern et al. 2015: 415). To sum up, the change in professionals’ mindsets has become the precondition for the subsequent alterations in practices and organisational arrangement.

As other scholars propose, ‘identities describe the relationship between an actor and the field in which that actor operates’ (Lawrence, Suddaby 2006: 223), hence, changes in professional identity shape the relations with other domains of the institutional field. The empirical data enables to argue that, basing on the new professional identity healthcare practitioners initiated to act as institutional entrepreneurs, setting and changing organisational rules in order to meet the demands of their professional commitment (Suddaby, Viale 2011). As both, the senior midwife and the head of the department highlighted, implementation of the new approach requires continuous training, awareness of the latest and most topical issues of the specialty, and participation in conferences and other academic events. As observation conducted in this unit revealed, health practitioners regularly attended professional events, organised by both regional and federal associations, they also subscribed the medical journal on obstetrics and gynaecology and looked for the actual information on the professional forums in the Internet.

Hence, empirical evidence confirms the general assumption that change to the organisation of maternity care and medical approach occur by virtue of the institutional work accomplished by the health practitioners. It occurs not due to the formal requirements imposed on the field of maternity care in a top-

down manner and generally framed by managerial or market rationales, but rather through the agentic efforts of professionals to practise medicine in a way that corresponds with their altered notions of professional ethics and commitment.

In addition, medical personnel in the maternity ward participated in regional competitions between healthcare practitioners, and in 2006 took first place in a 'best midwife in the region' competition. In addition, they regularly created video and musical projects devoted to their professional practice and the hospital, and arranged intra-organisational competitions. The medical personnel's initiatives became an important means of articulating and facilitating institutional reorganisation. In particular, the unit's senior midwife conducted an anonymous survey of patients on the ward in 2010, in order to investigate patients' perspectives on and attitudes to the maternity facility, the personnel and other issues. The data collected were later used by the senior midwife for additional coordination of the staff's activity, and some comments were considered in the process of technical renovation. However, this set of professionals' attitudes was not the only condition of the institutional change in maternity care provision. Another feature of the case observed were inter-professional relations, characterised by the blurred formal hierarchy.

### **7.3.2 TEAMWORK AND STAFF COORDINATION**

Collaboration is recognised within neo-institutionalism as one of the key mechanisms, allowing to manage the rivalry of institutional logics and process of institutional change (Reay, Hinings 2009: 633). The empirical evidence from this case confirms this assumption: so-called team work of the maternity ward's personnel has become an important precondition for the alteration of organisational principles.

After the course attendance described in the previous section, the senior midwife and the head of the maternity facility attended all the other educational programs coordinated by the 'mother and child' initiative. They gradually started to rearrange the structure of the hospital's maternity ward, and slowly introduced some additional changes to how maternity services were organised and provided. Hence, the first 'partnership-childbirth' in the unit did not occur until 2009, three years after the initial educational course. Moreover, not all proposed alterations were adopted immediately. According to the senior midwife, not all medical personnel favoured and unquestioningly accepted the new recommendations: 'I used to have many more experienced midwives who were used to the old system and resisted [the new approach]'. Therefore, she sometimes had to 'force, demand, intimidate and watch' her subordinates.

However, despite the initial resistance, during the data collection period (2015–2016), all healthcare professionals in the maternity facility (six obstetrician-gynaecologists including the head of the department, one

neonatologist, and five midwives including the senior one) practised within the framework of the new model of childbirth. Moreover, teamwork by the facility's personnel was described as a key aspect of the reorganisation: *'It would be unreal if doctors switched to a new model while midwives did not – it is possible only if all personnel [cooperate]'*. Healthcare practitioners' cohesion and the solidarity of other medical personnel in the unit were defined by the senior midwife of the unit as core prerequisites for the institutional change:

*And even our sanitary personnel are a very strong and good. I mean they all are aware of what is necessary at that exactly moment. I mean sometimes you even do not need to tell, what is required – attendant knows herself what to bring, what to ask, with whom and how interact (...) yes, staff – is the most important part of any work.*  
(I.S., female, born 1972; case B)

Thus, gradual retraining of the medical personnel and the fine-tuning of teamwork became a second condition for the institutional change observed in the maternity unit. This is how these inter-professional relations are being described by the senior midwife:

*We were all young [the main midwife and the head of department were then aged about 30-40 years], we used to be a team, everyone was creative and we used to approach everything with enthusiasm! We used to have energy, used to have a desire to work and do it with pleasure* (I.S., female, born 1972; case B).

Such a precondition of the institutional change, initiated by health professionals is recognised by other scholars as well, who emphasise the role of the management team in 'both the process and outcome of reconfiguration [of the hospital work]' (Fulop et al. 2012: 134). Possibility of inter-professional collaboration in terms of 'collective decision-making with more equal representation of conflicting approaches' (Huq et al. 2017: 514), is not a widespread institutional form in the field of healthcare, since it brings challenges the formally structured hierarchy, usually headed by doctors and not other professionals (ibid.: 518). Hence, the relatively high intra-organisational status of a senior midwife of the maternity unit comprises one more prerequisite of the institutional change.

### **7.3.3 HYBRID POSITION OF THE SENIOR MIDWIFE**

Another important aspect of the reorganisation toward a 'humanistic' model of childbirth was the specific position of the senior midwife within the professional hierarchy of the unit. The empirical data collected through participant observation allows the conclusion to be drawn that the relationship

between the main midwife and the head of department (obstetrician-gynaecologist) was in many respects collegial rather than a superior–subordinate mode of communication. The senior midwife’s professional authority and standing were recognised even by the head of the entire central district hospital (who was also an obstetrician in the maternity unit). In the interview and while organising the fieldwork, he acknowledged her as the most active and knowledgeable member of the maternity unit’s professional community.

At the same time, the senior midwife recognised that she herself exercised the most initiative and was the most responsible actor in the process of organisational reform: *‘There is a model that I wanted to see here. I have created it.’* Thus, I view these features of both her position and personality as important components of the change and conditions for further social and technical changes. In other words, the senior midwife in this particular organisation after some ideational changes has become an institutional entrepreneur, i.e. leading agent of change. Such a conclusion correlates with the results of some previous institutional studies, which highlight the importance of manager–professionals ‘hybrid’ position for the maintenance and hybridisation of professionalism ‘in managerial organizational and policy contexts’ (McGivern et al. 2015: 427).

The senior midwife of the unit used to work as both administrator, coordinating the work of the midwifery and the nursing staff, and as health care practitioner (usually on night shifts), providing maternity care. Such a shift of role (when a public services professional moves into managerial role) is also analysed as a trigger for the change of work identity, through the development of new skills and knowledge bases (Denis et al. 2015: 280). Some previous researches examine the position of hybrid nurse managers (who combine managerial and clinical responsibilities) as the favouring the professional agency in the organisational settings (Currie, Spyridonidis 2016: 78, 80). At the same time, the settings themselves can become a condition, which favours the accomplishment of the institutional work.

#### **7.3.4 SIZE AND REMOTENESS OF THE MATERNITY FACILITY**

According to the informants’ narratives, the size and location of the maternity unit in which they worked appeared to be an equally important condition for change:

*You know, we have more home-like conditions. Firstly, everything is small; secondly, we do not have as huge a patient flow as large maternity facilities have, which is why everything here is more similar to home – cosiness, things like that.*

As the professionals explained, the remoteness of the district in which the facility was located allowed them to avoid excessive and unnecessary attention

in terms of the number of inspections and control procedures by the Ministry of Health and the regional administration during the initial stages of change. The small number of childbirths per year (about 200-300 during the period of the fieldwork in 2015–2016) and medical personnel working on the ward allowed smoother and easier coordination, and enabled the new measures to be implemented more efficiently, while also allowing particular attention to be paid to every patient as necessary: *‘we have not a lot of childbirths. We can “pamper” and please every woman’*.

The size and remoteness, as well as other social conditions, of the obstetric fields studied exert ambivalent effects on the path toward transformation. As concluded in the previous chapter, the scarcity of social and material resources in these maternity facilities, aggravated by the implementation of recent reforms (particularly the routing law and changes in funding), may lead to considerable deterioration in service provision, and even threat of closure. However, for grassroots initiatives, the size and remoteness have some positive impact, since the small size of such facilities gives rise to a density of professional networks, in some cases compensating for the scarcity of other resources.

In conclusion, the reorganisation of childbirth in this case occurred not as a consequence of a single decision or an immediate one-step process, but rather as a continuous process of change entailing substantial institutional work, accomplished by individual professionals. In particular, the necessary conditions for change in this case were access to new training programmes, the social cohesion of the medical personnel, structural conditions such as the size of the facility and its location, and hybrid position of professionals-managers.

However, the organisational and physical position of the maternity unit brought both opportunities for smoother changes, and institutional challenges in terms of limited administrative autonomy, economic poverty and threat of closure. The ambivalent position of small maternity units is not Russia-specific. As other research has shown, similar ambivalence has occurred in free-standing maternity units in England, where the ‘therapeutic space’ of more home-like and family-oriented maternity care ‘was continually challenged by the location within an institutional setting’ (McCourt et al. 2016: 26). These and some other challenges for the institutional changes are addressed in the following subchapter.

## **7.4 BARRIERS AND IMPEDIMENTS**

Despite all the medical, communicative and material changes to maternity care services outlined in the previous section, it would be naive to evaluate such institutional settings as favourable for the accomplishment of institutional work. Key challenges to healthcare professionals’ further efforts to alter the institutional field included lack of material and administrative

resources, linked with limited access to the resource allocation process. The only paid-for service in the maternity unit was one family room. In addition, owing to the so-called routing law (see Chapters 2 and 5), the number of childbirths per year had decreased considerably, from about 500 births in 2010 to 200-300 births in 2015-2016. Consequently, insurance compensation for maternity services had reduced. At the same time, informants suggested that it was very unlikely that new paid-for services would be introduced, owing to both patients' inability to cover the additional costs of medicine in a remote district of a relatively poor region, and professionals' reluctance to increase their already disproportionate workloads.

In addition, there were challenges and impediments to changes in the communicative and medical approaches practised in the maternity unit. Some staff members continued to resist the new methods and remained reluctant to adopt changes to the model of childbirth. For example, a midwife of the same maternity department described some of the new methods as alien, strange and artificially imposed:

*I welcome fit-balls, welcome rags, but active placenta's extraction seems savage to me! From where do they adopt these methods?! Probably from America! What innovations do we need actually? Especially in obstetrics! We look towards West too much! But we have completely different our own experience, and completely different medicine – there shouldn't be the same things as there are in western countries' (N.V., female, born 1966; case B).*

In addition, as the doctors and midwives reported, the patients themselves did not always welcome the reorganisation of the maternity facility and the 'humanisation' of maternity care. For example, some mothers were reluctant to stay in the recommended joint accommodation for mother and child during the postpartum period, and criticised this measure for not allowing them to get sufficient rest.

As other studies have shown, many alternative (including more humanised) childbirth practices have appeared in response to patients' requests (Temkina 2016, 2017; Borozdina 2016). Many pregnant women and their partners want to share responsibility for childbirth, and participate actively in the preparation for and process of delivery. However, in the case under investigation, such external initiatives were quite limited, as were organisational opportunities to involve patients in the process of decision making, train them for childbirth, etc. There were no courses for pregnant women in the district hospital or in local antenatal clinics, and the women themselves seemed to the medical professionals to be insufficiently prepared, as a midwife of maternity department argued:

*They [pregnant women] come to us unprepared, psychologically at least, but they should also perform a complex of exercise therapy,*

*recommended for each term of gestation (...) But women come dull, even those, who give second birth... Women's behavior leaves much to be desired. There is now desire to work with them! (N.V., female, born 1966; case B)*

Other challenges emerged due to the administrative circumstances of the unit. As a maternity ward in a central district hospital, it had insufficient autonomy, in terms of either the material provision of medicines and equipment, or administrative decision making in relation to the recruitment of medical personnel. For example, during 2016 the number of beds for newborns and the number of nursing positions were reduced, while the round-the-clock duty of a neonatologist had been cut. As a result of these amendments, midwives' workloads had increased dramatically, since they had to care not only for pregnant women, women in labour and mothers, but also for newborns. An example is the description below from a midwife of a maternity unit:

*...especially since we have the pediatric nurse only working day shifts, so we work without a pediatric nurse on weekends, on holidays and in the night time. ... Yeah, well, the [pediatric nurse's] workload becomes ours – even though it's only three beds, but sometimes there are two or three women staying [in the maternity ward], and other times there are ten or eight – anyway, you can't pay attention to everyone if you're working alone. Because [you're] in the delivery room, in the post-natal ward, in the operating room, yeah, and you have to take care of the baby. (N.V., female, born 1966, case B)*

Consequently, healthcare professionals working in the maternity department found themselves in a position of total dependence on the hospital, district and regional administrations, and on decisions made by the regional healthcare committee. In particular, the so-called routing law (described in Chapters 2 and 5) considerably reduced the number of births per year in which the facility assisted, and made it impossible for the facility's personnel to assist in complicated cases. Therefore, as the practitioners complained, they had started to forget some professional skills and lose competence, while work was no longer interesting, the senior midwives sums it up in the following quote:

*I mean it is quite offensive for us, and... how to say, there is no any development, you become dull. We used to deal with urgent pathological cases, with a complicated pathology, all doctors were training all the time, developing... but now – I don't know... it has become so... of course any childbirth can become [difficult] But when you have a half of all cases urgent, and another – planned, it is one situation, and when you have urgent childbirth only once a year, it is scary. I mean, if we used to be on the alert all the time, we always*

*used to be in tonus, but now we have become relaxed. We know that complicated cases we will forward there [to facility of the second or third level]. (I.S., female, born 1972; case B).*

In addition, there were quite extensive cutbacks in personnel, and the top managers of hospitals in the district were replaced. For example, the head of the hospital was dismissed in August 2016 by a decision of the regional healthcare committee. Thereafter, staff members expected further dismissals and were discussing the probable closure of the maternity department. The evidence in this particular case only confirms such a threat. After completing the fieldwork, I returned to the maternity unit and found that it had stopped providing maternity services and had been reorganised in 2017 into a gynaecological department. The formal reason given for the closure was the retirement of the single neonatologist in the unit, although informants argued that the unit had become too unprofitable for the hospital to keep it.

Thus, analysis of the empirical data provides evidence of considerable institutional change initiated in the field of maternity care in a bottom-up way. This was framed by a shift toward a more 'humanised' model of childbirth, and consisted of material, communicative and medical alterations. However, grassroots initiatives by healthcare professionals faced many impediments to the accomplishment of their institutional work. In particular, patients often appeared to be unprepared for the new model of childbirth, while organisational conditions impeded options to improve material provisions and meet the demands of professionalism.

To conclude, reorganisation of maternity care may take place in many different forms, including taking a 'humanised' medical approach in various contexts, including small maternity facilities in small Russian towns. These changes are likely to occur by virtue of institutional work accomplished by particular midwives and obstetrician-gynaecologists analysed as institutional entrepreneurs. Motivated by new ideals of childbirth and corresponding notions of professionalism (ideational change), as well as a desire to practise more patient-centred maternity care services, healthcare practitioners changed their medical approaches, how they interacted with patients and their families, and the material infrastructure of the maternity unit.

Institutional change in the maternity field, in terms of altering the model of childbirth, demands considerable effort and resources, such as adjustments to teamwork, and coherent actions by all medical personnel, including doctors, midwives, nurses and administrative staff. The authority of the senior midwife, as a key institutional entrepreneur, in the maternity facility, and her hybrid role of manager-professional can be conceptualised as a particular kind of institutional work, i.e. as a key prerequisite for changing ideals and practices. Importantly, such changes do not occur as a single-stage movement, but in a continuous, multi-stage and time-consuming process.



The administrative and spatial position of the maternity unit presented both advantages and challenges to the reorganisation of childbirth. On the one hand, its small collective, its limited number of childbirths per year, and its remoteness from the regional administration contributed to coherent and consequential changes. On the other hand, its status as a first-level facility within the framework of the so-called routing law, and its limited access to economic and administrative resources appreciably impeded its transition toward a more 'humanised' model of childbirth.

In conclusion, analysis of the empirical data provided in this chapter enables the key research question on the role of professionals in the organisation of maternity services to be partially answered. Despite the quite rigid institutional setting characterised by top-down change, and the dominance of managerial and market logics of regulation, there was still space for professional agency, investigated through the institutional work accomplished by the most committed midwives and obstetrician-gynaecologists. However, no optimistic evaluation can be made of this institutional setting, which remained quite rigid toward change initiated from the bottom, and eventually eliminated the results of the professionals' institutional work.

## **8 COVERT PROFESSIONAL AGENCY IN MATERNITY CARE OF SMALL-TOWN RUSSIA**

In my research, I sought to answer the question: *how the macro-level institutional changes and top-down led reforms in the field of maternity care shape the street-level practices, and in what conditions there is space for professional agency?* In particular, I addressed the work of healthcare practitioners working in maternity facilities in small towns in Russia, at a distance from the regional centres. I investigated this issue through evidence at all levels of the institutional field of maternity care in Russia. Having examined state orders, laws and programmes, and previous researches on health and maternity care in Russia, in Chapter 2 I proposed that all changes at the structural level of this field appear to be centralised and top-down. As a result of these alterations over the last decade, how maternity services are organised, financed and regulated reveals the dominance of managerial and market logics of regulation. By design, the institutional field of maternity care in Russia in many respects derives from the previous Soviet system, and leaves little space for the manifestation of professional agency.

To analyse the organisational context of maternity care and professionals' attitudes and practices, I conducted multiple-case study and applied the methods of in-depth semi-structured interviews with healthcare practitioners, expert interviews with former main obstetrician-gynaecologists in one of the regions, participatory observations and document analysis. Analysis of the data collected reveals partial correspondence with the conclusions on structural features of maternity care. In particular, Chapter 5, based on the practitioners' narratives, revealed the domination of marketisation and managerialisation in the organisational context in which they worked. Doctors, midwives and nurses in different maternity units evaluated both the structural/organisational conditions and how they had recently been changing as negative for professional agency, owing to the overwhelming bureaucratisation of their practice and the decline in professional autonomy.

However, one finding of the research is that different organisational settings present differing combinations of institutional logics and their hybrids. Chapter 6 focused particularly on key dimensions of this variability: prevalence of a managerial logic, traces of marketisation, space for professionalism and the role of informality as organisational principles. Addressing the organisational level of maternity care, the chapter revealed the dominance of the managerial institutional logic, which on the level of both state reforms and organisational settings appear to be unfavourable for professional agency and autonomy. In such structural conditions institutional work can be accomplished to both maintain already established forms of

professional approaches and hierarchies in order to withstand emerging challenges, and to create new organisational forms of maternity care.

Institutional work, analysed in one of the cases investigated consisted of changes in the rules of interaction, working conditions and approaches to childbirth in accordance with notions of the 'new professionalism', rather than satisfying managerial rules or market demands. However, an opposite understanding of professionalism was also examined, which presupposed maintenance of rigid hierarchy within organisation, and borders between both, different professional groups and patients. I analysed these various notions of professionalism, in terms of different forms of institutional hybrids were formed. The study also emphasises the role of the informal institutional logic, which is enacted in order to navigate institutional complexity of the managerial and market logics' rivalry.

The research also examined some particular examples of the institutional work, accomplished by the health practitioners, working in the context of small-town Russia. The possibility to introduce new approaches to maternity care and to alter the organisational arrangement of maternity unit are analysed as an example of professional agency, revealing itself in structurally unfavourable settings.

## **8.1 RESEARCH RESULTS: OPPORTUNITIES AND CHALLENGES FOR THE PROFESSIONALS' INSTITUTIONAL WORK**

Based on evidence from one of the maternity units investigated, analysed in terms of institutional work carried out by healthcare practitioners, it can be concluded that some institutional alterations are possible, at least at the level of professional practices. The process that reveals professional agency in changing the approach to childbirth includes the stages of gaining new professional knowledge, changing the conceptualisation of maternity care and its ideal, altering professional practices, and changing perceptions of what professionalism actually consists of. The list of institutional, organisational and interpersonal conditions is a key result of the research, as it illustrates the role of healthcare practitioners in the organisation of maternity services, and how change can be implemented.

The ideational change, which happened by virtue of getting additional professional training and further integration of new knowledge into medical practices was the first condition for organisational change investigated in this case. Thorough coordination of this gradual integration, at the level of inter-professional collaboration and opportunities for teamwork within the whole maternity unit, was also required to accomplish this institutional work. The authoritative position and competence of the unit's senior midwife, recognised by all the other professionals, including the hospital's administration, appeared to be a key condition for this coordination. Unexpectedly, the

remoteness and small size of the maternity unit investigated were narrated as a prerequisite for the changes to occur. This contextual specificity and its 'positive' effects in terms of space for professional agency in such a non-democratic context are another important result of this research.

Re-evaluation of the conditions that small remote towns in Russia create for professional agency appears to be another significant finding. On the one hand, this setting, characterised by scarce material and administrative resources, does not favour the development of market mechanisms. Consumerisation of patients' behaviour and commercialisation of medical services, which in regional centres and large cities result in changes to healthcare practices, are undeveloped in rural areas and small towns. On the other hand, the density of social and professional networks and controlling bodies' lack of close attention to the activities of the smallest maternity units allowed the childbirth approach to be redirected toward 'humanisation'.

In conclusion, the results of my research confirm a top-down approach to change in the field of healthcare in Russia, and suggest that most recent state-led changes have been centralised in character and have resulted in the predominance of managerial and market logics of regulation. The organisational settings of maternity care in small Russian towns reproduce these structural features but vary considerably across different maternity units, in terms of healthcare practitioners' evaluations and efforts to resist such state ideals. One of the empirical cases revealed ground-level forms of professional agency, analysed as an example of institutional work carried out by practitioners to alter maternity care services' arrangements. However, the effects of the structural arrangement of the services and the dominance of managerialisation, together with the introduction of market mechanisms, appear to have been stronger than the ground-level initiatives, since the only unit examined that left space for professional agency was closed after the fieldwork had been completed.

## **8.2 APPLICABILITY OF THE RESULTS**

This work has revealed that some federal state orders and reforms may have unintended consequences for healthcare professionals working in the maternity units of small Russian towns. In particular, the implementation of so-called routing law, aimed at the betterment of accessibility and quality of maternity care, has unintentionally led to the emergence of the new forms of inequality. Such a restructuring in the context of remote areas resulted in aggravation of material provision of healthcare, loss of professional skills and even closure of maternity facilities. Statistical data provide a general picture of macro-tendencies, but these are insensitive to the organisational and micro-level particularities of maternity care and the professional workers who provide it. Qualitative methods are not widely used by state bodies in Russia; however, some of my research findings may be useful for organisers and

managers of public health. In particular, they reveal the importance of considering healthcare practitioners' perspectives and learning more about the actual conditions of their work, as well as about the challenges that impede their agency.

Not only the concrete results but also the process of this research provide evidence that there is a particular vulnerability of health practitioners in Russia. Russian scholars elsewhere have demonstrated that doctors and other medical practitioners in post-socialist settings lack professional autonomy and depend on state institutions (Mansurov, Yurchenko 2005). My own fieldwork has demonstrated that healthcare practitioners are very sensitive to this institutional configuration, and in many ways suffer this managerialist and controlling burden.

My findings suggest several courses of action to solve the problem of professionals' disenfranchisement. First, the professional institutional logic might be facilitated and enacted not only on the organisational and micro-levels, but on the structural one of state orders and macro-scale stakeholders, which affect the arrangement and organisation of maternity care. This might be implemented through an increased role for professional associations and a reduction in the number of controlling bodies. The key suggestion is to consider healthcare professionals' perspective in future reforms, in order to provide more space for their agency in terms of the institutional work they might accomplish to make the system of maternity care more safe, accessible and patient-friendly. I believe that the research may improve knowledge about the position of health professionals in the system of maternity care in Russia, and recommend that policy-makers could be in dialog with professionals in their efforts to rearrange this institutional field.

Another recommendation on the way, maternity care in Russia could be improved and healthcare professionals' agency can be promoted, consists of policy measures, which would promote the patient-centred approach in Russian healthcare services. In particular, new state reforms could address still persistent paternalism in doctor-patient relations and promote more egalitarian and sensitive model of interaction. New educational programs for healthcare practitioners could be elaborated in order to introduce less medicalised and authoritarian approaches. The updated professional standards for midwives and nurses, which enable their professional autonomy and widen the space for professional agency could additionally challenge the existing power imbalance in maternity care.

Finally, some potential limitations of the study need to be considered. Only two of the four initially approached cases were investigated thoroughly, hence, all the conclusions can hardly be generalised for the entire institutional field of maternity care in small-town Russia. In addition, the project has only addressed the districts, located in the Central and The North-Western Federal Areas, while due to the regional heterogeneity of the Russian healthcare, other areas can provide a different evidence. Despite this I believe my work could be

the basis for the further research of the health professionals' work, accomplish in this context.

### **8.3 FUTURE WORK PROPOSED TO CARRY OUT**

My research findings suggest the following directions for future research. First, it would be beneficial to investigate the perspectives of patients who receive maternity services in small remote towns and third-level maternity care facilities in the regions, such as technologically developed perinatal centres and maternity hospitals in the regional centres. The evidence of this study addresses in detail the perspective of healthcare practitioners working in first- and second-level maternity care, and emphasises the structural and organisational challenges that emerge in this context and may influence the content of the work. However, it also enables partial insights into the difficulties experienced by pregnant women, newborns and their families in dealing with issues of life and death.

Future research might consider the potential effects of top-down changes to maternity care on the childbirth experiences of families living in remote areas of Russian regions. My work has revealed that the smallest maternity units at the first level, located at a distance from the regional centres, may become settings for more patient-centred maternity care. Hence, reducing such services and closing the facilities affects pregnant women in terms of worsening access to and the quality of medical care. The current risk-oriented model of maternity care favours technological development, but remains insensitive to other dimensions of quality that are important to pregnant women.

This assumption of multiple ways to evaluate the quality of maternity care might also be addressed in future studies. In particular, the organisational context of other maternity units, located in small towns, as well as perinatal centres and other third-level maternity facilities might be investigated to determine whether alternative approaches to childbirth might be practised on a state-funded basis.

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## APPENDIX 1. LIST OF INFORMANTS<sup>10</sup>

### CASE A.

1. (B.I.): Boris Ivanovich – male, born 1969, the head of neonatological department, case A.; key informant, neonatologist (work experience around 25 years), provided the access to the field;
2. (L.A.): Lyudmila Alekseevna – female, born 1959; gynecologist, works in in antenatal clinic №1, (women’s consultation), 30-year work experience;
3. (D.P.): Dmitry Petrovich – Male, born 1952; the head of Maternity Ward of Central District Hospital (since 1988). Since 2016 performs the duties of the main obstetrician-gynecologist of the district. His wife used to work as a midwife in the same facility, but now retired and is engaged in farming. They live in a private house (besides the garden there are still two cows). D.P. has one daughter, who also works as obstetrician-gynecologist in the same department.
4. (S.B.): Sergey Borisovich – male, born 1964; obstetrician-gynecologists in antenatal clinic №1, sonographer. S.B. works in antenatal clinic №1, but comes on night shifts at Maternity department; 25 years of work experience;
5. (V.P.): Valentina Petrovna – female, born 1947; The head of the antenatal clinic №1, practice as a gynecologist, work experience is about 40 years;
6. (N.A.): Nikolay Aleksandrovich – male, born 1956; gynecologist, works in the antenatal clinic №1; 30 years of work experience;
7. (N.G.): Nina Georgievna – female, born 1965; gynecologist and sonographer, works in the antenatal clinic №1, more recently, used to have shifts at maternity ward; 25 years of work experience;
8. (T.P.): Tatyana Pavlovna – female, born 1950; gynecologist, works in the antenatal clinic №1, from 2001 to 2011 used to work as a head of the Center for Family Planning of Central District Hospital, 28 years of work experience;
9. (O.A.): Olga Alekseevna – female, born 1983; gynecologist, works in in the antenatal clinic №1, work experience is about 6 years;
10. (M.A.): Maria Alexandrovna – female, born 1960; gynecologist and sonographer, works in the antenatal clinic of the K-village of the V-district, 24 years-work experience;

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<sup>10</sup> All informants’ names are changed to pseudonyms to meet demands of anonymity. The names of towns are changed as well

11. (G.V.): Galina Viktorovna – female, born 1964; gynecologist, works in the antenatal clinic №1, until recently used to work as a gynecologist in the female correctional colony, work experience is about 25 years;
12. (T.V.): Tatyana Vasilievna – female, born 1949; gynecologist, works in gynecological department of the Central District Hospital, work experience is about 30 years;
13. (E.L.): Elena Leonidovna – female, gynecologist, head of gynecological department of the Central Regional Hospital, used to perform the duties of the main obstetrician-gynecologist of the district until 2016;
14. (V.V.): Victoria Vladimirovna – female, born 1947; gynecologist and the head of the antenatal clinic of City Hospital; work experience is about 35 years;
15. (A.A.): Anastasia Andreevna – female, born 1960; midwife of Maternity Ward of Central District Hospital. A.A. has a 36 years-work experience: used to work in all the units of the Maternity Ward of Central District Hospital (prenatal, postnatal, emergency ward, when there was still a separate maternity hospital, maternity ward);
16. (L.N.): Lyudmila Nikolaevna – female, scrub nurse, work in the Maternity Ward of Central District Hospital; has been working since 1981;
17. (G.S.): Galina Sergeevna – female, midwife of the postnatal unit in the Maternity Ward of Central District Hospital; works since 1977;
18. (O.N.): Olga Nikolaevna – female, born 1975; neonatologist at Maternity Ward of Central District Hospital, also works as a district pediatrician in a children's clinic, has been working since 1998 in children's polyclinic and since 2003 in the Maternity Ward of Central District Hospital. Studied at the regional center; has two children – gave birth to both of them at the same Maternity ward she works in.
19. (E.I.): Elena Ivanovna – female, born 1975; obstetrician-gynecologist of Maternity Ward of Central District Hospital, also works in the gynecological unit of the female colony, as a sonographer is in the gynecological department of the Central District Hospital. Also has a practice in a private clinic, where women can have testing and health screening as a paid service. Has been working since 2003 (in 2002 she passed internship). E.I. studied in St. Petersburg from 1996 to 2002. Has two children - gave birth to both of them in the regional center (third level maternity facility) for a fee;
20. (I.P.): Irina Petrovna – female, born 1956; The senior midwife of Maternity Ward of the Central District Hospital, has been working at Maternity hospital since 1976 and used to work in all the units (prenatal, maternity, postpartum); performs the duties of a senior midwife for about 20 years;

## CASE B.

1. (S.A.): Saveliy Antonovich – male, born 1961; the head of Maternity Department of the Central District hospital (second level) since 2006, district T.; has been working as an obstetrician at the same unit since 1989; 30 years of work experience.
2. (A.V.): Andrey Viktorovich – male, born 1964, The head of Central District hospital, obstetrician-gynecologist, district B., since 2000; has been working since 1989; used to work for 4 years in the institution of the second level of the region, district T., then transferred to the district B. Member of the National Medical Chamber of the region.
3. (I.S.): Irina Sergeevna – female, born 1972; The senior midwife of gynecological and maternity departments of B. Central District Hospital and antenatal clinic since 2006. I.S. has been working as a midwife since 1993, has received education in another district of the region, has worked only in this institution.
4. (G.L.): Galina Leonidovna – female, born 1965; The head of gynecological and maternity departments of B. Central District Hospital, the main obstetrician-gynecologists of the B. district. G.L. had an internship in 1989 in the same institution, and after that she remained there.
5. (O.G.): Olga Georgievna – female, born 1970; nurse of obstetric department of Central District Hospital; she has been working as a nurse since 1991. She studied in the same region. For ten years, she has been working in the therapeutic department of the same hospital and since 2000 she transferred to the gynecological department.
6. (N.A.): Nina Aleksandrovna – female, about 67 years old; Obstetrician-gynecologist with a working experience for more than 30 years. N.A. is the head of the gynecological department and antenatal clinic of the Central District Hospital located in a district P.. She opened her private gynecological clinic in 2006-2007 (the only one in the area) and continues practice as a private gynecologist.
7. (N.V.): Natalya Arkad'evna – female, born 1966, midwife of maternity department in B. district. N.A. used to work in another district until 2007, then for several months in the second-level hospital in district T., but it was not easy to get to, so she transferred to the Central District Hospital of the district B..
8. (A.R.): Albina Rodionovna – female, born 1991; obstetrician-gynecologists of antenatal clinic and maternity department in B. district. A.R. received education in the First Medical University in St. Petersburg (used the district quota to be enrolled into the educational program; and now it obligates her to work at least 5 years in this district), during the year she practiced in one of the maternity hospitals of St. Petersburg (maternity ward) and the Regional Hospital (gynecological department).

## **APPENDIX 2. GUIDES FOR INTERVIEWS WITH HEALTHCARE PROFESSIONALS**

### **GUIDE FOR IN-DEPTH SEMI-STRUCTURED INTERVIEWS WITH HEALTH PRACTITIONERS**

#### **Personal data**

1. How old are You?
2. What is your marital/family status? Do you have children?
3. Where and when did you get your degree? Why did You choose this specialty?
4. Why did you choose to work in this town and in this organisation? In which organisations have you also worked? In which position? What duties did you perform?

#### **Work and profession**

1. What is your position currently? Are you satisfied with your work? What are the benefits of this working position? Do you work somewhere else?
2. How long have you been working here?
3. Have you ever taken additional education or courses? Do you participate in scientific events on your specialty? Which sources do you use to get the information on the practice in your field and its changes?
4. Are you a member of any professional association? Why did you decide to enter it? What functions and tasks does this association accomplish? Is the work of the association appreciable for your practice (does it help in some cases, in which particularly)?
5. What are your responsibilities? Have they changed recently?
6. What is a feature of your specialty (obstetrics, gynecology, midwifery, nursery or neonatology)? What is the difference between the work in maternity unit, in antenatal clinic and in gynecological department? Why do you work in this particular unit? Have you ever thought to transfer to any other?
7. How many patients do you have during a day? How many hours per week do you have to work? Do your friends or acquaintances come to visit you? Do you accept them after working hours?
8. Has your workload recently increased in term of duration, number of patients or responsibilities? How much paper work do you have to accomplish?
9. How would you characterize your relationship with the healthcare managers (head, chief physician, chief specialist of a district or a region)?

Are your requests considered in the work? Do you have the opportunity to influence working conditions?

10. How are your relationships with colleagues? Do you have the opportunity to coordinate with them? Do you discuss complex cases together? What are your relationships with health professionals of adjacent specialties (obstetrician-gynecologist, midwife, pediatrician, nurses)?

### **Institution**

1. What is the status of the medical institution in which you work? What level is it assigned within the routing scheme? What is its capacity? How many specialists of your specialty (related specialties) work in it?
2. From what moment did this maternity unit become a maternity ward (not a hospital)? What has changed? Are there any advantages in the subordinate position with the Central District Hospital? Can you use the technical devices or recruit specialists working in the Central District Hospital?
3. How many doctors, midwives and nurses are currently working in the unit? Is there an anesthetist (is epidural performed)? How many obstetric beds there are?
4. How is work regulated and coordinated within your medical organisation? Who does inform you and explain new orders, requirements, rule changes (for example, in financing or reporting)? Who do you consult with regarding formal and legal issues? Would the situation change if a doctor of your specialty became a head of a hospital? Or, conversely, does the work of health manager depend on his or her medical specialisation?
5. When did you have the renovation of a unit last time? Do you have enough medication and do you have all the necessary equipment? Are the new delivery methods being introduced? What new drugs, devices, techniques would you personally like to implement into practice?
6. Are there any paid room in the facility? Are there any paid medical services? When did they appear? What has changed with their introduction? (Have patients become different?) How do you feel about paid services in maternity care? Do you have informal payments in your practice?
7. What are the main challenges to the medical work in your organisation? What is the reason for their occurrence? From what moment did they appear? What would you like to change in your facility, in your practice?

### **Maternity care**

1. How has different maternity services being coordinated in your district, region?
  - a. Between the maternity facility and the Central District Hospital
  - b. Between the maternity facility and antenatal clinics
  - c. Between different levels of maternity care (other maternity wards of the region, and with the Perinatal Centre)



2. Features of the "post-Soviet" maternity care: what has changed after the change of the political and economic regime in your work (working conditions, patients, professional status)? If you compare work in the USSR with the one you have now, which model would be preferable for you and why?
3. Can you somehow characterise the ongoing reforms, including changes in funding? Speaking generally about health care and, in particular, maternity care, how have they changed lately? Which change was the most noticeable for you, which greatly influenced your work, interaction with colleagues, patients?
4. How do you assess the measures taken by the state in the field of health care (so-called 'modernisation' in particular)? For example, the construction of perinatal centers or the law on the routing pregnant women (Order No. 572n) - does this improve the maternity care in the district, in the region? Does it complicate or simplify the work of the local (district) service?
5. Measures of "optimization" (unification of medical institutions, staff reduction, beds recounting) - what have happened lately in the frame of optimisation, do you think they are justified, rational, necessary?
6. Is your facility autonomous in terms of financing and decision-making? How do you evaluate the possibilities of autonomous financing and administrative independence of your medical organisation? Is this the desired change or not?
7. Are there any differences in approaches or methods of maternity care practiced in your unit and others in this district or region (if there is an opportunity to compare)? How would you characterize your approach or methodology? What would you like to change in it, why?

### **Cultural context and patients**

1. Do patients differ in cities and towns, rural areas? How did your patients change after the 1991 year, after 2006, have they become more responsible, independent, demanding? What reproductive health problems do you consider the most acute right now? What do you associate them with?
2. Informed consent - does it simplify or complicate your work? Did it affect the nature of the interaction with patients? How would you evaluate this form?
3. Have there been any legal proceedings in your practice? Is there more of them? What do you associate this increase in the number of legal claims with?
4. What are the features of the place where You work? Is the work in your specialty different in a large and small city? How do you evaluate the professional training of medical specialists at the present time? Where would You recommend giving birth to your daughter or a close friend? Why?

5. The specifics of a small town: what, in your opinion, is the difference between the organisation of maternity care (health care, in general) in a small town and large centers?

## **GUIDE, FOCUSED ON THE PARTICULAR CHILDBIRTH APPROACH ('PATIENT-CENTRED MODEL'), ELABORATED FOR ADDITIONAL INTERVIEWS WITH OBSTETRICIAN-GYNAECOLOGISTS AND MIDWIFES**

### **The approach in general**

1. How would You describe the methods of delivery that you have in your hospital?
2. What is their fundamental difference from how you used to work before, from other approaches and methods ("Soviet approach", "natural childbirth" and others)?
3. What are the key characteristics of your approach? In terms of the relations with patients, between colleagues, medical practice, in the conditions of assistance?
4. What are the main stages of change? Reconstruction of the maternity hospital (individual delivery rooms), changes in the institutional environment (sanitary norms, other rules), social?
5. What competencies, skills, knowledge, techniques do you need to know in order to introduce and practice this approach? How did you learn new techniques? How do you train your staff?
6. Is any additional preparation for patients necessary?
7. Are there any changes being implemented now? If so, where do you get the information from?
8. Do you share your experience with other colleagues? (from other maternity facilities)

### **Conditions**

1. What made these changes possible?
2. What is needed for such a reconstruction (both material and social)?
3. Was it a collective or individual initiative mostly?
4. Are a small town and the first level assigned to your facility more likely advantages or additional obstacles for the introduction of new methods?
5. What is the role of the senior midwife and the head of the department, the head physician of the hospital in such a change?
6. Is this more likely a 'midwifery' or 'obstetrics' (medical) project?
7. Was your own childbirth experience significant?

### **Obstacles**

1. What problems did you encounter at the beginning of the change? On the part of colleagues, on the part of administration, on the part of patients?
2. What challenges emerge now when the facility is working on a new model of maternity care? In terms of personnel, material resources, patients?
3. Regulation of the maternity care system (orders, protocols, recommendations) - does it facilitate or, on the contrary, complicate the introduction of such changes?
4. The framework of a state-funded health care unit – does it simplify or complicate the work? Would something change with the introduction of paid services for maternity care in your case?
5. What other changes would you like to implement if you had the necessary conditions and resources (material, time, social, etc.)?

## **GUIDE FOR THE EXPERT INTERVIEW WITH THE FORMER MAIN OBSTETRICIAN-GYNAECOLOGISTS OF THE REGION**

### **General questions**

Age

Marital status, do you have children?

How did you manage work-life balance (in particular, in terms of urgent business trips)?

In which city was you born and used to live? If moved, then when, where, why?

What education (where and when) did you receive?

Why did you decide to stay in this specialty, in this position?

What is the difference between scientific work and medical practice?

Where besides university did you study by profession? Have you ever participated in any international conference, internship?

What do you do in the framework of scientific educational activities?

### **Practice as obstetrician-gynecologist**

Where did you practice after graduation?

How did you choose the direction of work? (obstetrics or gynecology)? Why?

Where did you work? Which positions have you changed? When and why?

How are you related to the O. Institute and Academician A. (referred to A. as a teacher)?

Since when did you start working in private clinics? What is the difference of work in private healthcare from any state-funded organisation?

Do you have problems of interaction with patients? What kind of? Are they gender related?

Are patients' practices changing?

How, in your opinion, should the doctor-patient relationship ideally be built on?

What are the benefits of your work? What do you like most about it, is it satisfying?

### **Position of the main obstetrician-gynecologist of a region**

How and when did you get this position? How long have you performed the duties of the main obstetrician-gynecologist of a region? What are the key responsibilities? Who were your immediate subordinates and superiors? Does this position involve medical practice or just administrative work?

How is the service coordinated between the nearest regions and within the region?

Have you ever traveled around the region, coordinated work on the ground?

What are the difficulties of such a job (professional burnout, bureaucratic overwhelming)?

Why did you leave the post? How is appointment and continuity carried out?

Are you connected with administrative work now?

Are you currently collaborating with colleagues on budgetary health care?

How are the meetings of the regional obstetrician-gynecologists? Do you attend them? (is there still an access? What is the relationship with the chief specialist of the region now?)

Who is lobbying for the construction of the perinatal center in this particular place in the region?

Who lobbied for the adoption of the Mother and Child program in the region?

What organizations implemented? How were doctors invited to study (optional or directive?)

Are there any positive results of this program?

### **Specialty features (obstetrics and gynecology)**

What are the features of work in the specialty of obstetrics-gynecology? (Why did you choose it?)

The main moral and ethical issues. Do you participate in discussions about abortion?

Difficulties of work, what are they connected with (gender status, segment of medicine - in which ways?)

Patient features, which categories would you identify? (for example, pregnant - is it more difficult to work with them?)

Do you think the relationship between doctors and patients has changed lately? Has patient responsibility increased?

Have the tasks of the doctor changed concerning these changes in doctor-patient relations?

How are obstetrics and gynecology coordinated among themselves and at different levels of healthcare? (Federal Okrug; Region; Districts; organisations)

### **Organisation of the obstetric care in the region**

What are the main problems of healthcare organization in Russia? In the field of maternity care in particular? And specifically – in this region?

How is maternity care coordinated within the region?

Coordination of service and administration of the region. What institutes and organizations (administration of the region, city, health committee, heads of the district, head doctors of the central district hospital) interact with each other in this field?

Closure of first-level maternity facilities - who makes such decisions, how are they regulated? What are the effects of such a restructuring for doctors and patients?

How has the work of your service changed under the construction of a perinatal center in the region?

Priority areas of service development. What measures are to be taken in this field? In which directions, what are the priorities? For example:

- Technical support
- Qualification and education of personnel
- Improving services performance
- Prevention

How do insurance companies and administration affect the work of the service?

How has the service changed lately?

### **Features of maternity care in small cities (level 1-2)**

How has the position of the first-level institutions changed after the law on routing (outflow of patients, reduction in funding)

What are the changes resulting from the closure of maternity wards in the districts?

Are there any particularities in the medical practices and culture of the patients in the context of small towns and rural areas?

Are there any differences from the work of maternity care in large centers?

What are the main difficulties in the organisation and operation of the service (transport accessibility, financing, remote coordination, lack of staff, insufficient educational centers, outflow of patients - reduction in the number of births)?

### **Health care reform(s)**

Law on Routing Pregnant Women with Pathology (No. 572) ('routing law') – was it necessary measure? How would you evaluate its implementation?

Some other reforms - how have they been implemented?

What are the other services reorganization occurred recently?

Changing the financing model (turn to a single-channel) - what are the effects for maternity care provision?

“It is not enough to draw up an order - it is much more difficult to implement it” [quote from informant's report]: what needs to be done for this?

Have you ever participated in the development of orders, their adaptation to the region? In which way?

### **Private health care development**

How do you evaluate the growth of commercialisation in healthcare?

What is the potential for such development in the region?

Does commercialisation affect doctor-patient interactions?

Is the relationship between a doctor and the administration in private clinics different?

Is private healthcare more effective for the medical services provision?

The problem of access to health care and the lack of private clinics in small towns

### **Professional projects and professionalism**

What are the best opportunities and conditions for the implementation of professional projects of obstetrician-gynecologists? (Private medicine, Public-private partnership, Chamber of doctors)

Is it possible to professionalise in the region?

What, in your opinion, makes up the main provisions of the profession? What does it mean to be a professional?

Professional cooperation - is collegial work important for your specialty? What should be the relationship with colleagues?

How do you think the relationship between a doctor and a midwife (medical nurse) should be built? If we talk about the Scandinavian model as ideal, should the supervision of pregnant women be reduced by a doctor and delegated part of the tasks to midwives?

How do you feel about “natural”, soft delivery tactics? How do you think they should (should not) be implemented? In what direction should the service be developed?

What are the main difficulties for the doctor’s work at present (administrative control, patient demands, bureaucracy, lack of resources)?

What is the “ideal” model of healthcare (and maternity care, in particular) in your opinion?