

## **Abstract**

### **Health and Well-Being in Moscow and Helsinki**

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Russia underwent a political, economic and social crisis in the 1990s, and also a health crisis unforeseen in the history of industrial countries. Usually major societal changes are reflected in the health of the most vulnerable groups such as children and the elderly, but in Russia the crisis hit the middle-aged population, and especially men, the hardest. In order to provide some background for interpreting the present cross-sectional study conducted in Moscow and Helsinki in 1991, the thesis first reviews health development in Russia and Finland, mainly in terms of mortality and life expectancy, in 1950-2000. Life expectancy in Russia increased rapidly after the Second World War, reaching practically the same level as that of Finnish men and women by the mid-1960s. The paths in Russia and Finland diverged in the early 1970s as life expectancy in Finland and other West European countries steadily increased, but in Russia stagnated among women and decreased among men. After the fluctuations in the 1980s, life expectancy plunged in Russia in the 1990s, especially among men, and at the beginning of the 21<sup>st</sup> century is still lower than it was around 1960. Thus, there perhaps had already been a crisis in the mid-1960s and a deeper crisis in the 1990s. The thesis summarizes the main attempts to explain the Russian health crisis in recent literature. These range from general explanations connected with the consequences of the socialist modernization process in Russia, to more specific suggestions, such as the generation lag hypothesis, while the main models turn to lifestyle factors, psychosocial stress and social inequalities, all of which have been relevant to the analysis of the present study.

The empirical part of the study is based on a survey, which examined health, health-related behavior and attitudes of the adult populations aged 18-64 years in Moscow and Helsinki, the capitals of the neighboring countries, in 1991. The data were collected by mailed questionnaires and comprise 824 responses in Helsinki (response rate 71%) and 545 responses in Moscow (response rate 29%). The data represented the sex, age and marital status distributions of the cities fairly well, but the Moscow sample was biased towards higher education. This bias has been taken into account by various methodological solutions in the analysis and in interpreting

the results. The Soviet Union was dissolved at the end of year the study took place and the political unrest showed in the response rate in Moscow. Nevertheless, the year was still relatively 'normal' in terms of life conditions and health, in comparison to the dramatic changes in the next few years. At the same time, Finland was in the beginning of the deepest economic recession of the century, which, however, was not yet reflected in the Helsinki data. The theoretical approaches applied in planning the questionnaire and in the interpretation were derived from welfare research, which addresses health and welfare in terms of available resources and the satisfaction of needs, and from health lifestyle research and social psychological concepts of attributional styles.

The Muscovites suffered from physical and mental work stress and had experienced stressful life events to a greater extent than the Helsinki respondents. Life satisfaction among the Muscovites was lower on all measured areas, including family, work, household economy, friendships and health. The Muscovites were more prone to giving high ratings to traditional and private spheres of life, such as family, children, religion, recreation and leisure, whereas the Helsinki respondents were somewhat more individualistic and hedonistic in their choices, and considered peace of mind, life enjoyment and friendships more important than the Muscovites. Health was among the most highly valued areas in both cities, but health consciousness was mostly on a lower level in Moscow than in Helsinki. The Muscovites were somewhat more external and fatalistic in their causal attributions of success in life, whereas the Helsinki respondents believed more often that success in life was dependent on internal factors such as talent and strength of character.

The Muscovite women had the worst health on most indicators: self-rated health, long-term illness, psychological symptoms, health worries and satisfaction with health. The Muscovite men reported poorer health than the Helsinki men on other indicators except long-term illness. Sex differentials were wider and age gradients were steeper in Moscow, which points to a more health-taxing life there. In view of a 'classless' society or a relatively homogenous social structure in a socialist society, weaker social gradients on health were expected in Moscow than in Helsinki. This was the case among women according to all social stratification indicators (education, income and occupation), but among men the pattern of associations was inconsistent.

It was hypothesized that feelings of alienation would undermine the motivation to lead a healthy life. Alienation was thus considered a mediating link between social structure and health-related behavior. The Muscovites expressed more alienation in terms of feelings of hopelessness and powerlessness than the Finns. Some of the health-related habits of the Muscovites were less healthy and some were healthier than those of the Finns. The Muscovites reported a low-quality diet and infrequent

physical exercise much more often than the Helsinki respondents. Daily smoking was most common among the Muscovite men, but least common among the Muscovite women. Almost all reported use of alcohol in both cities, but men in Helsinki reported the highest frequency of drunkenness. Men and women in Helsinki were more 'egalitarian' in their health-related habits, while the sex differentials were larger and more traditional in Moscow. It was more common to have an 'all-healthy' lifestyle (no smoking, no frequent heavy drinking, healthy diet, physical exercise) in Helsinki, where 39% of women and 29% of men were in this cluster, but only 7% of the Muscovite men and 6% of the women. Alienation was indeed associated with unhealthy lifestyles, but more strongly in Helsinki than in Moscow. The lifestyles were interpreted in a Weberian framework, which sees collectively patterned life choices as enabled or restricted by structural life chances.

Methodological problems of a comparative survey were particularly challenging in a period of rapid societal change. The cross-cultural comparability of the concepts and their operationalizations was explored by assessing to what degree the indicators could be considered identical or equivalent. It turned out that identical measurement, in a strict sense, was hardly ever achieved, whereas sufficient equivalence seemed possible. Partial mismatch in measurement, reflecting problems in contextual, functional and cultural aspects of equivalence, was found in several key variables. A detailed exploration was made of the widely-used question on self-rated health, which was one of the main health-outcome measures in this study.

The differences in health between the residents in Moscow and Helsinki were not as large as could be expected in view of the mortality differences between the countries. This was probably partly due to the bias in the Moscow data, but also due to the capitals being different from the rest of the respective countries: Moscow had somewhat lower mortality than the country at large, whereas Helsinki was somewhat worse than most other parts of Finland in terms of mortality among the middle-aged population. Nevertheless, the differences in life chances were evident as differences in health-related lifestyles, levels of stress and life satisfaction in the two cities. One of the methodological conclusions of the study was that both resources and need satisfaction ought to be empirically assessed over and over again, when comparisons of health and well-being in changing conditions and in different societies are made.