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Health lifestyles and political ideology in Belarus, Russia, and Ukraine

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Abstract

This paper examines the association of political ideology with health lifestyle practices and self-rated health in Belarus, Russia, and Ukraine. The political trajectory of post-Soviet societies has taken two divergent paths, either toward democracy or autocracy. The health trajectory has followed the same pattern with the more autocratic states continuing to experience a mortality crisis, while those former socialist countries that have embraced democracy and moved closer to the West have escaped this crisis. This paper investigates whether political ideology in three post-Soviet countries that are firmly (Belarus), increasingly (Russia), or recently (Ukraine) autocratic is related to health lifestyles and health self-ratings. Data were collected by face-to-face interviews ($N = 8406$) with a representative national sample of the adult population. The results show that respondents who are against restoring communism have healthier lifestyles and rate their health better than respondents who wish to see communism return.

Keywords: Health lifestyles; Self-rated health status; Political ideology; Communism; Belarus; Russia; Ukraine

Introduction

The purpose of this paper is to examine the association of selected health lifestyle practices and self-reported health status in relation to communist political ideology in Belarus, Russia, and Ukraine. Few studies have ever explored the relationship between political ideology and the health lifestyles of large populations. Yet ideological beliefs can be important in many facets of a population's daily life, including their health behaviors (Cockerham, 2005; Cockerham, Snead, & DeWaal, 2002; Franco, Álvarez-Dardet, & Ruiz, 2004; Smith, 2004). This is because political ideologies often stipulate a wide range of normative behavioral standards appropriate for their adherents, and these behaviors may affect health lifestyle practices.

While considerations of ideology are recent in sociological studies of health, this is not the case in the wider discipline of sociology where ideology's social functions have been discussed since the 19th century. The work of Marx and Engels (1976)—who referred to ideology as a weapon to perpetuate the interests of dominant social classes—has been at the center of much of this discussion. They depict the ideology of the ruling class as the ruling ideology for society as a whole. This

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perspective joined with those of Mannheim (1936, 1952) and others (Althusser, 1971; Bendix, 1951; Parsons, 1951) to stimulate deliberation over the role of ideology in shaping social behavior and political outcomes. While there is no single definition of political ideology, a general view is that such ideologies are shared sets of normative political ideas and values held in common by individuals, groups, parties, classes, and nations advocating particular forms of conduct, social relationships, and solutions to problems.

The dominant ideology thesis and Soviet health lifestyles

Out of Marxism comes the dominant ideology thesis that maintains all societies based on class divisions have a dominant class controlling political ideology and material production (Abercrombie, Hill, & Turner, 1980). The dominant ideology presumably penetrates the consciousness of both the governing and subordinate groups and classes that are encouraged to interpret reality through its conceptual framework. Such an ideology becomes a source of power when it offers plausible solutions to problems transcending class boundaries and purports to represent the "truth" as in the case of both capitalism and socialism (Mann, 1993). In a democracy, there are usually competing ideologies whose degree of dominance and menu of political solutions vary. However, in an autocracy, a single dominant ideology is aligned with both powerful political elites and the state as an official doctrine designed to systemize the population's behavior.

Nazi Germany, for example, launched public health campaigns against smoking and alcohol use, while fruit, vegetable, and whole grain bread consumption was promoted along with the avoidance of fatty foods (Smith, 2004). A particular target was smoking (Smith, Ströbele, & Egger, 1994). Smith (2004) notes that it seems a paradox that identification of the link between heavy smoking and lung cancer was initially established through research that took place in a totalitarian state. Nevertheless, the first case–control studies of smoking and lung cancer originated in Nazi Germany in 1939 and 1942. These efforts, however, were rendered meaningless by the devastation of World War II.

Nazism or fascism's great foe communism took a different approach to health lifestyles as a dominant ideology. Instead of trying to mandate healthy lifestyles in a top-down fashion—other than a short-lived effort to ban drinking in the early days of the Soviet Union (White, 1996)—the communists largely ignored the behavioral aspects of health maintenance. Instead, they focused on improving public health through better sanitation and greater access to medical care. Following the imposition of communism on the population in the new Soviet Union, health and life expectancy improved via massive public health campaigns combating infectious diseases. The initial results for medically deprived populations were impressive.

The Soviet Union provided the model for health policy under communist regimes elsewhere. Faced with serious problems, including epidemics and famine, the state assumed responsibility for health. This step was taken in the Soviet Union at the Fifth All-Russian Congress of Soviets in 1918. Measures to improve hygienic conditions in the Soviet Union's cities and towns were implemented, while a nationwide system of free health care was established. In order to satisfy immediate requirements for physicians, large numbers of nurses were sent to medical schools where they were certified as medical doctors following short training courses and lesser-trained physician assistants (feldshers) provided services in some rural areas (Knaus, 1981). New medical students consisted almost entirely of the children of peasants and workers.

The political philosophy behind this approach was "Soviet Social Hygiene" that claimed diseases and premature mortality were products of "unhealthy" capitalism that socialism and communism could overcome by transforming the class system and educating people (Demin, 2005). However, the social hygiene philosophy in public health was de-emphasized in the late 1920s as the Soviet government focused its attention on industrialization and the collectivization of agriculture. The health care delivery system was put in line to support this effort and its funding subjected to the "residual principle" as a non-productive sector of the economy. Under this principle, health care was funded by monies left in the government budget after higher priority areas like heavy industry, the military, and agriculture received their allocations. Moreover, as Demin (2005, p. 4) reports, the Soviet leadership postulated that socialism had ended class distinctions and therefore the health of the population no longer depended on social conditions.

The population was passive in this arrangement as the government made health care a state benefit and dictated how it would be provided. The idea that individuals were also responsible for their own health because of the limits of medicine and the importance of healthy lifestyles in either causing or preventing diseases was not recognized (Cockerham, 1999). The first line of disease prevention was not the individual, but the health care system. As Field (2000) points out, the paternalistic approach of Soviet health philosophy precluded giving a significant role to the individual in adopting a healthy lifestyle. Health care joined other government benefits like free education, old-age pensions, guaranteed employment, and low cost food and housing as a form of state patronage. The state provided basic benefits and in return freedom of individual choice and reliance on one's self was severely curtailed (Bauman, 1992).