# Social and Economic Differentiation of the Issues Affecting the Health of Modern Russians

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## ABSTRACT

Health is one of the factors that allow for identification and self-identification, and lead therefore, whether one has good health or not can lead to a sense of inequality. Not only is health a prerequisite in social interaction and social cohesion, it is also an essential factor for guaranteeing public and private psychological well-being among social groups and communities in modern society. This study employed sociological methods to study the health of the population, and was limited to information selection and analysis similar to that of the health department system. The qualitative method was used to analyse the social logic of people's behaviour and motivation in attending to health. Social and statistical study of public health is at its initial stage and is characterised by its descriptive character, limited database, discrepancy and even bad indicators. These serve as information reference points for statistical studies. In Russia, such study is lacking. In the area of public health, social and economic differentiation is one of the factors of social dependence.

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## INTRODUCTION

One of the reasons for this study was that available medical research data and medical statistics cannot characterise the true determinants of health as well as health status in Russia. Eliseeva listed three areas that lack sufficient data for proper analysis: assessment level of medical aid for the population, characteristics of medical institutions of different types and statistical analysis of clinical trial results (2003). In these areas, social statistics tend to be substituted for medical statistics. However, the social statistics must be orientated on polyaspectual coverage of the social factors, which are focussed on discovering new approaches to medical sociology.

Eliseeva also noted the lack of data on the social statistical indicators of public health (2002), listing two main indicators, namely, demographic determinants such as length of life and death-rate by sex, age and causes of death, and morbidity rate, which includes persons sharing different health status (by sex, age, etc.), the number of acute diseases, the number of new proven diagnoses and indicators of self-assessment of health by the population.

These indicators are the usual focus of interest in medical statistics. Only two of them are beyond this traditional focus: length of life (a demographic indicator) and self-assessment of health (Lapin, 2000; Rzhanitsyna, 2001). The most significant social and socio-medical characteristics of public health are not indicated; there is a need for medical social statistics indicators to be updated according to subject and scientific practical mission (Karelova, 1999; Karyukhin, 2003).

One of the signs of insufficiency in scientific data collection and methodology is the dearth of social statistics of public health. Theory and social statistics on public health as a scientific branch at this stage of its development are inadequate and therefore, researchers, managers and practitioners are left unhappy and dissatisfied, unable to do their jobs properly.

The development of modern social statistics must begin with the definition of principles and conceptual approaches as well as the establishment of traditions tied to social statistics as a branch of study and an independent profession that is serious about investigating the problems of public health. Underestimating this methodological and organisational scientific task is quite dangerous. This danger is determined by that the general lag in the social statistics of public health or the private gaps in the special problems of the public health service, which impede information support of public health services. This lag complicates the scientific and practical implementation of the social and system concept of the public health service, which embodies the scientific ideas of the social dependence and social structure of public health. Most of the research results will remain in non-demand until the social statistics reach a stage of institutionalism and self-actualisation as a profession (the methodological fundamentals clearly

defined, which meet the scientific and methodic standards and staff training system for the information and analytic departments of the public health system).

## METHODS

The social and statistical characteristics of the public health service are available for selection and analysis. Experience has shown that corresponding scientific interest and material resources, as was made available in some regions of Russia such as Novgorod, Moscow and Tyumen, allows for a modern social and statistical base that characterises the regional health system. This also allows access to problems, social and professional opportunities and directions in developing personnel in the health system for at least three or four years (Dobrokhleb, 2008; Karyukhin, 2003). It is also possible to analyse social and statistical characteristics of public health where the indicators are often latent and arduous. These include information, specialised requirements in reference to representativeness and scientific and methodical conclusions.

This study hoped to discover the key principles of the social and statistical study of public health based on assessing the social statistics of public health status in Russia. The study also hoped to investigate results of sociological and statistical studies conducted with research centres under the Russian Academy of Medical Sciences. The studies included social statistics compliance with the social and system model of public health and healthcare services; the programme and instrument of social and statistical

research of public health interrelation with the theoretical apparatus of medical science and the infrastructure of the current health system (first of all, with preventive medicine); the social statistics of public health compliance with the information needs of the developing control system of the public health service; the internal scientific and methodical compatibility of the statistical databases being formed and analysed (for the comparative analysis and forecasting); and hope of minimising errors in the developed estimates of the social and statistical analysis of public health.

Providing complete and reliable sources of statistical information is a huge problem in collecting the social statistics related to public health. As a rule, the indicators of the state statistics, created from the results of the population census, sample survey of households or reports of medical institutions are limited and not complete in terms of demographics (sex, age, city/village, territory). They are overshadowed by other more important social factors.

One of the basic approaches to improving the medical and social statistics of public health is information and technical integration of the existing departmental databases for the purpose of creating a single personified database on patients that characterises public health sufficiently completely. At the regional level this problem is solved through the integration of the following databases: incidence of disease by appealability (being formed in medical and diagnostic establishments); regional funds needed for compulsory

medical insurance and other insurance companies; birth rate and mortality structure (collected by the Civil Registry Office and medicolegal investigation authorities); and invalidisation (formed by medical and social examination authorities). However, this information and technical solution does not provide a complete and adequate database on public health, as it should include statistical indicators, which are specially concentrated on the social aspects of public health and healthcare (Karyukhin, 2003).

It is necessary to develop a more effective accounting branch system soon to deal with the complexities of collecting these statistics. Such a system must cover the essential social factors of public health, rather than just status factors that are usually widely applied, for instance, gender or age, in addition to statistics related to activity and mental health.

Effective social statistics on public health and healthcare services will lead to a set of integrated quality indicators gradually. A concise set of social and statistical indicators includes medical (departmental) statistical indicators such as levels and structure of disease incidence, invalidisation and medico-demographic indicators. In order to limit indicators, it is efficient to include three blocks: (a) priority indicators of health among other vital problems (a tabular question in reference to three statements); (b) high-quality medical care availability; and (c) behavioural strategy in the health domain.

The specified characteristics are objectively interconnected in real life activity.

Therefore, their empirical measurement by means of an inquiry will allow assessment of the social and subjective prerequisites for public consciousness and behaviour in a range of problems dealing with health (Kuzembekova & Meimankulova, 2015). To solve the problem of the complexity of the social and scientific study of public health, the following points must be included among the integrated indicators: (a) quality of medical care (in its own medical and clinical indicators, invalidisation, mortality etc.); (b) social and economic efficiency of medical care (general duration of treatment of patients being cured; duration of patients' postclinical disability; and the necessary labour and professional mobility of patients, etc. during treatment); (c) accessibility of public health service resources for various social groups of the population; (d) behavioural strategies of the population in the health domain (real and ideal [conditional] commitment of different social groups to a lifestyle, self-treatment and its main technological types prevalence [behavioural strategies]); (e) health self-assessment and health status satisfaction; (f) health status awareness; (g) social groups' attitude towards their health; (h) and the main groups of the population's satisfaction with the action of the health system. Also, the list of its key weaknesses that are fixed in public opinion.

To select just these indicators we relied previous sociological study on public health according to the three stages of annual monitoring (the years of 2002-2005) and the complex research of public health in

the Novgorod region (the years of 2005-2006). In reference to these indicators, it was necessary to try out the empirical fixed threshold levels, which would fulfil the role of criteria in assessing public health processes and status theoretically and practically. Knowing how similar problems were slowly solved and the statistics system made inert in the country, it only remained to rely on large-scale complex studies of public health by means of using a set of social indicators.

Acting as a component of large scientific work, the sociological research, as a rule, solves certain tasks and uses corresponding methods. Socio-economic and demographic statistics collection is usually required and the data are then analysed. This is necessary for comparing economic development, the population's living standards, peculiarities of the region's settlement structure and demographics. Therefore, the characteristics of age and sex structure, the natural and mechanical movement of the population, economical and medical indicators (technological and personnel resources of public health service etc.) are usually included in the range of the empirical indicators. A specific place in a range of statistics is taken by the data characterising the ecological quality of the population or groups of the population environment being surveyed.

Other methods are focussed on the characteristics, which are out of the field of available economic and demographic or medical statistics and are necessary for analysing special social and behavioural

parameters of public health assessment. These methods include more traditional standardised inquiry that enables collecting the necessary information for checking such factors of behaviour as age and gender, marital status and the place in settlement structure, main occupation and living standards, real or retrospective characteristics of work and branch belonging.

Information collection about the socio-psychological and socio-cultural factors of consciousness and behaviour differentiation in the health domain is especially an important and difficult task of sociology. However, we have to admit the difficult character of many factors of behaviour, respectively, the quantitative and high-quality indicators, which allow for checking of the hypotheses related to public health social dependence. The necessary blocks of sociological research indicators covered:

- sociocultural properties (ethnic origin, level and nature of education, people's valuable attitude towards their health);

- socio-psychological and awareness indicators (general self-assessment of health, satisfaction and uneasiness concerning health status, knowledge of the established diagnoses of diseases existence, disability status and dispensary for diseases, professional medical care or self-treatment orientation);

- factors of health and risk of disease incidence (genetic burden, working

conditions and physical activity, dependence on psycho-active agents, level of stresses, etc.);

• availability of the general and specialised medical care, individual and group experience in getting help and social interactions in different sectors of health system, general satisfaction and sharpness of the single weakness perception in health system activity.

The typical groups of tasks and sociological parameters, defined above in public health research are efficiently reflected in the applied methods of data collection. They sometimes require an exit beyond more habitual quantitative methodology and an appeal to qualitative methods.

So, the present status of the social statistics of public health and healthcare remains low. The methodological plan given above do not settle all the important questions concerning this branch of knowledge and point to the need for special efforts on its further development.

## RESULTS

A person's social milieu determines the psychological specificity of his personality. This specificity is shown in personal self-sufficiency and orientation (concentration) of individual resources, including individual health. This hypothesis is generally confirmed in the statistical analysis of the standardised inquiry of adults data[1].

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[1] The following types of marital status were

A person whose activities generally revolve around his family lives in a smaller circle of social dependence and responsibility. Adult respondents living alone with no family of their own assess their health as bad or very bad by one third more frequently. They tend to worry more about their health than their peers of the same age and having the same health conditions but who have their own family do.[2]

The behavioural models of the two demographic groups being considered in the health domain are significantly different. The first group refuses to seek medical advice if they are ill less frequently and tend do so twice oftener if they have any diseases. A 'soft' refusal of medical advice is a prevailing behavioural model (to see a doctor only if seriously ill) among both groups i.e. single people (68%) and those married (72%).

The distinctions given above as to behaviour can be partly explained by the features of time budget and social connections of groups of different marital status (Frolova, 2014). An adult person

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fixed in the inquiry: (1) living out of wedlock, (2) divorced, (3) widowed, (4) married once, (5) living with a partner outside marriage, (6) married twice. Considering the variety and relativity of marital status and the given categories, the subjects could be divided into two groups: those living with their family (4, 5, 6) and those living without their family (1, 2, 3).
[2] In all 10-year cohorts of working age among people living alone, as a rule, the average number of those anxious about health exceeded the corresponding indicator of family men by 0.12.

having his own family generates little time and care for attending to his own health as he is more concerned about attending to the health of his family. This allowed for strengthened mutual help among family members, better labour and duty distribution and reliance on the physical, temporary and economic resources of relatives.

By primary occupation among the adult population (aged 18 and above) we distinguished seven groups in the research. They are presented in Table 1. Employed people and pensioners were the largest group. One of the most noticeable distinctions was found in these groups' attitude towards their health value.

Health value was apparently not the main concern among the subjects in most of the groups presented in the table. It was not considered a resource. The value of providing for individual or family living standards was more important to pupils and employed people especially during periods of radical market reforms triggered by social and economic degradation. This

value was more important than health, spiritual development and personal and public security. This finding is confirmed by many special studies (Lapin, 2000; Rzhanitsyna, 2001). This outcome is due to conditions prevalent in Russia since the two last decades of the 20th century. In this regard, pensioners were the exception.

The social and economic groups listed above differ significantly in their behaviour when ill as seen in Table 2 below. The findings show a prevalence of applying self-treatment strategies.

The group responding with a "rigid refusal" of professional medical care in case of illness varied widely from 7% to 20%. The highest prevalence of "rigid refusal" was shown, as one would expect, among pupils and women on maternity leave (prenatal leave or child-care leave), amounting to 20% of the group. The lowest prevalence was among pensioners, including the occupied population (7-9%). This is partly explained by their age; the elderly tend to show peculiar responses

Table 1
*Adults' primary occupation and their attitude towards health in percentage (%)*

| No. | Adults' primary occupation (%) | Those agreeing (%) | |
| --- | --- | --- | --- |
| | | Health is the main concern in my life | Health is not the main concern; there are more important concerns |
| 1 | Working (50.4) | 37.3 | 61.5 |
| 2 | Studying (3.8) | 31.6 | 56.7 |
| 3 | Studying and working (3.0) | 34.4 | 55.6 |
| 4 | Retired and working (6.7) | 55.3 | 36.9 |
| 5 | Retired, not working (27.5) | 83.3 | 19.8 |
| 6 | Not studying and not working (4.5) | 49.3 | 45.2 |
| 7 | On maternity leave and child-care leave (1.8) | 27.5 | 67.0 |
| 8 | Total | 50.6 | 46.1 |

Table 2

*Primary occupation and answers to the question, "Do You Always See a Doctor in Case of Illness?"*

| No. | Adults by primary occupation | Will not see a doctor (%)* | Will see a doctor if seriously ill (%)* | Will see a doctor if having a disease (%)* |
|---|---|---|---|---|
| 1 | Working | 15.2 | 71.5 | 10.7 |
| 2 | Studying | 18.7 | 56.1 | 22.5 |
| 3 | Studying and working | 13.2 | 70.9 | 14.6 |
| 4 | Retired and working | 9.0 | 73.9 | 14.7 |
| 5 | Retired, not working | 7.0 | 67.4 | 22.4 |
| 6 | Not studying and not working | 18.1 | 72.4 | 7.7 |
| 7 | On maternity leave and child-care leave | 19.8 | 62.6 | 16.5 |
| 8 | Total | 12.5 | 68.6 | 14.5 |

* Amount does not exceed 100.0%

towards personal health.

A "soft refusal" of medical care was seen among adults in general. The fact that two social and economic groups (students and those who study and work), in fact, being of the same age category (young people), showed a big distinction in their response (56% and 71%, respectively) should be noted. Proper strategies to counter this response to their health are needed.

One possible explanation for this distinction lies in the ratio of the sociocultural properties of the two social environments i.e. educational and production labour. A concentration on intellectual activity, cultural values, specially developed organisational models that protect from many negative external influences (for instance, climatic and technical), denser social guardianship (including questions as to food and health may have developed an infrastructure of medical care and its systematic character) are peculiar to those belonging to the educational environment

(Karelova, 1999; Karyukhin, 2003; Medik & Osipov, 2003, pp.75–89). However, the production-labour environment is noted for its absolute priority on economic matters and does not always develop a sound infrastructure for medical care.

Leaving educational collective and immersing in labour one, as we can suppose, becomes a decisive factor for the fact that the "soft refusal" gains the property of the absolute domination from the unstable prevalence quickly enough for young people. It is most likely that the social base of "rigid refusal" extends. Simultaneously, there is a sharp decrease in good strategy from 23% to 15%.

It has been already shown above that the objective key factor of people's attitude towards their own health is determined by the economic and social situation of an individual or a group, including occupation, qualification, official position and welfare. When a person reaches retirement age, health becomes an important value to him.

From the viewpoint of Russian society and the state's interests, we cannot concede that the current attitude towards health is normal i.e. when it is not a priority to social groups. Consequently, we cannot accept that students and workers do not understand the value of health. Most of the population does not listen to common sense when it comes to the value of their own health. They take risks with their life.

We need another system of values in which there is balance between public and individual interests, material and spiritual wealth as well as an orientation to the all-round development of the individual that does not reduce his achievement to mere professional success and the prestigious standards of material consumption. It is peculiar that economic success (material wealth) eclipses health in terms of value. This is the psychological product of 'economicratism', an ideology that was persistently imposed on the Russian public consciousness in the last two decades.

This ideology itself is logically false. In fact, it undermines the objective long-term resources of economic success and the modern principles of a sustainable social and planetary development that have always considered individual and public health as being important.

Social and economic groups of the population are greatly different in self-assessment of health (Table 3). The lower middle-aged group i.e. students who study and work at the same time or those on maternity or child-care leave seemed to be the groups most likely to assess their health on their own. This once again highlighted age as a factor.

Awareness levels among socio-economic groups having diseases were not identical. In an ideal situation, an average number of determined diagnoses can advance awareness among patients having diseases of the need to go for a medical examination. In fact, the awareness among patients having diseases lags behind the

Table 3
*Health self-assessment in groups by primary occupation*

| No. | Primary occupation and age of adults (middle-aged, in years) | Self-assessment of health | | | |
|---|---|---|---|---|---|
| | | Bad (%) | Satisfactory (%) | Good, Excellent (%) | No answer given (%) |
| 1 | Working (35.9) | 8.8 | 66.7 | 12.7 | 11.8 |
| 2 | Studying (21.2) | 6.4 | 51.9 | 33.1 | 8.6 |
| 3 | Studying and working (23.4) | 6.6 | 47.0 | 29.1 | 17.2 |
| 4 | Retired and working (58.9) | 17.4 | 66.7 | 2.1 | 13.8 |
| 5 | Retired, not working (67.6) | 49.5 | 39.4 | 1.0 | 10.2 |
| 6 | Not studying and not working (40.4) | 23.5 | 49.8 | 11.8 | 14.9 |
| 7 | On maternity leave and child-care leave (26.9) | 8.8 | 50.5 | 24.2 | 16.5 |
| 8 | Total | 20.9 | 55.7 | 10.0 | 13.4 |

real picture. Table 4 shows the average numbers of diseases according to the data based on standardised inquiry and objective examination[3].

From the table, it follows that judging by the average number of diagnoses reported in the standardised inquiry, awareness among patients having diseases would be two or more times below the real number of diseases, determined again during the objective examination of the same patientsfor all the groups. It is fair to suppose that the diseases of many of the patients had developed over several years, passing from chronic to more severe forms. Therefore, there was a lag between the real situation and what was thought to be true, resulting in the fact that the vast majority of adults did not get the necessary treatment and did not change their way of life accordingly, thereby compromising their health.

As a rule, awareness of having chronic diseases lags behind the real figures (Medik & Osipov, 2003, pp.75–89) and this calls for further research. The information provided by patients cannot be taken as reliable[4]. This finding merits further research.

Awareness levels of having diseases by socio-economic group varied from 46% (patients who were on maternity leave) to 67-68% (pensioners). So, in the group of

employed patients, the average number of determined diagnoses reported was 1.6, whereas the medical data indicate about 2.4 diagnoses. On average 1.6 diagnoses were determined during the follow-up medical examination for this socio-economic group. There was low awareness of having diseases among young people who were studying (53%): on average there were almost two diseases in appealability for every known one (called by the patient during the preliminary inquiry) and in addition 1.11 diseases were determined again while patients were taking a medical examination.

Column 6 of Table 4 shows that the highest average of diagnoses determined during a medical examination was recorded by pensioners who were unemployed and the employed (2.8 and 3.1, respectively). These groups were under a great risk in terms of hidden diseases. To determine the presence of disease and to begin curing it requires time. The lowest average of diseases determined again was recorded by women who on maternity or child-care leave and students (1.0 and 1.1, respectively). In these groups medical examinations was more regular.

In general, the statistics speak about the inverse dependence of these characteristics: the higher a person's welfare, the weaker is his attitude towards his health.

Many local researchers have noted that the differences in social and economic groups are dependent on age as a factor. Here, we see that those in the age group of 40 years showed little regard for their health (10%) while those in the elderly group

[3] In this case we did not consider awareness among patients based on single nosological forms owing to the large number of subjects. This can be studied in other research work. This analysis is limited to the general statistics about the number of the known and new determined diseases.

[4] The social and psychological dependence of information on health status derived from using standardised inquiry was noted earlier.

Table 4

*Awareness of having diseases according to inquiry data and number of diagnoses determined again during medical examination*[1]

| No. | Adult population by primary occupation | Awareness of chronic diseases (%) | Average number of chronic diseases | | | | Awareness level |
|---|---|---|---|---|---|---|---|
| | | | According to inquiry data | By appealabi-lity | Determined again | Total | |
| 1 | Working | 45 | 1.59 | 2.44 | 1.63 | 4.07 | 65 |
| 2 | Studying | 29 | 1.01 | 1.89 | 1.11 | 3.00 | 53 |
| 3 | Studying and working | 44 | 1.53 | 2.28 | 1.34 | 3.62 | 67 |
| 4 | Retired and working | 74 | 2.58 | 3.79 | 3.07 | 6.86 | 68 |
| 5 | Retired, not working | 79 | 2.94 | 5.16 | 2.75 | 7.81 | 57 |
| 6 | Not studying and not working | 47 | 1.89 | 3.23 | 1.76 | 4.99 | 59 |
| 7 | On maternity leave and child-care leave | 41 | 1.54 | 3.38 | 1.03 | 4.41 | 46 |
| 8 | Total | 54 | 1.98 | 3.37 | 2.06 | 5.43 | 59 |

[1] Awareness level was calculated as the ratio of the number of diagnoses during the preliminary inquiry to the number of diagnoses in appealability, in percentage.

Table 5

*Adults' attitude towards their health by level of prosperity*

| No. | Utterance | Those in agreement, by level of prosperity | | | | |
|---|---|---|---|---|---|---|
| | | Very low (%) | Low (%) | Average (%) | Good (%) | High (%) |
| 1 | I am a healthy person. | 11 | 8 | 15 | 28 | 46 |
| 2 | Health is the main concern in life. | 66 | 62 | 52 | 38 | 36 |
| 3 | Health is not the main concern; there are more important things. | 42 | 35 | 48 | 55 | 36 |
| 4 | Size of population (%) | 7 | 24 | 51 | 17 | 1 |

(70-74 years old) showed higher regard, exceeding the previous group by 30%.

## DISCUSSION

The social importance of public health is shown in a functioning public health system developed into a rather independent professional branch and a social subsystem with a difficult infrastructure. A lot of examples can serve to provide additional evidence of the importance of a good health system. The real or perceived condition

of public health is a reason for assessing national (state) security and substantiating large and resolute economic and political actions, major investment projects and international relations.

People tend to refuse medical care during illness, preferring to seek medical help only when severely ill. This seems to be the adult population's attitude towards its personal health and it seems to cut across gender and age.

The specificity of people seeking medical advice if they are ill is the most important social distinction and unequal availability of medical services in urban and rural areas. Among the adult rural population the number of persons who refuse to seek medical advice (a "rigid refusal") is higher than among the adult urban population. The urban population refuses to seek medical advice to a lesser extent (a "soft refusal"). This is connected to access to intermediate medical and nonprofessional services (consulting pharmacists or "qualified" acquaintances).

From the viewpoint of the Russian society and state's interests, we cannot accept the current attitude towards health as normal, where health is not or less of a priority. Consequently, we cannot accept that the employed population and students have no or understated idea of the value of health. Most of the population do not listen to common sense, taking an objective stance towards health. They take risks regarding their health and life as well as those of the people around them.

## CONCLUSION

The interrelation between people's occupation and their social strategies in the health domain makes us define the problem as to the social quality of the modern public and production environment as a determinant of the population's behaviour and the decisive sociocultural factor of public health status in health sphere more sharply. Stating the importance of this factor is absolutely new for the local medical science. However, strengthening the social orientation of developing the Russian state and accepting health protection as one of the priority national projects supposes that the sociological research area of public health covers the problematics of the modern production and labour domain. Judging by the conclusions drawn above, the sociocultural mechanisms of people's behaviour in health and healthcare services are being formed in this modern production and labour domain.

The level of an individual or a group's prosperity is an essential factor of health status and dynamics. It can be direct (sufficient money resources for obtaining medical services and goods in case of need) and indirect (age, money costs and quality consumption of an individual, his family, group and their social status, i.e. their way of life).

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