Karen Amlaev

HEALTH INEQUITY, TREATMENT COMPLIANCE, AND HEALTH LITERACY AT THE LOCAL LEVEL: THEORETICAL AND THE PRACTICAL ASPECTS

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Health inequity, treatment compliance, and health literacy at the local level: theoretical and practical aspects

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Karen Amlaev

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Foreword by the leader of the WHO Healthy Cities project

Healthy Cities since its inception 25 years ago has put a strong emphasis on equity and strategies and interventions aimed to support individuals and communities have more control on decisions and developments that affect their health and wellbeing. Health literacy is increasingly recognized as a very promising domain of public health and health promotion. It is an important component in our strategies to promote empowerment and community resilience.

Translating theory and evidence into local practice can be challenging. Concepts need to be expressed and understood in professional terms that are used locally. Recommendations and frameworks for action need to be adapted to local political and organizational contexts and realities. The support of local academic institution can be vital in such efforts.

The monograph at hand prepared by Karen Amlaev, Member of the European Advisory Committee, Professor of the Stavropol State University is a good example of an endeavour to address equity and health literacy in Stavropol, linking theory and evidence with situation analyses and action plans.

I should like to congratulate professor Karen Amlaev for this initiative and his commitment to supporting the Stavropol Healthy Cities project and the work of the Russian Healthy Cities network and beyond.

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Introduction

The project Healthy Cities has been making its contribution to health promotion in the European Region for several decades now. The peculiar feature of it is proper response to the issues arising in public health and healthcare systems in European countries. This is reflected in the topics that are taken as key ones at certain stages of the Healthy Cities project.

The Russian Federation has been an active member of the European network of Healthy Cities and dozens of Russian cities have joined our movement in the latest years.

The monograph presented here focuses on relevant issues of modern healthcare – health inequity, low health literacy and treatment compliance.

Health inequity has become one of the key priorities for the European Strategy 2020. Even though the health status indicators, such as the death rate, are improving all over Europe there are still sharp health differences between countries, inside countries, and even between cities and social groups. Unfortunately, health inequity is increasing the global economic recession being among the key causes here. The growing unemployment and cut budgets on public needs will affect millions of people's living conditions in Europe, and will have the greatest impact on the health status of the

most vulnerable groups. Should there be no timely and proper measures taken this health inequity may only increase.

The issues of low health literacy and treatment compliance, even though seemingly belonging to a different area, yet are indirectly linked to the issue of health inequity. It is obvious that improving literacy among the population in general and especially among its most vulnerable groups (socially disadvantaged) would add to the local community resilience against the socio-economic negative effects of the crisis, as well as contribute to the reduction of health inequity.

On the other hand a higher level of health literacy will improve patients" treatment compliance, which allows gaining better results in terms of improving people's health status with no financial cost. Our research demonstrates that the compliance among the vulnerable groups (low-income and those with a low level of education) is poorer than among other groups. This means that improved health literacy and treatment compliance would also promote reduction of health inequity.

This entire range of issues with their potential solution is reflected in this monograph. The book offers a theoretical overview of the current state of the issue as well as provides the author's own findings and the experience of the City of Stavropol gained due to the participation in the Healthy Cities project. This monograph would make a good reading for politicians and specialists representing various professional areas (healthcare, education, etc.) whose activities have an impact on people's health in any way.

Health inequity

The current state

Health inequity: political and social aspects

Literature will often use the term HEALTH INEQUITY as a synonym to HEALTH INJUSTICE. However, these terms are not similar. Since health inequity is a general term typically used to define differences, changes, and disproportions in the health status of individuals and groups not any health inequity will be unjust. Yet, many types of health inequity are undoubtedly unjust as the concept of health injustice focuses on distribution of resources and other processes that drive certain types of health inequity, i.e. on systematic disparities in terms of health (or in its social determinants) among various social groups enjoying more or less favorable opportunities. In other words it focuses on health inequities that are unjust and unfair.

Speaking of the English terms "inequality" and "inequity" that are used to define "disparity": in healthcare the expression *social inequalities in health* imply the same disparity [just like *social inequities in health*], which is unfair and unjust" (Whitehead and Dahlgren, 2008).

Some researchers suggest a definition based on which unfairness in health will be related to those health disparities that are considered avoidable, removable, unfair and unjust (Braveman P. et al, 1996, 2001; Newton K.,1997; Anand S., 2002; Whitehead and Dahlgren, 2008).

Health inequity is increasing both inside countries and among them. Besides, in all countries there is a large gap in terms of health status dividing various groups irrespective of their income. In high income countries there can be observed a more than 10-year life expectancy gap between various groups depending on such factors as the ethnicity, gender, social & economic status, and the geography of residence. In poor countries all regions show significant difference in child death rate depending on the household welfare.

Socio-economic conditions (social determinants) have a significant impact people's health through their entire life-span. People with lower income demonstrate at least twice the likelihood of developing a serious disease or premature death if compared to those with high income. Besides, the social disparities in health status, which could be called the social health gradient, can be observed through all the stages of the social ladder and go beyond the low-income group. In particular, even in the middle class those with lower positions contract diseases and die more often than their colleagues holding higher positions (Whitehead M., Dahlgren G., 2008).

When viewing the behavioral factors – either positively or negatively affecting health – we shall come across numerous undeniable facts showing that poorer (from socio-economic point of view) groups usually demonstrate poorer nutrition, lower physical activity at their spare time, have a higher level of tobacco use or some other alcohol-related behavior patterns that seriously affect health. Special literature available reflecting the findings received from qualitative research into poorer groups" living conditions and lifestyles, serves evidence that such people have more restricted choices in terms of healthy lifestyles, which is due to the limits on their time, space, and money available to them, and could also be accounted for by the psycho-social mechanisms influencing them. All this is aggravated with the difference in access to goods, conditions and services, which could prevent or reduce the health damage from the socio-economic factors. For instance there are differences about access to the major medical care and their quality when we talk of various groups of the society, where healthier and better-off groups enjoy more of that access. The same holds true both for preventive services and for treatment (Whitehead and Dahlgren, 2008).

The economic standpoint contains reasons showing that such healthcare disparities result in huge loss and waste of human resource, which could otherwise be used both for individual prosperity and for the society at large.

Health inequity means that a significant part of the society has no chance to reach their full health potential, and this cuts them from access and a chance to enjoy other basic human rights. The conclusion here implies that the society should be equal and fair in distributing the resources available so that to make these accessible for everyone (Whitehead, M. et al., 2008).

Socio-economic factors are meaningful factors in health inequity. This assumption is based on the ideas of the mechanisms connecting health and socio-economic inequity. In some cases such mechanisms are rather obvious while in other cases they are more complicated and are not so visible from the surface. Thus, the level of income determines the differences in living standards – the quality and the quantity of the goods and services consumed. This, first of all, affects the nutrition calorie content, food diversity and balance, protective and sanitary-hygiene features of the clothes and footwear, as well as the comfort and convenience of the living micro-environment. Differences in the living conditions develop unequal capacities to adjust and to cope with physical and emotional stress. Inequity in living conditions determines unequal access to efficient ways of coping with health disturbances. Such mechanisms of socio-economic inequity "rubbing off" onto health is linked to the hypothesis stating that the relationship between the health and the socio-economic status could be expressed through the interconnection of "better economic status – better health status". The health status is subject to the influence of individual behavior – smoking, alcohol, poor or imbalanced nutrition, and lack of physical activity. The differences in health status that are due to lifestyle shall be unfair when the choice of the lifestyle is restricted with socio-economic factors never directly depending on the person himself. For instance, poorer (from the socio-economic viewpoint) groups have been shown to tend to adopt behavior patterns posing potential threat to their health (Тапилина В. С., 2004).

The findings from a number of European research projects suggest that the death rate among those found at the "lowest" rank of the social ladder is typically 2–3 times as high, while the life expectancy in non-qualified employees is 5 years shorter if compared with qualified personnel; also there is a 9—12-year gap between the poor and the well-off in terms of their life expectancy free from any disabling condition (Anand, 2002; Mackenbach, Kunst, 1997; Marmot, 2004).

Studying social inequity in health and its change over time is one of the key areas in the modern research into the sociology of health. Such research will help deeper comprehension of social mechanisms in the development of health and how much health inequity is due to economic and social changes that the society faces; this will also bring about the idea of the trends – either increasing or decreasing – in health inequity between different social groups. Such research projects are of great importance in terms of developing a social policy aiming at better public health, as well as of assessing the efficiency of the currently implemented measures (Anand, 2002; Mackenbach, Kunst, 1997; Marmot, 2004). According to the documents of the leading international organizations (World Health Organization, WHO, 1990; Braveman, Pitarino, Creese, and Monash, 1996) the nowadays policy of public healthcare is based on the concept of health as a specific public benefit the access to which should be determined following the principles of social justice. This implies equal opportunities in getting the key health resources for people representing various social groups. The implementation of this requirement would involve special attention towards the groups whose status is less favorable compared to others (Anand, 2002).

Mention should be made here that a policy aimed at reducing the health-related burden in low-status social groups will not just meet the justice principles, yet it will also contribute to significant improvement in the population's health in general (Mackenbach, and Kunst, 1997).

Even though the latest decade has seen measures to reduce inequity taken across Europe, there are still many countries with a growing concern that the disparities and inequities are expanding, which is especially obvious in the Central and Eastern Europe where the phenomena in question have adopted in this century an unprecedented scale if compared with other industrial countries. In some countries (the Russian Federation being one of them) where the worsening general health

status in people is a common fact, the increasing inequity and disparities are a dramatic consequence of severe socio-economic shock. However, even countries with a good state of things in healthcare (e.g. Denmark, the Netherlands, and Sweden) also demonstrate significant evidence of retaining and even increasing inequity, which puts them, too, among the top concern objects from the point of view of public healthcare. The differentiated aggravation of women's health, in particular in those belonging to vulnerable social groups, has become an issue that is attracting more and more attention from policy-makers in those countries. In some countries there is direct evidence of health inequity depending on the ethnicity. The findings received from the United Kingdom as well as from other places suggest that this is largely a result of the poor socio-economic conditions of certain ethnic groups.

Inequity and injustice are quite different and vary from area to area in different periods of time, which is evidence to the fact that they are not fixed and inevitable and could, actually, be altered. The best results gained or underway in a particular country should become a sample and a guide for other countries in their attempt to reach achievable aims in improving their people's health.

Social inequity in health is systematic health disparities in various socio-economic groups. This inequity is socially determined (and, therefore, is changeable) and is unfair. Such a judgment of justice is based on the common principle of human rights. There are facts showing that there is huge (and still increasing) social inequity in Europe nowadays, at least as far as relative criteria are concerned (Whitehead and Dahlgren, 2008).

The range of socio-economic inequities is wide: gender– and age-related, educational, race-ethnic, professional, power-related, material– and property-related, territorial, etc. And way, socio-economic inequities violate the principle of social justice. In this respect the concept of social justice could be analyzed.

Social inequity has existed for the entire comprehensible human history. Even though inequity has always been subject to destructive criticism and has never been approved, yet people through history have demonstrated extreme resistance to any "ideal" society based on social equity and absence of suppression among groups.

There is special concern over social inequity when it comes to children's health. During that the report on health inequity, including the issues of qualitative assessment of gender, age, geographic, and socio-economic factors influencing health disparities, contains data on the health status of adolescents aged 11, 13, and 15 in 2005–2006 representing 41 countries and the WHO's European region and North America. The purpose of the report was to detect the actual differences in youngsters" health status, and provision of information that could be useful for the development and implementation of specific programs, also contributing to improving young people's health at large.

This research has produced convincing evidence showing that despite the high health status and well-being in young people many of them still have severe issues related to overweight and obesity, low self-esteem, dissatisfaction with their life, and substance abuse (Whitehead M., Dahlgren G., 2008; C. Currie, S. N. Gabhainn, E. Godeau, C. Roberts, R. Smith, D. Currie, W. Picket, M. Richter, A. Morgan, V. Barnekow, 2008).

The World Health Organization has developed an ambitious program Health for All, which targets at a 25 % reduction of health inequities both inside countries and among them by the beginning of the XXI century (World Health Organization, Targets for Health for All, 1990). However, given the results obtained from numerous research projects the WHO European Bureau once again has defined the European targets for health inequity reduction.

HEALTH-21: European target 1 – Solidarity for health in the European Region.

By the year 2020, the present gap in health status between member states of the European region should be reduced by at least one third.

HEALTH-21: European target 2 – Equity in health.

By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all member states, by substantially improving the level of health of disadvantaged groups.

HEALTH-21: European target 3 – Multisectoral responsibility for health.

By the year 2020, all sectors should have recognized and accepted their responsibility for health (Whitehead and Dahlgren, 2008).

Prior to dealing with the prominent health inequity there should be an understanding of its major causes and health inequity manifestations.

Complete and proper understanding of how inequity develops – be that in terms of income or health – as well as what factors influence the process, how these inequities are related, and finding ways to reduce the inequity down to a socially acceptable level – all these are important premises for the development of an efficient socio-economic policy (Кислицына О. А., 2005).

The most vulnerable to inequity groups still remain the youth, women, retirees, and low-qualification workers. Along with poverty and beggary (sometimes referred to as deep poverty) there is also disadvantage. This typically affects children, the disabled, retirees, representatives of another race or ethnicity, and the chronically poor.

A society may eliminate absolute poverty, yet there is always some relative. This is because inequity will inevitably accompany complex societies. Therefore, relative poverty will always be present even if the living standards for all the groups of a society have gone up.

The relation between the death rate and the income, the likelihood of a shorter life expectancy develops due to long accumulation of negative impacts from financial hardships and the emotional reactions linked to them. An individual's health status is largely determined by the social group this particular person belongs to. A preliminary analysis of the relation between health inequity and economic status shows that towards various health indicators there is both inverse (higher status – fewer diseases) and direct relation. The position held by an individual in the social hierarchy – no matter how it may be defined – through job, level of education or income is always the determining factor both for the health status, and for the prevalence of behaviors that are destructive for health. The issue of social determination of health has been widely discussed by Russian authors (Назарова И. Б., 2007; Русинова Н. Л., Браун Дж., 1997; Журавлева И. В., 1999, 2006; Русинова Н. Л., Панова Л. В. Сафронов В. В., 2007).

They showed in their research that people employed in areas with lower status and low income more often demonstrate stress symptoms. Stress can act as an effect modifier. This means that in case of comparable levels of harmful impacts those experiencing stress are more susceptible to diseases and accidents. We should also keep in view the extra effects of behavioral stress manifestations, such as smoking, alcohol abuse or violence.

An empirical illustration of interrelation between health inequity and income inequity is, for instance, the data on differentiation of the medium number of health deviations in various groups of subjective economic status. The highest number of health issues has been registered in the groups with the lowest economic status, and the number will decrease as the status of the group grows.

A similar relation between health and the objective economic status can be seen in case of some specific diseases, blood circulation issues in particular. The highest concentration of those who suffered myocardial infarction can be seen among the population with the lowest status, and this number of infarction occurrences goes down as long as the subjective economic status goes up (Blaxter, 1990; Marmot, Stansfeld, Patel, North, Head, White, Brunner, Feeney, Marmot, Smith, 1991; Wilkinson 1992; Adler, Boyce, Chesney, Folkman and Syme, 1993; Marmot, 2004).

The role of economic factors in health inequity

The dependence of health from the objective economic status is also an illustration of the type of health issues.

First, it shows a higher concentration of people with low income among those with high or very high likelihood of health loss: groups of those unable to maintain self-care and suffering from limited physical capacity include the elderly. In other words, inverse relation between the objective economic status and the health status is mostly typical of the elderly and the oldest groups of the population, which supports the hypothesis concerning the fact that the development of a stable negative relation between health and economic status is largely subject to the factor of accumulating the negative impact from financial hardships and their consequences over a long time. Second, there is direct relation between chronic diseases and the economic status. A complementary analysis of the relation in view of the age factor among people with various incomes also shows that the poor have a higher share of those suffering from diagnosed chronic diseases in all age groups, if compared with similar age groups with the maximum income. As for acute communicable diseases both the poor and the rich are equally vulnerable to them, with the middle class demonstrating a lower level of vulnerability.

The distribution of the different age population suffering from health issues in the groups of the subjective economic status also suggests that in the young age (or in the first part of life) the share of people with detected (diagnosed) issues is growing along with the subjective economic status growth. Yet, there is a tendency seen in those approaching the end of their age: the higher subjective economic status the higher concentration of people with health issues.

People who are rather well-off have significant material possibilities to get the medical assistance needed and to take care of, and maintain their own health. This could be seen, in particular, in the prevalence of preventive visits to medical institutions. Among the well-off this index is significantly higher, if compared to the disadvantaged, both in general, and within specific age and level-of-education groups (Русинова Н. Л., Панова Л. В. Сафронов В. В., 2007; Падиарова А. Б., 2009).

Thus, there has been both direct and inverse relation identified between health and the objective and subjective economic status. On the one hand, the higher economic status the more often people visit medical institutions for preventive purposes and the higher the number of those with chronic diseases detected. On the other hand, the higher economic status the lower (on average) the number of people with health issues, the lower the share of people with severe heart diseases (myocardial infarction), and the lower the share of those with significant and stable loss of health. In general the individual findings on health support the conclusions and assumptions concerning the prolonged and ongoing impact of income on health, which were done based on the analysis of socio-economic inequity and territorial differences in people's health status. There we can see both cumulative effect where "the quantity (of money) shall transfer into quality (of health)" after a certain period of time, and the stimulating role of higher income on the ongoing health monitoring and timely response to its disturbances.

The relation between the social status and various aspects of mental issues has been of interest for both doctors and researchers since long ago; the findings from a lot of research have demonstrated the meaningfulness of social status in understanding mental diseases and disability. The epidemiological research projects conducted all over the world have shown an inverse relation between mental issues and the social class. There has been consistent data obtained suggesting that mental disturbances are more common for the lower social class (Meltzer et al, 1995). At the same time, lately there have been discovered other channels of the significant impact that inequity has on health. In particular, it has been shown that chronic stresses related to the dissatisfaction with one's socio-economic status may result in neuro-endocrine and psychological functional alterations thus contributing to the disease likelihood. It has already become a common opinion that a longer feeling of fear, uncertainty, low self-esteem, social isolation, inability to make decisions and be in charge of the situation both at home and at work impact health seriously: this may cause depression, increase susceptibility to communicable diseases, diabetes, high blood cholesterol, and cardio-vascular issues. Low socio-economic position, therefore, impacts health directly through deprivation and financial

hardships, and through the subjective vision of one's "unequal" position in the society and the related judgment, relations, experiences. When studying the influence that the socio-economic status has on health focus should be kept on both the objective and subjective socio-economic status. Therefore, there is an undoubted connection between the financial status and health, which can be seen both from the scientific-theoretical viewpoint, and at the level of common sense (Падиарова, А. Б., 2009).

Many researchers state that low socio-economic status is associated with high prevalence of mood disorders (Dohrenwend et al, 1992). There was also a suggestion that belonging to a particular social class will influence the nature of psychopathological symptomatology in depression. Patients demonstrating symptoms of somatized and anxiety disorders more often belong to a lower social class. At the same time cognitive symptoms were more often detected in patients from a higher class. The severity of depression in adults, related to financial issues, may depend on age. Mirowsky и Ross (2001) found that it goes down as the age goes up. Financial troubles and poor marital relationships are significant factors contributing to the risk of depression onset and its chronic course (Patel et al, 2002). Just like depression, poverty is typically chronic in its nature, so it usually needs focus both from caregivers and from decision makers.

If compared to the general population people who attempt suicide more often belong to the social groups where social instability and poverty are typical.

Gunnell et al. (1995) investigated the relation between suicide, parasuicidal behavior, and socio-economic issues. They identified a connection between suicide and parasuicidal behavior, while negative socio-economic factor offered nearly complete explanation. Besides, these murders and suicides more often happen in densely populated poor areas (Kennedy et al, 1999). Crawford and Prince (1999) also support these findings. They noticed an increase in the suicide rate among young unemployed men living under severe social deprivation. It also true that the frequency of cocaine or opiate overdose cases is associated with poverty (Marzuk et al, 1997).

Both unemployed men and women demonstrate a higher level of alcohol or substance dependency in case they belong to the unemployed. The social class is a risk factor of death due to alcohol abuse, which is also related to such structural social factors as poverty, disadvantage position and the social class. The rate of alcohol-induced death is higher among men involved in physical labor than among clerks, yet the relative index will depend on the age. Men aged 25–39 and involved in common non-qualified physical labor demonstrate a death rate 10–20 times higher than representatives of the middle class, while among those aged 55–64 the same index is only 2,5–4 times higher if compared to those who are involved in a type of labor requiring special skills (Harrison & Gardiner, 1999).

The relation between the lower socio-economic status and personality disorders is far from being well-investigated. Low family income and insufficient living conditions are prognostic factors for crime among adolescents and adults (based on official and survey data). However, the connection between poverty and crime is a complex and a continuous one. The interrelation between impetuosity and the neighborhood in connection to criminal activity show that impetuosity is higher among residents of poor areas rather than among those residing in better-off ones (Lynam et al, 2000). A Cambridge research into the development of minor delinquency produced data stating that unstable employment at the age of 18 was an important independent predictor of previous conviction history among young men aged 21–25 (Farrington, 1995).

The growing number of researches into the relation between poverty and health indicates that low income combined with unfavorable demographic factors and insufficient external support causes stress and life crisis, which serve risk factors for children and may trigger mental disturbances in them. Children from the poorest families show a 3 times higher rate of mental disturbances than children from more prosperous families. Poverty and disadvantaged social status have strongest connection with insufficient skills in children and their poor academic performance (Duncan & Brooks-Gunn, 1997).

Kaplan G. A. et al, (2001), after studying the socio-economic status in childhood and the cognitive functioning in adulthood, concluded that a higher socio-economic status in childhood and a higher level of education determine a higher level of cognitive functioning in the period of maturity, while both mothers and fathers, independently, contribute to the development of creative cognitive functioning in their children and their cognitive capacity at older age. Obviously, a better socio-economic status in parents and a higher level of education in children may improve cognitive functioning and reduce the risk of dementia at a later stage of life.

Confused, strict and full of violence upbringing as well as lack of control and poor child-parent attachment will aggravate the poverty effect and worsen other structural factors, when it comes to minor delinquency. A Cambridge research into the evolution of minor criminals poverty was taken as one of the most important predictors for delinquency (Farrington, 1995). It was also shown that, in view of mother's education and behavior in early childhood, poverty also affected academic performance and delinquency (Pagani et al, 1999). Eyler and Behnke (1999), after studying the effects of most common psychoactive substances in children (on their first and second years of life) who were subjected to that in the prenatal period, concluded that the children living in poverty demonstrated obviously aggravated effects of those substances.

The materials of the WHO show that social inequities may also have an impact on the level of vulnerability to environmental risks and the severity of these risks" impact on health. There have been 4 of such mechanisms demonstrated:

?Mechanism 1. Social determinants correlate with the quality of the environment. Socially disadvantaged groups often live and work under poorer environmental conditions if compared to the general population.

?Mechanism 2. The levels of impact are in a certain dependency on the factors related to social inequity (such as level of knowledge and type of behavior in terms of health). Therefore in case of similar environment disadvantaged groups may be subject to a more intense impact than the population in general.

?Mechanism 3. Factors related to social inequities (such as health status and biological susceptibility) affect the dependency "impact – response". Given the same level of impact, disadvantaged groups may reveal a higher level of vulnerability to unfavorable consequences for health, e.g. due to synergy of various risk factors.

?Mechanism 4. Social inequities have a direct impact on the end results related to health, which may reveal itself through both environmental and non-environmental mechanisms. However, under similar dependency parameters of "impact – response" disadvantaged groups may reveal a higher level of vulnerability to unfavorable consequences for health due to poorer access to the respective services and reduced capacity to cope with the negative effects. The absolute scale of the consequences can also be higher in disadvantaged groups because of higher prevalence of previously existing health issues (Whitehead and Dahlgren, 2008).

According to most researches representatives of lower socio-economic groups stand a higher vulnerability to negative environmental factors (Braubach M, Fairburn J., 2010; Bolte G, Tamburlini G, Kohlhuber M., 2010).

Gender features of health inequity and the family role

Research conducted all over the world show that gender is another important factor determining health inequity.

The feature typical of Russia is an extremely high death rate among men and an unprecedented gap between the life expectancy among men and women (12–14 years).

This attracts more attention to men's health in modern Russia, which overshadows the fact that, according to medical statistics and opinion polls, women have been consistently showing higher rates of health issues.

The lower status of health in Russian women – not only compared to Russian men yet also to women in other countries – is also seen from the calculations of the healthy life expectancy. According to the data provided by the leading Russian demographers the huge gap in the healthy life expectancy of the 20-year olds (both Russian men and women) and their Western counterparts (13 years), in men is due to a higher level of death rate (especially in the working age), and in women – due to a lower health status (mostly in the older age) (Масленникова Г. Я., Оганов Р. Г., 2002, 2004).

Actually, the so-called gender paradox, which could be expressed as "women become ill more often while men die earlier", which is a global tendency, typical of civilized countries at least, has always been of interest to researchers. For a long time this gender paradox has been explained by medical statistics, supporting the fact that men typically suffer from fatal illnesses and fall prey to illnesses that do not reveal well expressed symptomatology; as for women – they typically suffer from acute and chronic, even though less severe conditions.

Thus, a number of empirical research projects have shown a significant variability in the scale, and sometimes in the patterns of gender-bound health differences at various stages of life cycle, as well as within different health indicators.

According to the theory of unequal impact, women demonstrate a higher level of ill health due to their restricted access to material and public resources that would save health, and because of increased stress accounted for by their gender and family role.

If compared to men women hold different positions: they are more often unemployed, get employment in other areas, and in general they have to enjoy lower income. There are also some gender differences in behavior stereotypes as men are more prone to smoking, alcohol abuse and unbalanced diet, while women are less active physically.

It has also been proven empirically that women carry a heavier burden of responsibility in fulfilling their social roles. They also possess a smaller psychological resource required to cope with stresses. In particular, women have a lower awareness of control over life circumstances. At the same time women, if compared to men, have various sources of obtaining some social support.

According to the second approach – vulnerability difference – women demonstrate more health issues as they respond differently (compared to men) to financial, behavioral and socio-psychological circumstances that develop health.

Thus, empirical data shows that full-time employment along with taking care of the family, as well as social support are more important health predictors for women rather than for men.

Tobacco and alcohol consumption are more meaningful health determinants for men while overweight and low physical activity affects women more. While maturing educated girls create smaller and healthier families. The survival rate in their children is higher, and they stand a higher chance of getting education, if compared to children born to less educated mothers (Expert Group Meeting, United Nations, Division for the Advancement of Women (DAW), World Health Organization (WHO), United Nations Population Fund (UNFPA), Tunisia, 1998).

The research conducted in Russia has shown that in women the meaningful determinants of physical functioning include the level of education, awareness of personal responsibility for health, as well as a possibility to spend some time taking care of oneself, while men's physical condition depends more on a balanced diet and preventive measures. Men's physical health is especially vulnerable to external impacts at a certain stage of their lives, the pre-retirement decade, to be exact (51–60 years. Gender differences are especially obvious in the health developing mechanisms when analyzing the levels of realized welfare (Назарова И. Б., 2007; Русинова Н. Л., Браун Дж., 1997; Журавлева И. В., 1999, 2006; Русинова Н. Л., Панова Л. В. Сафронов В. В., 2007).

In important issue in healthcare is getting assistance by women in many countries. There is significant evidence showing that women are subject to gender-bound restrictions in terms of getting access to medical assistance, which is true in particular for women from the poorest groups. The obstacles they have to face include lack of culturally adjusted types of assistance, shortage of

resources, transportation troubles, suppression, and sometimes even a ban imposed by husband or other family members. Lack of public funding for healthcare affects men as well, yet in view of a limited family budget women's healthcare needs do not enjoy priority.

Similar issues remain in relation to identification and measuring abuse, family violence, and sexual abuse. The life expectancy of an American woman will depend on ethnic factors: white women live an average of 82,2 years, while for black women this index is 75,5. The infant death rate (per 1,000 births) among the black population is 13,6, among Chinese the infant death rate in America is only 3,5. The maternal mortality among black women over 35 is 71,0 per 100,000 labors, while among white women it is only 11,4. Hite women have a higher rate of breast cancer; however the survival rate within 5 years following treatment in black women is 15 % lower because the tumor in them is detected at later stages. Latin American women have a cervical carcinoma rate that is double of the rate among white women, and their death rate from this issue is 40 % higher. American Indians get antenatal assistance in 69 % of cases while American Japanese – in 90 % of cases. The HIV and AIDS prevalence (per 100,000 women) is 2,3 among the white, 11,8 among Latin Americans, and 50,0 – among the black population. The death rate for infants born to white mothers with no special education is twice higher if compared to white mothers with a degree in higher education (Expert Group Meeting, United Nations, Division for the Advancement of Women (DAW), World Health Organization (WHO), United Nations Population Fund (UNFPA), Tunisia, 1998).

Males also have some specific features contributing to the development of health inequities. For instance, men's mental health is significantly due to the position they have in the society.

It is interesting to note though that the relation between men's mental health and the key markers of their social position – education and financial welfare – is inverse. While a high level of prosperity has a positive effect on men's mental well-being, their mental health clearly deteriorates along with their education level.

As for women, their realized welfare is largely determined by behavioral factors, mental issues faced in the family environment, and the capacity of their psychological resources allowing them to cope with stress (Expert Group Meeting, United Nations, Division for the Advancement of Women (DAW), World Health Organization (WHO), United Nations Population Fund (UNFPA), Tunisia, 1998).

A number of research projects carried out in Western Europe stress the importance of family in shaping a certain level of health inequity. The parents" resources alone already have an impact on young children's life quality and create inequity between children from prosperous and poor families. First, the parents" economic capacity determines where and how the family will live. There is a difference if children live in a small rented apartment located in a disadvantaged urban area or in a large house with a garden in a fashionable neighborhood (Meulemann, 1990). Empirical findings show that different life quality among children from poor and prosperous families does not just matter in itself yet it also serves precondition for further inequities. The level of recognition that children enjoy among their friends depends on their toys, sport gear, pets, fashionable clothes, opportunity to travel, pocket money, the configuration of their own computer (Szydlik, M., 2004).

At the same time already in the earliest childhood the parents" resources set important milestones for the entire biography and for the position in the social inequity structure. The parents" choice of the residential area has a direct impact on their children's first friends" social position. Peers, in turn, have a significant impact on children's and adolescents" secondary socialization – they either increase or suppress the interest in education and culture. This means that parents, be that deliberately or not, through the social groups of their children's first friends set the framework for the common and desired standards in education, about which their children learn from their closest environment. Of course, it is also important that the residence determines the choice of school and the level of education in the child's school friends.

The parents" impact on their children's education can hardly be overestimated. Education determines the opportunities in life. The individual education has a decisive influence on income, choice of profession, prestige, career, employment opportunities, working conditions, match between the professional background and employment, property, retirement benefit, choice of partner, health and life expectancy. This is why education is a central measure for social stratification. The one with the best education shall get the highest score in all the above-mentioned areas. Each year of school or professional training adds around 6 % to the salary. Better educated people will have less trouble finding an employment and they are fired more seldom. Those with a University degree stand a better chance to find an employment within their area of training (Szydlik M., 1996).

Parents set important educational standards for their children. This is not only about the decisions concerning education itself but also about the general level of education in the family. The very first years of life lay the basis for future academic and professional success. The decisive role here is rather common – the financial capacity of the parents. Therefore, the family connections reproduce social inequity through the entire life. Especially impressive here is the connection of inter-generation solidarity and social inequity. Solidarity between generations is well expressed not only in relation to minor children who still reside with their parents. This goes on after the children leave the parental home. This solidarity continues for the entire life, thus constantly reproducing social inequity.

Parents from higher social groups create better conditions for their children not only in childhood and adolescence. When children become independent they still get support through regular money transfers, gifts, property and, finally, inheritance. This is how the support provided by the upper class to their children through their lives will enforce and even increase the social inequity. The youngster who had better chances due to the parents" resources will have obvious advantage in adulthood.

In general solidarity between generations is well expressed through all the social groups. However, bigger opportunities mean bigger support. Parents without significant resources can never provide such support. This is how families strengthen and increase social inequity. This enhances the chances of children whose parents hold higher social positions thus reducing the opportunities of children from poorer families. Here we must recognize the invaluable service done by the family and assist it in every way. However, an important public and political task is to reduce inequity based on parentage (Szydlik, M., 2004).

Role of education in health inequity

As stressed above, education is one of the major determinants of the economic inequity and its role is increasing year after year.

The public expenses on education make up about 60 % of the total national educational budget; the part covered by the population is about 30 %, with another 10 % coming from the employers. This ratio of public and non-public funding on education (60/40) is significantly different from what economically developed countries have where the population has a higher level of income in general and, which is equally important, where the differentiation in income is much lower, while the private funding from employers and sponsors is higher. For instance, in 2001 in the USA the public budget for education was 69,2 %, in Germany – 81,4 %, in Great Britain – 84,7 %, in Italy – 90,7 %, in Sweden – 96,8 %, in the Czech Republic – 90,6 %, in Slovakia – 97,1 %.

The crisis of public funding for education in Russia stimulates paid education and getting fee from the family for various services, which increases inequity in access to education. Selection is more and more based not on the aptitude criteria but on the applicants" parents" financial capacity. A survey conducted in 2005 by the Russian National Center for Public Opinion showed that half of the Russian population (55 %) cannot afford educational services that are paid, while 21 % of Russians can afford it in extreme cases only. Besides, attending an educational institution and graduating from it with the respective degree certificate does not mean having quality education. The growing density

of education both in school and in universities is one of the factors for a certain reduction of its quality. This already contributes, and will contribute on, to the growth of inequity.

However, it is common knowledge that each extra year or education in Russia accounts for a nine-percent death rate reduction in men and a seven-percent death rate reduction in women, while those involved in mental work (especially leaders) demonstrate a higher survival rate than those involved in physical labor (Тапилина В. С., 2004). Researches carried out in St. Petersburg (Russia) showed significant differences in health status esteem depending on the level of education and financial deprivation – in the social groups with limited educational and economic resources the health status was lower (Русинова Н. Л., Браун Дж., 1997; Русинова Н. Л., Панова Л. В., 2003; 2005; Максимова Т. М., 2005; Назарова И. Б, 2007). Foreign authors, too, focused on the issue of social differentiation of health in our country. In order to support the facts mentioned it was shown that the level of financial hardships and education are important predictors of the perceived health (Bobak, Pikhart, Hertzman, Rose and Marmot, 1998; Bobak, Pikhart, Rose, Hertzman, and Michael Marmot, 2000; Carlson, 2000). These works also stated that one of the significant health status determinants is such an indicator of social well-being as the perceived control over the life circumstances.

The differences in education related, to a certain degree, to income differentiation, may also reveal themselves in the value and behavioral aspect of the way someone treats his/her own health. In particular, education is connected to the specificity of ordinary health conceptualization, the level of personal responsibility for one's health status, and the differences in people's awareness of health issues, healthy lifestyle, and medical care. People with a degree in higher education are usually involved in a wider network of interpersonal connections thus standing a better opportunity to get instrumental and emotional support. The level of education has also been repeatedly noticed to have relation to the differences in the prevalence of health destroying behavior patterns (Демьянова А. А., 2005; Cockerham, 2000; Pomerleau, Gilmore, McKee, Rose, and Haerpfer, 2004). For instance, in 1998 in the female part of the city 64 % of the respondents with a level of education below average referred to their health as poor or very poor, while among those with a higher degree of education the same response was obtained from 20 % only. As for men, about 58 % of St. Petersburg residents with no complete secondary education considered their health as unsatisfactory, while in the most educated segment the same response was given only in 10 % of cases. In the same year the share of respondents with poor health in the first (lowest) and the fourth (highest) income quartiles were: for women – 30 % and 13 %, and for men – 21 % and 4 % (Русинова Н. Л., Браун Дж., 1997, 1999; Rusinova and Brown, 2003).

The economic status is a projection of income inequity, which has direct relation to health inequity. However, the differences in income are also known to reflect the differences in the level of education, the professional background. The educational status in many countries is used as the major indicator of people's status in the socio-economic inequity hierarchy, while the economic status, in turn, is viewed as the indicator of the return from the investment into the cultural capital. Apart from that education can be considered as an indicator of an increased capacity to take and process information, as well as make decisions allowing taking proper and meaningful approaches to maintaining and caring for one's own health. There is an obvious relation between income and profession. Low income is typically connected with unqualified heavy physical labor, which, in addition, contains the risk of being injured or maimed.

A separate issue that requires solution within health inequity is marginalized groups that are to be found in any country and in any society. Unfavorable working conditions that potentially exacerbate the impact of environmental risk factors are mostly typical of marginalized groups, such as refugees and migrants even though they could pose a problem for people with a low level of education. The concept of "unfavorable working conditions" may embrace such types as working with no contract signed, child labor, as well as forced and coerced (as a pay for a debt) labor. Working with no contract

signed is the major source of inequity in relation to the environment and health, as well as violation of regulations for national labor safety, working hygiene, and working conditions, which involves various negative effects on the health of the employees.

In Hungary, for instance, 15 % of Gypsy settlements (Roma) were located within 1 kilometer from illegal dumps, and 11 % – within 1 km from the places for destroying dead animals (Gyorgy et al., 2005). In Serbia similar settlements had a 2–3 times lower water supply and hygienic facilities (Sepkowitz, 2006).

Therefore health inequity has along historical context; this issue is determined by many factors and is found anywhere regardless of the socio-economic level of development of the country as a whole. Yet, in view of ethical, legal, economic, and medical-social implications this issue requires urgent response at all levels, from local to global.

Health inequity in Russian Federation: state of things

The issue of inequity in income distribution in the post-socialist area has been a subject for wide discussion both in our country and abroad. This point has always been the focus of researchers and politicians, from time to time giving raise to acute socio-political debate. Russia is no exception here given the significant changes it has undergone in the latest decade. Quite a tough issue is developing human potential under rapidly progressing market conditions and similarly rapidly disappearing social benefits for the disadvantaged. In view if this, experts define two types of challenges: on the one hand the country is facing typical of poor countries troubles like spread of communicable diseases, regions with stagnating poverty (still present in Russia), undeveloped infrastructure and high death rate. On the other hand the country is suffering from healthcare and education crisis, and such issues are common for advanced post-industrial countries as well.

Poverty profile in Russia

Poverty in Russia has a number of typical features. For instance, most vulnerable are families with children and, therefore, children themselves, who are under 16. Note to be made though that this issue is not common for most countries. As for retirees they are under lower risks of being affected by poverty because most of them work and the social benefit system is oriented, first of all, at the elderly.

Special mention should be made of the fact that working population is the larger part of the poor group even despite of salary growth. In order to reduce the number of poor people among the working population the minimum salary should be at least 150 % of the minimum cost of living. In the April of 2009 25 % or the working population received their salaries below this minimum. 70 % of them had children. 37,4 % of the working population received salaries below 200 % of the minimum cost of living.

This level of pay for labor is sufficient for meeting the minimum needs of one employee and one child. Therefore, even in a situation where two parents are employed such salaries cannot be enough to support two children at the minimum level.

The largest share of the poor population is accounted for by the people who are able to work, especially youth. Countrymen are more vulnerable to poverty than urban population. Besides, the maximum poverty risk affects the unemployed population, economically inactive groups, as well as those living on social and disability benefits.

Level of poverty and inequity

The dynamics of poverty and inequity is determined by the consumption share for the 20 % of poorest against the total volume of consumption. Up until 2000 this index was about 5,8–6,1 %. Later on the share of the poorest 20 % has gone down, which serves perfect evidence of the fact that the poor have got no access to the results of economic growth.

(The World Bank in Russia Russian Economic Report, No. 21, March 2010, http://siteresources.worldbank.org/INTRUSSIANFEDERATION/Resources/305499-1245838520910/6238985-1269435660465/RER21rus.pdf).

The liberal economic reforms went along with a significant fall in the standard of living and an increase in the socio-economic differentiation. The growing economic inequity has become a serious challenge both for the people and for the government. Our country now has significant inequity in terms of health and accessible medical assistance due to polarization of income and opportunities, which means limited and clearly deficient current social policy carried out in our society. The recent research findings have provided quite a clear demonstration of significant differences in people's opportunities at birth, during the preschool and school period, in terms of getting access to higher education, housing, transportation, shopping, recreation and fun activities, relationships with the state, access to medical services, life expectancy, maintaining health status and healthy lifestyles, religious affiliation, funeral services, inheritance, etc. Just 20–25 years ago when the disproportion was not so extreme some specialists in social hygiene and healthcare arrangement even talked about potential homogenous conditionality of health in our country.

We must admit that health inequity is a new and, obviously, a long-term issue in Russia. Even though there have always been differences in people's health status this point never got so much attention. One of the sources of social tension in any country is the gap between people's welfare, in the level of their prosperity. The level of prosperity is determined by two factors:

1) the size of (any kind of) property possessed by individuals;

2) the size of the individuals" income (Дашкевич П. Р., 1995; Денисов П. Р., 1997).

One of the criteria of civilization in any country's social sphere is maintaining the respective appropriate living standard for the groups (families) that for some reasons cannot meet even the minimum standards and customs (food, clothing, leisure, etc.). One of the most urgent social issues in Russia that came into being because of economic changes is unprecedented inequity in income. According to the Russian Statistics Agency (Rosstat), by 2006 the income of the most prosperous groups was 16 times the share of the least prosperous ones (Российский статистический ежегодник, Россия в цифрах, 2006). However, if we take into account that the official statistics often underestimates the socio-economic differentiation in Russia not taking into view the shadow economy, then the true gap in question may be much larger. According to the data provided by T. Zaslavskaya (2005) the inequity gap between the 10 % at the extremities is 30–40 times. As noted at the Report on Poverty Evaluation made by the World Bank (2004), this fast growth of income inequity in Russia was close to a record – Russia here is very much different from other countries including Central and East Europe, where they also had a transfer to the market economy. Experts say that socio-economic differentiation similar to Russian should be looked for in Latin America rather than in European societies (Murphy, Bobak, Nicholson, Rose and Marmot, 2006). The social stratification trend in our country that became especially obvious in the 1990-s is still there under the rather long process of economic growth noticed in the recent years – income differentiation was detected in 2007 as well (Щербакова Е. М., 2008).

The high rate of economic and socio-structural changes in Russia that were ahead of most people's adjustment capacity brought to many increased levels of chronic stress, loss of control over life circumstances, and resulted in prevalence of behaviors related to health risks, first of all high alcohol consumption (Cockerham, 2000; Bobak, Pikhart, Rose, Hertzman, and Marmot 2000; Cockerham, Hinote, Abbott, 2006).

All this could not but affect Russian people's health, which is well seen from the growing death rate and reduced life expectancy.

As a result, by the early 21st Century (2000) the death rate brought Russian into one line with African countries located south of Sahara, namely 15 deaths a year per 100 people, which is nearly double the index of developed societies (Римашевская Н. М., Кислицина О. А., 2004).

The recent years have witnessed quite clear a vicious circle where the national Russian healthcare system has found itself – the more funding is invested into specialized inpatient care and hi-tech clinics the less funding is given to prevention and early detection, which results in an increased

number of patients, adds to the severity of their conditions, detection of diseases at later and even very bad untreated stages, and chronization of pathologies, which requires even more funding for tertiary healthcare.

Therefore, the modern Russian healthcare system could be described with a high level of inequity in distributing health opportunities among individuals and groups of people, as well as with a conflict between the state and the society, with erosion of the aims and objectives in the sphere of healthcare (Сизова И. Л., 2007).

The impact of social inequity in the Russian society has been especially seen the young generation, whose origin and development came onto the reforms.

Under the reforms in Russia, apart from traditional disturbances there have come into being new trends in youth's health: "psychization" and "psychologization" of diseases, increasing social disadaptation, loss of confidence about one's strength, increased feeling of "social loneliness". This aspect creates the necessity of a sociological reflection on the changing social conditions and their impact on new deviations in youngsters" health, and the development of new practices in certain classes and social groups.

Even though we have already discussed poverty as the most important factor of inequity, Vladimir Putin's words – Russia is a rich country of poor people – make us turn towards the issue again, yet in the context of the Russian reality.

On the initial stage of the economic reforms in Russia the core group of the poor was traditionally represented by the so-called vulnerable groups including retirees, disabled, large families and one-parent families with children. Nowadays the focus is definitely shifting towards a different risk group – the "working" poor, the part of the society that are able to work and, due to various reasons have low income, which keeps them from supporting themselves and their families properly.

Quite often poverty has also socio-psychological preconditions. One of them is the "overtaking" poverty. This term could be used to describe a phenomenon implying prestige consumption. It is typical for youth, rather than for older people, to dress well and to look no worse than others. The things that prosperous parents" children have (fashionable and expensive clothes) set up certain example attracting children whose parents cannot afford that. If a prosperous parent can buy something never feeling and financial issue then a poor parent's budget may be seriously affected by the same purchase. This prestige consumption makes many people live beyond their financial capacity. Those from poor families feel uncomfortable due to their own position and that of their family, which does not allow them live better. This causes a generation conflict where children blame their parents for not wanting or not being able to "make money", even despite all the morals. As a result poor people's children find illegal ways to make money, which they need to "catch up" with the rich ones, to live up to the standards imposed on them by the middle or the upper class (Падиарова А. Б., 2008, 2009).

The poor's focus is shifted towards negative evaluation of the reality, pessimism, and despair. They are often unable to build proper relations within their families – high voice in the family, mutual reprimands, obscene words and abusive language become a common thing. Such conditions develop a special lifestyle and a value system, which could be described by restraint and voluntary isolation, economic and social dependency, lack of clear behavior role models, separation and political passivity, absence of future plans and self-confidence; increased disposition to conflicts in family relations (rude talks, quarrels between parents and children, frequent divorces) (Кислицина О. А., 2005).

Other reasons responsible for acute aggravation of health inequity in Russia during the transition period include:

1. Actual shift in healthcare from caring for health to clinical medicine, i.e. from mass recreational and preventive measures to individual treatment.

2. Increased share of paid services, development of new relationships with patients, which destroy the basics of medical ethics, and which make it possible to view the patient as another source of income; chronic deficit of funding with a large number of various sources of that, which never contributes to financial transparency.

3. Sharp increase in inequity in terms of people's access to medical services, while the majority of these people are socially disadvantaged.

4. Prominent inequity in doctors" incomes.

5. Unequal access to medical services for certain groups of people: homeless people, neglected children, migrants, and just financially vulnerable people.

4. Continuing practice of increasing the share of costly and expensive medicine, a huge gap between the quality and quantity of medical assistance in cities and in the provincial areas, and the gap between the assistance provided to rural and to urban residents is increasing.

5. Obvious and neglected mismatch between people need for preventive medicine, treatment and rehabilitation, and the funding allocated to the area. All this makes medicine spontaneous, paid, creates new issues and even power abuse, which may result in undermining the entire structure of the system. Since recently, instead of improving medical assistance, managers in healthcare have started talking about lifestyles, thus trying to avoid responsibility for current state of things in medicine and shifting it onto people who abuse tobacco, alcohol, stick to unhealthy diets and just do not take care of their own health, even though, actually, all this is one of the tasks for the system of healthcare.

6. Overly complexity of the very system of healthcare and, as a result, its poor controllability and efficiency (Комаров Ю. М., 2010).

Thus, we believe that in order to reduce the urgency of health inequity it takes comprehensive intersectoral measures, which should be initiated by the public health sector, while all the municipal agencies and public groups should be involved as equal partners.

Measures for reducing health inequity

Health inequity determinants lie within areas of public life other than healthcare alone; then it is obvious that there is a need for a policy in all these areas aiming at assessing their impact on health, especially on the health of the most vulnerable groups, which would allow coordinating the policy respectively.

From the viewpoint of social policy, first of all there is a need to realize the scale of the issue. This is why the top aim for a social policy in this area should be activity for, at least, limiting the impact of poverty and income inequity on people's health.

The Committee for socio-economic determinants recommends the following

– to carry out a quantitative assessment of potential effects on the health of different groups of the population due to particular risk factors;

– to detect the risk factors (including social determinants) whose effect could be prevented;

– to carry out a differentiated analysis of the impact on health that competing risk factors have, e.g. such as tobacco smoking and diet;

– to detect and carry out a deeper analysis of the cumulative effect of multiple impacts;

– to investigate additional and synergetic (or, which is less likely, antagonistic) interaction between socio-economic factors and the negative environmental factors;

– to get to deeper understanding of the nature and gender differences in the vulnerability of children, older people and the elderly to negative environmental effects (CSDH, 2009).

The countries looking for counter-measures in order to reduce social and environmental inequities should take into account their driving forces and the underlying reasons. No doubt, there are no easy ways to eliminate the inequities, proof to that being the social processes that have been going on in the latest decades. The key to success of the strategies that are being implemented is a clear

division between short– and long-term objectives, and reducing socially determined environmental issues takes various approaches.

?In the long-term outlook disadvantaged groups will gain the maximum benefit from interventions aiming at creating a safer environment just because these groups are more often subject to negative environmental impact.

?The long-term measures that should be part of the local, national, and international agenda must include special events and campaigns aiming at serving the groups with the detected risk of the most serious or specific unfavorable effects of environmental inequity.

Since poverty is one of the key factors determining health inequity, this inequity cannot be resolved unless this key issue is resolved.

The major stream in overcoming absolute poverty is ensuring productive employment, increasing labor efficiency, creating conditions allowing the working population earning more thus supporting themselves and their families.

In this case the size of the salary comes out as the major guarantee against poverty. The role of the state here implies establishing market conditions for increased competitive capacity in the national economy through increased competitive capacity of the Russian enterprises – implementing the required industrial policy, proper adjustment of the system for staff training, introducing measures for supporting the national manufacturer.

Higher selectivity in offering social assistance, application-based priority, and individual social benefits – all these make up an efficient way of eliminating poverty.

When selecting socially vulnerable groups there is a need to match the officially established poverty line with their income, the officially established minimum property standard with the property that they possess. Special attention should be paid here to the issue of homelessness, neglected children, and children in crisis families.

An important task for social policy is detecting the obstacles on the way to obtaining social support and benefits.

The current system for revealing and supporting poor families and people providing them with various benefits, advantages, sand other types of assistance is far from being perfect and needs adjustment to market economy. The funding allocated nowadays to provide social support to the poor is not efficiently distributed and will often go to the families that are poor indeed. As a result the truly poorest population remains even in worse condition.

The international practice includes the following measures to combat poverty:

– Redistribution of income.

First of all there should be measures for the development of an efficient labor market. This issue implies resolving two key tasks:

– Measures for reducing the number of low-paid employees;

In the major measures aiming at the reduction of the number of low-paid employees the following can be defined:

– Increased salaries for public employees through bringing up the expenses for remuneration of labor;

– Implementing a policy aiming at reducing illegal types of labor remuneration, which contributes to impoverishment of the working population (delayed pay, payment in kind). Such a policy must include economic and administrative measures targeting, first of all, the employer;

– Encouraging employment for those who want and can work, new workplace establishment. To ensure prompt the establishment of new workplaces takes stimulating the priority in the development of the economic areas that can provide new workplaces with minimum investment. This is, first of all, small– and middle-scale business.

– measures for reducing income inequity at the expense of social transfers and increased minimum guarantees in social security sphere;

– introducing a progressive income tax for individuals. Officially the gap between the 10 % of the poorest and the richest is 15 times (CSDH, 2009).

No doubt, apart from solving general healthcare issues, the measures for reforming the national healthcare system should also contribute to reducing health inequity in Russia. Such organizational measures include:

1. A multifunctional network of healthcare institutions with its internal and external connections, which would allow calling this network a healthcare system.

2. A rather branchy system of medical examinations, check-ups and measures. There should be extensive work to offer general public training in self-help in certain cases (in case of trauma, bleeding, etc.) and self-examination (regular examination and palpation of breast, taking the pulse, blood pressure, etc.); this will take circulation of special literature.

Besides, the tasks for healthcare both in general and locally (by health criteria) include:

– bringing closer to densely populated areas shopping malls offering everyday goods, pharmacies, institutions for primary medical assistance, recreational institutions, schools and preschool institutions, places of everyday use, public transport, etc.;

– Improved facilities, reduced environment pollution, improved quality of water, air, and soil;

– Improved local environment, planting of greenery, establishing recreational areas;

– Improved structure and quality of food, efficient control of food safety;

– Increased level of culture and education, encouraging involvement of children and adolescents into activities based on their interests, organizing their spare time and creating conditions for public physical activities (stadia, swimming pools, skating rinks, skiing paths, sport gyms, etc.);

– Strengthening the value of family, crime prevention;

– Activating the movement for health and mobile lifestyles;

– Eliminating drug abuse, tobacco smoking, alcohol consumption, preventive work with children, youth and adolescents;

– Sanitary education of the general public, increasing the level of sanitary literacy and culture, teaching simplest ways of primary self-help and mutual assistance;

– Combating prostitution, STDs, and AIDS;

– Vaccination and immunization;

– Establishing paramedical and nurse respite service, integrated medical support at home (day-time or day-and-night), establishment of municipal or neighborhood nursing homes or hospices;

– Health and working capacity recovery, establishment of rehabilitation centers;

– Conducting preventive, special periodic medical check-ups, early diseases detection, primary medical assistance;

– Detecting socially vulnerable groups and providing them with the individual required support;

– Working and living conditions. Since health inequity is often related to unequal living or working conditions then reducing the inequities should imply eliminating the underlying causes. Some public policies aiming at the establishment of proper and safe residence, increased standards of professional health and accident prevention, even though they were developed to help people in general, still may prove most efficient for those employed and living under the worst conditions, through increasing their physical and social environment standards;

– Choice of lifestyle. The state policy here should be aiming at offering people equal opportunities in choosing healthy lifestyles. Recreational institutions and sport facilities, for instance, should be accessible both by their location and price, while shopping mall chains should guarantee cheap and nutritional food supplies. At the same time the advertisement and promotion of products that have a negative effect on health should be restricted (Комаров Ю. М., 2010).

The areas of social policy that could have the most efficient contribution into improving people's health include the following ones (CSDH, 2009; Final report by Commission on Social Determinants, WHO, 2010):

– Intervention into early life.

More and more research support the role of the environment where a child lives in the early childhood, which has an impact on the child's future behavior, academic performance, and health for his/her entire life. People whose childhood included residing in families suffering from financial issues were more prone to various diseases in adulthood. Therefore, offering equal opportunities requires the earliest intervention possible. It is common knowledge that mother's nutrition during pregnancy will impact not only the child's health in the first year, yet for the entire life. Therefore, a woman's weight prior to pregnancy is a good predictor of the child's weight at birth; a lower weight, in turn, is related to a higher risk of coronary heart disease, hypertension, and diabetes in the future life. This means that investing into policies reducing negative early effects may prove profitable not only in the present, yet in the future generations as well (Gilmore. G., 2009).

The role of the population in the system is extremely important and may reveal itself in municipal volunteers and activists involved in all the aspects of healthcare and in solving all the issues. It is becoming more and more popular to join patients in groups of self-training (with some professionals involved as well), teaching them how to make the best of their living and working with some particular chronic disease or after overcoming some dependency (alcohol, tobacco, drugs). Here we can also mention the currently popular in Russia so-called schools of people with diabetes, hypertension, asthma, osteochondrosis, osteoarthrosis, etc., anonymous alcoholics groups and so on. Involving people from the most disadvantaged groups into common work will give them a chance to become part of political processes and define measures for inequity reduction, which would allow better detection and elimination of the most relevant inequities. Based on the data analyzed we can make a preliminary conclusion that breaking the vicious circle of increasing poverty and poor health, even under scarce resources, is mostly about their mobilization in three areas: successful employment (improved conditions based on involvement that may bring satisfaction); strengthening social connections, development of a stable communication circle for people who are related and who share similar ideas; consistent and economical disease prevention, which includes a wide range of issues (proper nutrition, absence of negative behaviors, general activity, maintaining social connections, positive emotions, etc.). (Комаров Ю. М., 2010).

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