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Inequality in the sphere of health: the case of Russia

1. Introduction

The *scientific problem* is that in Russia the economic crisis has come already. The experience of OECD countries the passing of the crisis there is important. Understanding these is important not only for monitoring societal wellbeing, but also because social tensions and a shifting social fabric can trigger and drive fundamental social, cultural and political change (Castells et al., 2012). The relevance of experience of OECD for Russia is that the economic crisis has arrived in this country, and the relationship of health, social differentiation and the crisis is very important. The article is geared to meet the growing demand of quantitative data on the social situation, trends, and possible driving forces (drives) in different OECD countries and in Russia. One objective is to assess and compare social outcomes in the field of health and crisis that are currently the focus of scientific and policy debates. Another is to provide an overview of societal responses, and how effective economy and policy actions have been in furthering social development.

The used approaches to a solution: the analytical, statistical researches and involved data (*Health at a Glance 2015…*; *Europe 2020 indicators…*; *Income, expenses…*; and others).

2. Literature review

The value of health expenditures and their dynamics are being discussed as indicators of the volume of medical services of the quality required for the effective functioning of health systems under conditions of the third demographic transition and the second epidemiologic revolution. The main content of the "first demographic transition" is a reduction in mortality and the ensuing fertility decline to the level which ensured

approximately zero population growth that occurred in Europe, mostly before the Second world war (Lesthaeghe, van de Kaa 1986; van de Kaa 1987; Lesthaeghe 2010).

One of the founders of the theory of the first demographic transition is F. Notestein, who first wrote a classic article about the first demographic transition (Notestein 1945). In the work of van de Kaa, there is also the explanation of the mechanism "the first transition to low fertility". He was called as "indirect determinants" this transition, industrialization, urbanization and secularization (van de Kaa 1987, 5).

The beginning of the "second demographic transition" dates from the mid 1960-ies. Specific determinants of the "second demographic transition": rising incomes, economic and political security which democratic welfare States offered their citizens. "Trigger" the second demographic transition is detected in the economic, social and political spheres. Relatively recent concept of a "third demographic transition" refers to the specific important stage of a single global demographic process.

According to D. Coleman's third demographic transition is, first of all, changing the ethnic, cultural, socioeconomic, socio-differentiating structure of the population of the host countries as a result of immigration. The prerequisites for such immigration creates a low birth rate in host countries where the population does not play. They are forced to compensate for the decline in the population, accepting large numbers of migrants, and generates a phenomenon of a "third demographic transition" (Coleman 2006).

Speaking about the dangers of mass Latin American immigration to the United States, Huntington points to the "differences irreconcilable" (irreconcilable differences) in the culture and values of Mexicans and Americans. He talks about the differences in the understanding of social and economic equality, distrust of people outside their family; unlike Americans, Mexicans do not consider education and hard work as the path to material prosperity, they have a weak desire for education, while poverty is perceived as a dignity, without which it is impossible to go to heaven (Huntington 2004). Bjørnskov takes a closer look at the importance of fractionalization for the creation of social trust (Bjørnskov 2008).

The theory of epidemiological transition is generally perceived as relevant only to the explanation of the mechanisms and characteristics of mortality decline over the last centuries (Omran 1971). During the first epidemiological revolution, the main objective of the health strategy was to “treatment until recovery” which was successfully resolved in the most developed countries in the mid-20th century. During the second epidemio-

logical revolution, the main task of health was the prevention strategy and the “distancing fatal complications” the long-term ongoing chronic diseases. M. Terris talks about two epidemiological revolutions (Terris 1985). The term "epidemiological" is as indicating the nature of mass phenomena. Health status is a fundamental objective of health care systems, but improving health status also requires a wider focus on its social determinants, making health a central objective of social policy.

The links between social and health conditions are well-established. Indeed, economic and educational gains, public health measures, better access to health care and continuing progress in medical technology, have contributed to significant improvements in health status, as measured by life expectancy. Health problems can sometimes have origins in interrelated social conditions – such as unemployment, poverty, inadequate housing. For example, the poorer individuals, who generally have greater needs for medical care and also more likely to cut costs thus expose themselves to significant risk (Edwards 2008; Schoen et al. 2011). With household budgets under pressure of the crisis, families have reduced the use of conventional medical services since the economic crisis, especially in countries with health insurance plans, high co-pay. For example, in a study in the United States, 27% of respondents stated that they reduced their use of health services in 2009 (Lusardi et al. 2010). Such models highlight the significant risk of income losses translating into lower utilisation of health care services and, subsequently, into poor health. A study by Tefft and Kageleiry finds that a 1% increase in unemployment in the United States is associated with a 1.6% lower use of preventive care facilities (Tefft and Kageleiry, 2013).

There are also large differences in self-reported health between different socioeconomic groups, e.g. by income level or education level. For example, for Europe, the latest data show that in all countries families with low incomes above the average «*unmet medical needs*». Often the health focus is on objective health indicators. More subjective population-based indicators of health, such as perceived health status can be important to assess overall well-being. For example, in all OECD countries, the share of persons with low incomes reported "good" or "very good" perceived health status is significantly lower by 61% than the proportion of 80% among higher paid workers (*Society at a Glance 2014*…, 27). Canada, New Zealand and the United States are the three leading countries, with about nine out of ten people 90% reporting to be in good health (*Society at a Glance 2014*…, 124).

Economic downturns may result in lower rates of health care use if more people feel they cannot afford it, for example when private health insurance is tied to employment. Moreover, in response to deteriorating public finances governments may cut health spending and, by the same token, their health care provisions (Vangool 2014).

The family [household] with low income in four to six times more likely to report unmet need for medical care and dental care for financial or other reasons, than those with high income. In some countries, as Greece, the proportion of people reporting some unmet needs for medical assistance more than doubled during the economic crisis (*Health at a Glance 2015*…).

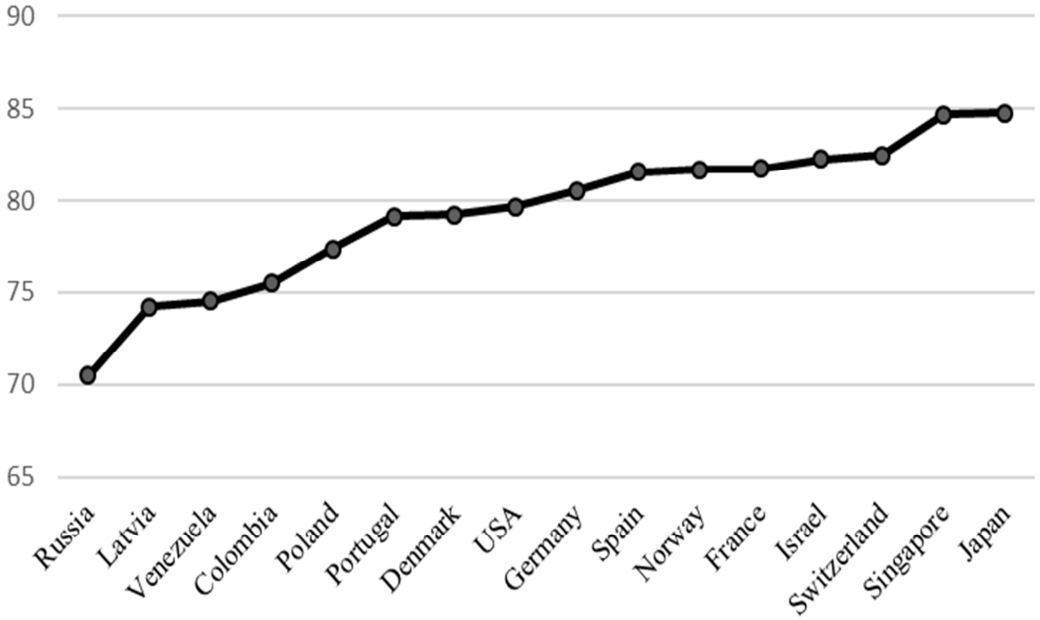
3. The hypothesis of research

Russia and its separate regions have not coped with the challenges of the second epidemiological revolution, and failed to implement prevention strategies and the "distancing fatal complications". This has affected particularly severely on the poorer segments of the population, which, in particular, cannot pay for high-performance and high-tech medicine.

4. The results of scientific research

Let's consider the statistical and analytical material assembled by the authors to test the hypotheses of the study. The significant progress in a health care sector made in the last decades had the extremely uneven character. For example, considering a remaining life expectancy at the birth – the main indicator of quality of a health care system in criteria of an assessment of the World Health Organization (WHO), it is possible to reveal burning issues of an inequality. Apparently from figure 1, the most part of the world countries promoted on the way of increase in life expectancy at the birth, but at the same time there is a considerable number of the countries which are sharply lagging behind on this indicator.

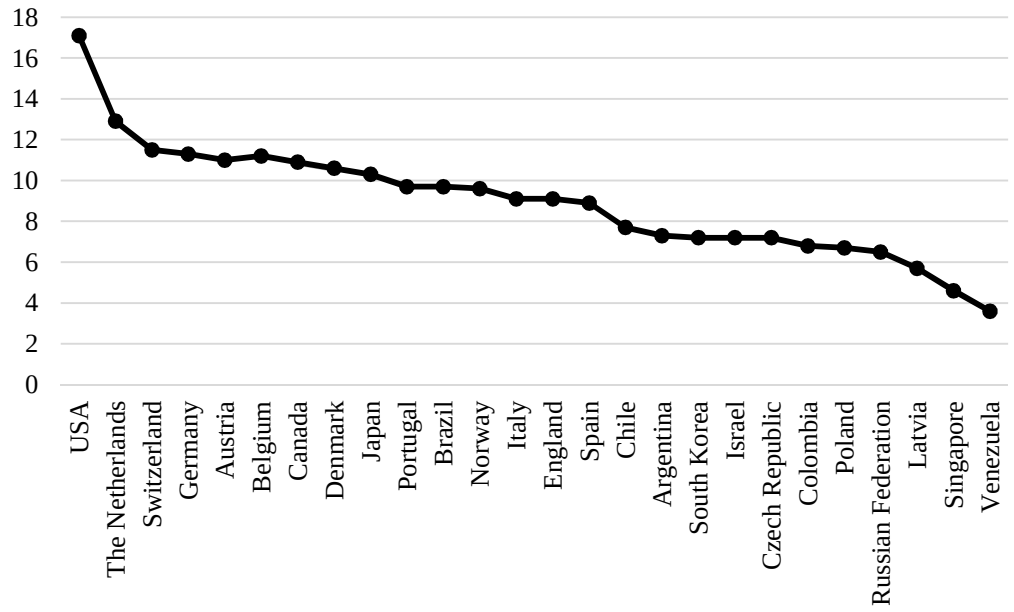
Figure 1. Average life expectancy at birth (2013)



Source: United Nations Development Programme (UNDP), http://hdr.undp.org/en (6.03.2016).

Expenses on health care is the most general and key part of political sensitivity of a health care system on care of a health state. As it is possible to notice (Figure 2), the gap in the level of health care system financing a remains between the certain countries. Despite the variety, health care systems of EU countries have a set of general characteristics.

Figure 2. The health expenditure per capita as % of GDP



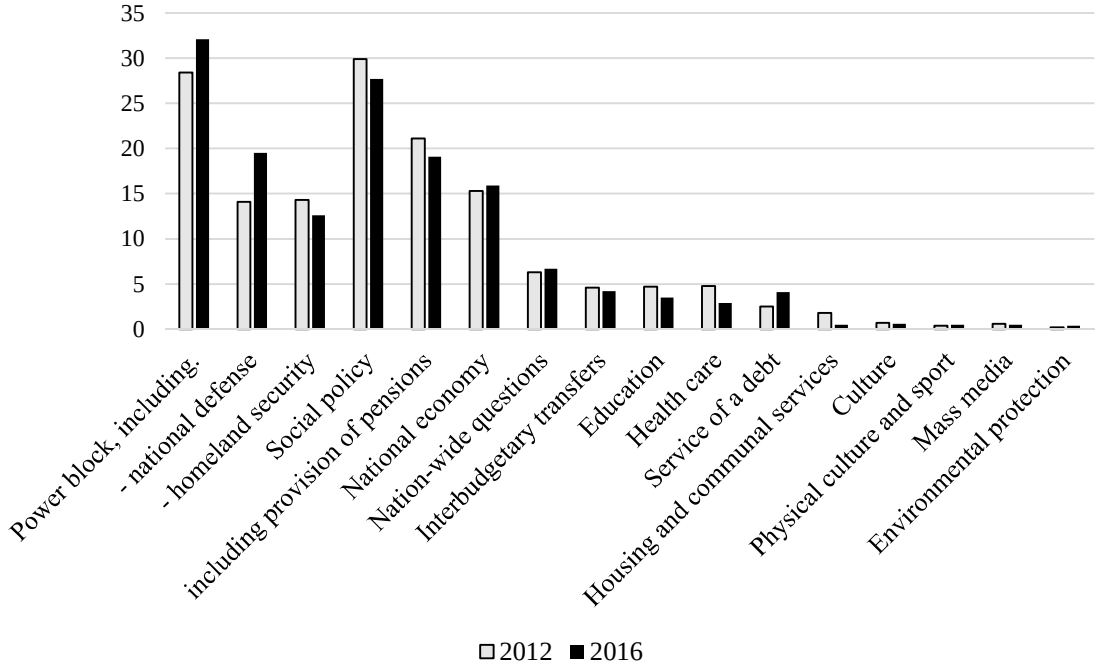
Source: World Health Statistics 2015, http://www.who.int/gho/publications/world_health_statistics/2015/en/ (6.03.2016).

First, in all countries there is a system of collective financing founded on the principle of solidarity which more often is called system of medical insurance. Medical insurance plays an essential role since covers the most part of medical expenses in connection with accidents and diseases and guarantees to each citizen access to very wide row of medical goods and services.

The health care systems structure in the different countries of Europe differs, however a general characteristic for health care systems structure in all countries of Europe is that all of them are based on the fundamental solidarity principle. For this reason, it is possible to speak about social model of health care in Europe. However now the complex problem rises before the new State Parties of the European Union and the developing states trying to correspond to level: they should raise expenses on health care gradually to reach Central European level. Meanwhile, the arising financial squeezes, and also regulation of public finances by the European Union strongly complicate achievement of this purpose. On the basis of identification of many European countries health care systems tendencies accurate, disturbing forecasts concerning the future began to express. According to it long-term goals are defined: first, restriction of public financing; secondly, medical services rationalization; thirdly, reduction of the list and volumes of medical services; fourthly, control over the prices; fifthly, transfer of expenses burden on patients. In spite of the fact that measures for decrease in an inequality in Europe are taken for the last years, in a number of the countries is shown the increasing concern in that these distinctions and manifestations of an inequality and injustice continue to extend that is especially visually shown in the countries of the Central and Eastern Europe where these manifestations and distinctions are absolutely unprecedented on the scales for industrialized countries this century. In some countries – such as the Russian Federation where the general deterioration of the population health state is available, – the amplified inequality and inequality are a drama consequence of the hardest social and economic shocks. Let's consider in more detail to an inequality question in the health sphere in modern Russian society. The cause is such factors as a level of living, educations, the social environment, type of employment, social and economic conditions, responsibility degree which influence as incidence of the individual and acquisition of illnesses by it, and preservation of health and possibility of its treatment. The social status of the patient has major importance under equal conditions of the address to the expert and equal opportunities of diseases diagnosing and their treat-

ments. The inequality in the health sphere can be described in three main measurements. First, geographical factor: level of health care availability correlates with a settlement size. Moreover, the interregional inequality as financing and a level of a health care system development in different regions very strongly differ is brightly expressed.

Figure 3. Structure of the Russia federal budget expenses, %

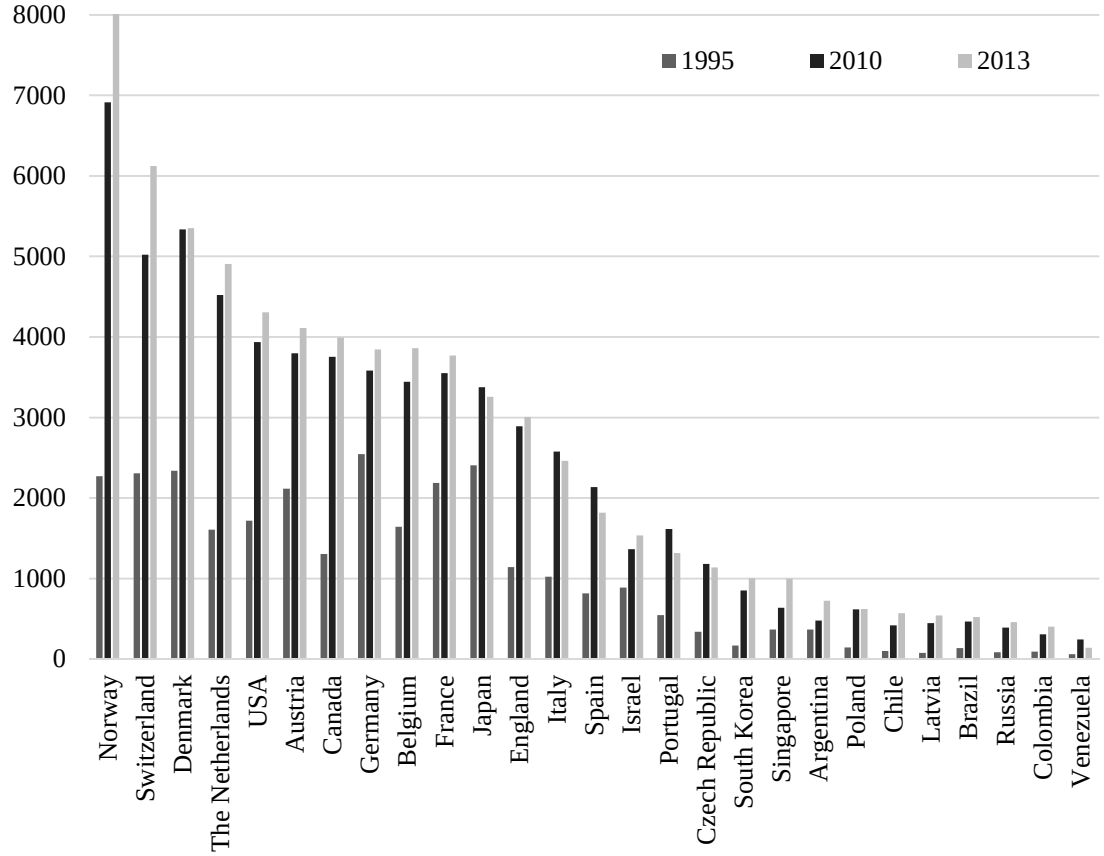


Sources: Ministry of Finance of the Russian Federation, calculations of Center of Development Institute of NIU HSE. Comments on the state and business No. 103. On October 16 – on November 13, 2015. Center of Development institute of National Research University "Higher School of Economics", 21.

Secondly, socio-economic factor: level of health care availability also correlates with the social status and position of the individual. So, the level of the income defines distinctions in vital standards – quantity and quality of the consumed goods and services. Caloric content, a variety and balance of food, protective and sanitary and hygienic properties of the used clothes and footwear, convenience and comfort of a microenvironment of dwelling, in turn, depends on it. Distinctions in vital conditions form unequal opportunities of adaptation, ability to cope with physical and emotional activities. The inequality in vital standards defines an inequality of opportunities in use of effective measures and ways in fight against the arising deviations from health. The Russian health care system is characterized by essential distinctions in requirements of different social and economic classes. Discrimination of separate groups, such as homeless, needy, migrants is widespread. The range of social and economic inequalities is wide: gender and age, educational, racial and ethnic, professional, imperious, it is mate-

rial – property, territorial and so forth. Anyway existence of social and economic inequalities is violation of a social justice principle. The structure of expenses of the federal budget of Russia in dynamics of 2012-2016 is presented on Figure 3. As we can see from Fig. 3, in structure of the Russian federal budget expenses, first of all nation-wide expenses on management are priority. The share of these expenses grows: in comparison with 2012 in 2016 this growth made 08-0,9 percentage points. A defense expenditure in 2016 grew in comparison with 2012 by 5 percentage points. It has very large financial resources, which go from the pockets of ordinary citizens of Russia on military and administrative expenses.

Figure 4. General government expenditure on health per capita, in USD, 1995-2013

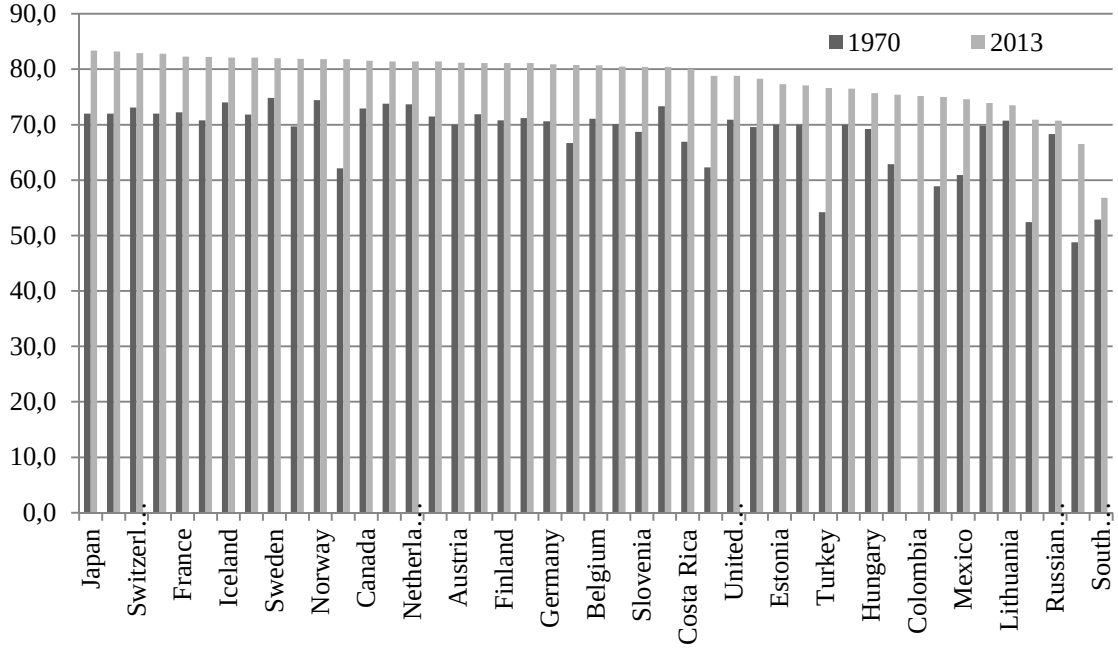


Sources: Global health expenditure database, http://apps.who.int/nha/database/Country_Profile/ Index/en (6.03.2016).

For the effective functioning of health systems in terms of the second epidemiological revolution and prevention strategy the "distancing fatal complications" should be aimed at increasing life expectancy, reducing premature mortality, in particular mortality in working age. In the health-care system the implementation of this strategy requires the equipping of medical facilities with the latest equipment and the number of staff

employed in the health, stimulates the rapid development of medical science and pharmaceutical production. However, all this leads to a significant increase in the cost of medical care and the resulting expansion of health care costs. Illustrative in this regard is the fact that almost all developed countries since the second half of the twentieth century and early twenty-first century saw a rapid and significant increase of health expenditure positively correlate with increasing life expectancy and reducing premature mortality. In Figure 4 presents total public expenditure on health per capita in US dollars in the period 1995-2013. We see that all significantly ahead of countries such as Norway, Switzerland, Denmark, Netherlands, USA and from substantially behind countries such as Poland, Chile, Latvia, Brazil, Russia, Colombia, Venezuela. These data clearly represent the attitudes top elites of these countries to medicine and health care.

Figure 5. Life expectancy at birth, 1970 and 2013



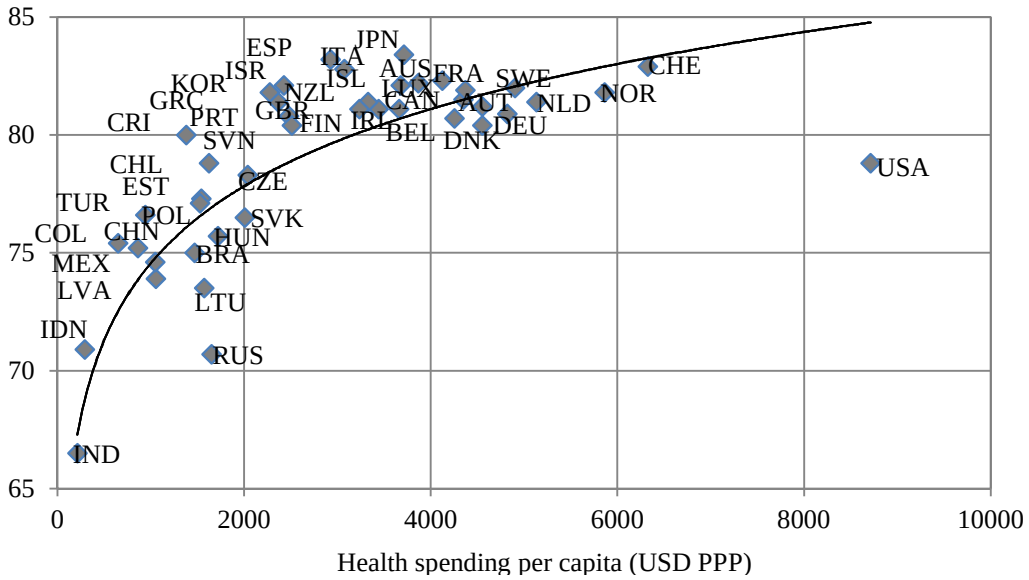
Source: *Health at a Glance 2015: OECD Indicators*, http://dx.doi.org/10.1787/health_glance-2015-en (6.03.2016).

Figure 5 presents the data on the basis: "life expectancy at birth" in the period 1970-2013, the countries of the world which show how demographic and epidemiological transitions was carried out actually (*Health at the Glance 2015…*). We can see that in 2013, life expectancy on average across OECD countries amounted to 80.5 years, the growth amounted to more than ten years since 1970. Although the life expectancy in countries such as India, Indonesia, Brazil and China remains well below the OECD average, these countries have achieved considerable gains in longevity over the past dec-

ades, with the level converging rapidly towards the OECD average. The least progress was in Russia, mainly according to experts, due to the impact of economic transition in the 1990-ies and the rising risk of morbidity because of inappropriate behavior among men, in particular, the growth of alcohol consumption. Among the rapidly progressing countries by the sharp increase in life expectancy it should be noted that countries such as Korea, Chile, Turkey, Indonesia, India, that quickly closed the gaps between life expectancy 1970 and 2013 (Fig. 5).

Figure 6 presents the ratio of the data "life expectancy at birth and health spending per capita, $ USA" (2013) (*Health at a Glance 2015*…), performed in Cartesian coordinates, allows you to show figuratively the place of any country in the world to implement the second epidemiologic revolution. As you can see, the higher the health expenditures per capita are associated with higher life expectancy at birth, although this ratio tends to be less pronounced in countries with the highest health spending per capita. Japan, Spain and South Korea stand out as having relatively high life expectancy. United States of America and Russia stand out as having relatively low indices of life expectancy, given the high level of spending on health care in the United States of America and the relatively low level of expenditure on health in Russia. In the United States, the gains in life expectancy over the past few decades have been more modest than in most other OECD countries.

Figure 6. Life expectancy at birth and health spending per capita, US$, 2013



Source: *Health at a Glance 2015: OECD Indicators*, http://dx.doi.org/10.1787/health_glance-2015-en (6.03.2016).

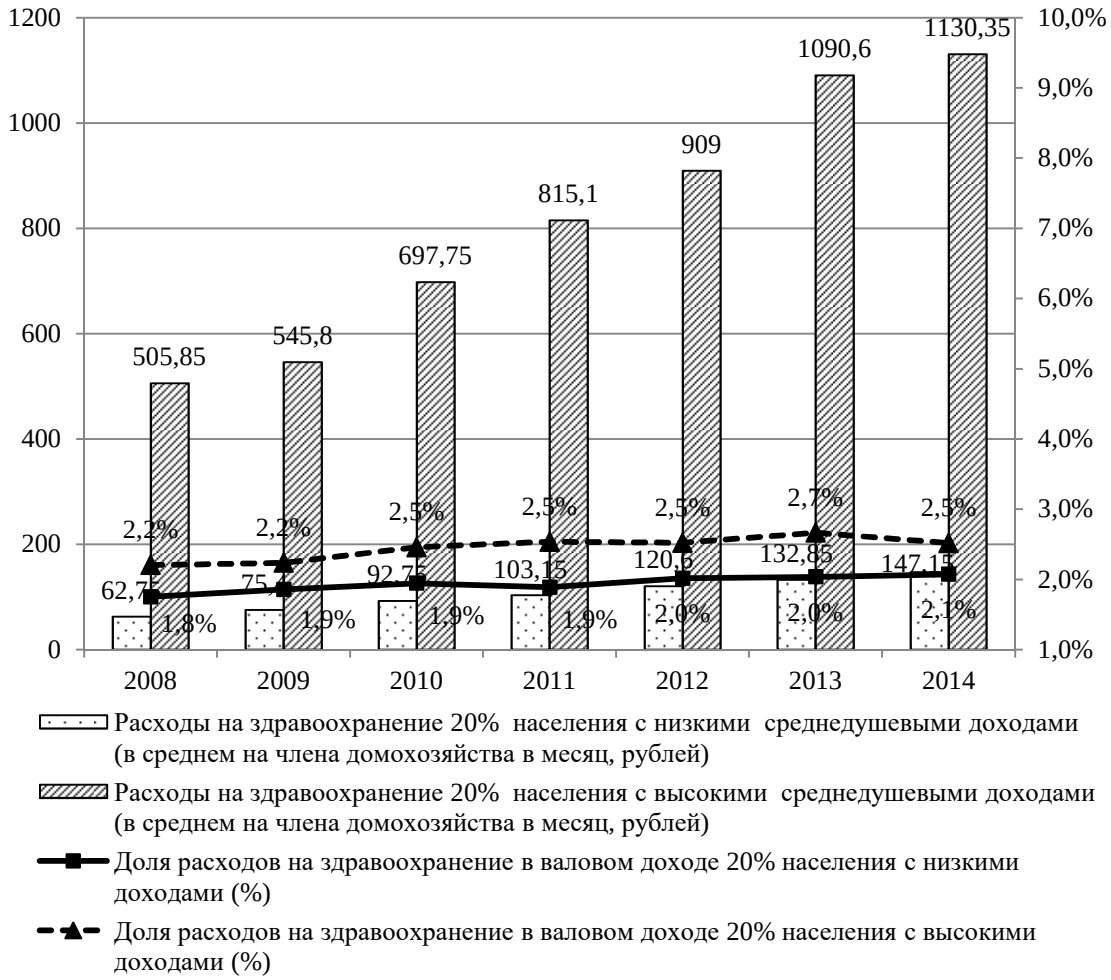
While life expectancy in the United States used to be one year above the OECD average in 1970, it is now more than one year below the average. Many factors can explain these lower gains in life expectancy, including: 1) the highly fragmented nature of the US health system, with relatively few resources devoted to public health and primary care, and a large share of the population uninsured; 2) health-related behavior's, including higher calorie consumption per capita and greater obesity rates, higher consumption of prescription and illegal drugs, more deaths from road traffic accidents and higher homicide rates; and 3) adverse socio-economic conditions affecting large segments of the US population, with higher rates of poverty and income inequality than in most other OECD countries (Woolf, Aron 2013; National Research Council… 2013] (Figure 6).

We see that Russia is not only much inferior to the most developed countries in terms of "Life expectancy at birth in the ratio with health spending per capita", but despite the higher economic growth in 2000-ies, chronically lags behind European and other countries with economies in transition with similar and even lower levels of economic development (Figure 6).

It should be noted that in such a *bad "case of Russia"* there are two fundamental reasons: an accelerated process of commercialization of health care in Russia and legally limited opportunities to increase public financing (especially significant in the context of economic recession), including by abolishing a progressive scale of taxation of income of individuals and substituting a flat income tax of 13% of the income of the individual, is almost unparalleled elsewhere in the world. Since 2012, the Russian government took the decision to increase salaries of health. The increase in salaries of medical workers could only be encouraged if not carried out at the same time "optimization" of health care costs, which has resulted, in particular, in the elimination of "unpromising" medical institutions and increase work load of employees. Such "optimization" could lead not to improved access to health services and improving their quality, but opposite results. In Russia severely lacks the necessary financial resources for the development of medical science and medical education, increase the number of medical personnel, building hospitals, and creating the pharmaceutical industry, large-scale sanitary-epidemiological actions. All these are no simple tasks, but their decision can be based on the borrowing ready-made "tools" and state paternalism and is very effective, because it allows you to jump through the whole stage of gradual development it took for the countries of the pioneers (Вишневский 2015). About the plight of the poorest

Russian households and low availability of paid medical services according to the data of numerous sample surveys conducted in Russia (see data in collections: *Income, expenditures and household*… 2006-2016).

Figure 7. Indicators on average household member in a month



Source: *Income, expenditures and household consumption in 2005-2015 in the Russian Federation*, "Statistical Bulletin", 2006-2016.

As we can see, according to the household budget survey, 20% of the wealthiest Russians in 2005-2015 accounted for more than half of the total volume of paid medical services, and the poorest 20% of citizens – 1,8%-2,1%, or about 30 times smaller (Fig. 7). This means that the least well-off Russians practically do not have access to paid medical services, in other words, they have to resort only to the "free" medical services, thereby initially limiting themselves to high-tech and costly medical care and, in fact, "to die on the street." This is a feature of the "bad case" of Russia in a medical context.

To respond to the new challenges of the second epidemiological revolution, Russia needs a new strategy, a new type of medical prevention aimed at the protection of health and life, new models of mass protective life behavior. All this requires a seri-

ous revision of the old system of priorities both at the level of society and at the individual level. All of this requires far more than before, expenditures on protection and restoration of health, a more active and conscious attitude towards their health on the part of each person.

5. Conclusions

The main objective of this article is to emphasize the magnitude and independence of the world are experiencing demographic change, including Russia. Demographic positions of all countries should be regarded as being on a single path of development. In this context, Russia is characterised as lower incomes compared with other developed countries and a much higher share of their socio-economic stratification and social differentiation. Stimulating rapid development of the private health financing, the Russian authorities have ignored, in fact, world experience in the development of health systems. Historically, the improvement of health system in developed countries was due to strengthening the role of the state in health organization and the transition from private to public funding. In this case, as shown by years of experience, the latter not only provides universal access to medical care, but also allows more efficient use of health resources. In Russia found the opposite trend to the global trend: by reducing the role of government in health organization and the transition from public funding to private funding. At the same time, Russia is characterised as lower incomes compared with other developed countries and a much higher shares of their socio-economic stratification and social differentiation.

General implications:

1. Transformations in the Russian health care in general, especially in its mass segment, finally turned into the process proceeding on not clear logic with unknown results for the medical personnel and unpredictable, sometimes lethal consequences for patients.

2. In words there was a wish "for optimization and modernization": increases of treatment medical aid and quality availability, decline in mortality, improvement of health and life quality, transition from financing of establishments network to a payment for work, reorganization of establishments network with amputation of excess links. In practice: the current achievements are reduced to that medical care becomes inaccessible to considerable part of the population, especially rural, loading of doctors increases

to the detriment of quality of treatment, mortality grows in hospitals, incidence increases, doctors are occupied, besides the official duties, an intensive paperwork.

3. Medical care in Russia becomes more and more inaccessible, constantly and significantly rises in price and all the time is commercialized that conducts to the expressed dissatisfaction of patients (citizens, the population, clients), doctors, officials and bureaucrats from medicine.

4. Many actions which are officially represented as "the population improving health" in reality happens that at all it does not improve.

5. At the same time, the positive moments which are noted above are noted.

6. Results generalization of our research showed that criteria of an assessment of population health care system in the Tyumen region are: justice of use and distribution of resources; quality and efficiency of the provided services, transparency and the accountability of functioning of all system of the Russian health care (that is noted generally at the level of "due" – as "has to be", but in general "as if it is not noticed" at the level of "real" – as is actually).

7. Low expenses on health care per capita in Russia will lead to lower remaining life expectancy at the birth. According to the theory of "a vicious circle of poverty and diseases" factors (Winslow), in Russia in general the strengthened reproduction of unsuccessful circumstances of poor national groups through the closed cycles in development in the course of which they passes through a number of states is expected, as a result coming back to initial ("the circle became isolated"). While in rather rich Tyumen region, in this region high-quality growth of medicine is expected.

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Streszczenie

Nierówności w sferze ochrony zdrowia: Rosja

Nierówności w zakresie zdrowia przejawiają się w wartościach takich wskaźników, jak: długość życia, postrzegany stan zdrowia, wydatki na opiekę zdrowotną, ubezpieczenie zdrowotne, liczba samobójstw. Wszystkie te wskaźniki należy analizować w przekrojach płci i wieku, społeczno-demograficznych, finansowych i materialnych, a także grup władzy od najwyższych do niższych klas. Analiza tych wskaźników ma znaczenie naukowe w porównywaniu krajów w długich odstępach czasu. Silny wzrost gospodarczy jest warunkiem koniecznym publicznej redystrybucji środków w zakresie zdrowia oraz zwiększenia dochodów niższych warstw społecznych. Przykładowo wyższe wydatki na opiekę zdrowotną na mieszkańca na ogół związane są z wyższą oczekiwaną długością

życia. Obecnie jednak głównym powodem trwającej dyskusji na temat nierówności w zakresie zdrowia jest to, że walka z ubóstwem i nierównościami wiąże się z trudnościami, gdy wzrost gospodarczy jest słaby. W socjologii ekonomicznej problem ten znalazł odzwierciedlenie w pracach Webera; w jego pojęciu nierównych szans życiowych, zjawisku nierównomiernego rozkładu korzyści, określonym przez Mertona jako efekt Mateusza; w terminologii Sztompki w powstaniu trwałej hierarchii przywilejów elity i niedostatku ubogich w odniesieniu do dostępu do pożądanych dóbr i wartości, w tym zdrowia.

Abstract

Inequality in the sphere of health: the case of Russia

The inequality in the sphere of health is shown in indicators: life expectancy, the perceived level of the health, expenses on health care, medical insurance, suicides which have to be considered in cuts of gender and age, social and demographic, financial and material, imperious and status groups from the highest to the lowest classes. The analysis of these indicators has scientific value in comparison of a set of the countries in long periods. Strong economic growth is a necessary condition for financing of redistribution measures in the health sphere and the income strengthening in the lower part social striations of public distribution. For example, higher expenses on health care per capita, as a rule, is associated from higher remaining life expectancy at the birth. However now the main reason for the proceeding discussion about an inequality is in the sphere of health that fight against poverty and an inequality are interfaced to difficulties when economic growth is weak. In economic sociology the specified problem found reflection in Weber's works in his concept unequal "vital chances"; a phenomenon of the uneven distribution of advantages designated by Merton as Matfey's effect; in Sztompka's terminology as emergence of strong elite privileges hierarchy and deprivations poor concerning access to the desirable benefits and values, including health. The article assesses the dynamics of health expenditure for all sources of their funding as an investment in human capital over the period 1995-2013 the data of the comparative analysis of expenditures for these purposes in Russia and other countries. The article considers the questions of efficiency of functioning of the health system, the differentiation of the population on the availability and quality of health services.

Keywords: a health care system, an inequality in the sphere of health.