Health education in the U.S.S.R.

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During a three week visit to the U.S.S.R. in September and October 1971 studying the organisation of various aspects of primary medical care (Stephen, 1971), I thought it would be useful to discuss health education. Perhaps Soviet experiences should influence the Health Education Council in their future programme in this country.

I was able to travel widely—Moscow, Tashkent, Yerevan, Tbilisi, Odessa and Kiev—and it was soon clear that it is regarded throughout the U.S.S.R. as a most important activity and a routine responsibility for every doctor and all paramedical personnel. It is a mass activity also carried out by officers of other Ministries such as Education and Culture.

Organisation

Health Education is controlled by the Ministry of Health of the U.S.S.R. which is headed by the Chief Health Education Inspector. There is also a Central Research Institute of Health Education in the Ministry of Health whose main functions are:

1. Research into techniques and methods of health education. The main trends are:

(a) to evolve methods suitable for establishments such as polyclinics, hospitals, schools and industry,

(b) to develop health education techniques to control urgent health problems such as cancer and cardiovascular disease.

2. Supervision of all health educational establishments in the U.S.S.R.

3. Training of health education personnel.

In the Republican Ministries of Health there are similar organisations.

At the local level, health education work is carried out by health education centres and special sanitary centres, of which there are almost 400 in the U.S.S.R. The main functions of these centres are:

1. Organisation of local health educational activities through hospitals and polyclinics.
2. Implementation of health education activities.
3. Evaluation of health education measures.

Doctors and health education

It is introduced in all stages of medical care beginning in mother and child polyclinics crèches, kindergartens, secondary schools (where it is the dual responsibility of teachers and doctors), adult and industrial polyclinics, hospitals and even research institutes.

Active health education is carried out by doctors in all these institutions: every Uchastock physician is expected to spend not less than 30 minutes per day in this work. In remote rural areas, health education is the responsibility of feldschers.

The usual techniques are used: lectures, newspapers and periodicals, television and radio, films and intensive 'health weeks'. A special feature of health education is the massive display of propaganda material, particularly in polyclinics and hospitals.

In paediatric polyclinics there were numerous posters, model demonstrations, and booklets about the upbringing of babies and children. Special rooms were set aside for instructing young mothers on: what foods are best at each stage in a child's life, how to keep house, accident prevention (swallowing poisons, danger of fire or burns) and general hygiene. Many of these posters and models are exceptionally good and 'catch the eye'.

As well as this propaganda in the polyclinics, there are special 'mothers' schools' in the districts which deal with similar subjects but include films and lectures. Paediatricians were

convinced that mothers who attend such schools produce healthier children. Breast feeding was also an important part of health education and the 90 per cent success rate remarkable.

In the adult polyclinic there was the usual propaganda against smoking and many have 'exercise schemes' on display: these were detailed maps of the locality surrounding the polyclinic showing walks of varying distances with suggestions that different categories of people should walk certain routes each day. Hospitals as well as polyclinics are provided with elaborate posters and transparencies showing every important disease with its prevention and treatment.

Personal assessment

Their attitude is completely different. In the U.S.S.R. health education is not a poor relation but is treated with equal and sometimes even more importance than clinical medicine. This whole philosophy permeates doctors and patients alike. There is nothing half-hearted in their attempts to educate the population about their health and an enormous amount of time and energy is spent in this direction at all levels of medical care.

It is not difficult to find the reason for this difference in approach. Throughout the six years of medical training every student, whatever his final specialty, spends considerable time learning about preventive medicine and health education. The Soviet system of health care believes that this branch of medicine is of paramount importance. Therefore the educators of medical students believe in this and naturally future physicians are infused with the same interest and enthusiasm. This is a far cry from medical schools in the United Kingdom.

Two aspects of this subject deserve special mention:

1. The campaign against smoking has failed completely: this was freely admitted by every doctor I met. In a country with a population which is susceptible to propaganda, and which has been subjected to a great deal of propaganda against smoking, the fact that it has failed, has serious implications for any programme devised in the United Kingdom.

2. The most obvious difference in attitude is that in the U.S.S.R. there is no differentiation between the need and demand of the patient. Doctors realize that there are unnecessary demands but they accept this as an inevitable part of their work. Repeatedly it was said "What a patient demands the state must give and try to provide". In other words it is an 'open-ended' service with no thought about spiralling costs. The idea of educating a patient to use a doctor's time effectively is quite alien to their philosophy and was dismissed as irrelevant. For example, there was certainly no question of educating young mothers about common childish ailments to see if they consulted the doctor less than a similar group without any health education as is being done in a practice in Bristol (Whitfield, 1971).

Recommendations

1. An alteration in the emphasis of the medical curriculum is suggested so that students are shown the value and purpose of health education. This is extremely difficult because the curriculum is still firmly in the hands of entrenched hospital clinicians who still lure the students away from the wider horizons of medical care with the latest 'status symbols' of modern medicine. Historians of medicine will surely rebuke twentieth century physicians for spending so much time, energy and money on hopeless surgical and medical intervention and so little on epidemiology, preventive medicine and health education.

2. The anti-smoking campaign in the U.S.S.R. is much more comprehensive than anything which could possibly be organised now in the United Kingdom and yet it has failed. This must be a warning for the Health Education Council. It would seem a waste of money to embark on any further large scale propaganda programmes using television and wireless advertising, newspaper and other sales techniques. Such programmes may salve the nation's conscience but on the evidence from the Soviet Union will do very little good. People continue to smoke, not because they are unaware of the dangers but because it is easy, socially acceptable and still relatively cheap. The unpalatable fact remains that smoking will only decrease when governments take action and patients are really frightened. It is therefore suggested that:

(a) smoking must be made very expensive.

(b) smoking must be banned from all public buildings (including cinemas, theatres, hospitals, health centres and doctors' surgeries), public transport, trains, aeroplanes and ships.

(c) smoking must be thought as socially unacceptable as spitting.

(d) visits to thoracic units dealing with lung cancer should be arranged for all school leavers; fear is still a great deterrent. Only when governments see the money lost through reduced cigarette sales will be more than compensated by the reduction in sickness benefits and time off work, will the death rate and morbidity from smoking stop increasing. (*Update Plus*, 1971).

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GENERAL PRACTITIONERS IN JAMAICA

The approval of six new membership applications from family physicians in Kingston, Jamaica, has resulted in the formation of a nucleus of ten members of the College of Family Physicians of Canada in this Caribbean island. For some years several family practitioners in the Caribbean have been members of the Royal College of General Practitioners in Britain. An agreement has been reached with the R.C.G.P. enabling those physicians in the Caribbean wishing to participate in the activities of the (Canadian) College to be associated with the College of Family Physicians of Canada. We welcome this association and look forward to a large number of family practitioners throughout the islands becoming members of the College, participating in a program of continuing education designed to meet the particular needs of physicians in that area.

Canadian Family Physician (1972). **18**, 10.

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