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EXPLAINING RISING MORTALITY AMONG MEN IN EASTERN EUROPE

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Abstract—Since the mid-1960s, rates of premature mortality have increased among men in all Eastern European countries, giving rise to an East–West health divide. The paper examines the existing data concerning the possible role of levels of smoking, fats consumption and/or environmental factors in explaining this phenomenon. An overview is offered of the key ways in which social experience in Eastern Europe has diverged from that in the West and it is argued that such an overview is pre-requisite for understanding the deteriorating health of men in the East. The importance of the 'incongruity' between aspirations and the means of achieving them is highlighted, as is the centrality of family-based coping strategies. It is argued that the devaluing of the public sphere and valorization of the private domain contribute to the greater health vulnerability of men under in Eastern Europe. The importance of the private sphere is reflected in the fact that the rise of premature male mortality has been overwhelmingly concentrated in the non-married population in the East European countries for which data is currently available.

Key words—mortality, Eastern Europe, health, gender, psychosocial factors, lifestyle, environment

INTRODUCTION

Over the last two or three decades, Eastern and Western Europe have come to be characterized by divergent mortality trends. Life expectancy has continued to rise in Western Europe throughout the post-war period, while in Eastern Europe it has stagnated, and even decreased, since the mid 1960s. This has led to what has been termed the "East–West public health divide" [1]. Moreover, rising mortality in Eastern Europe is a strikingly gendered phenomenon. Although the health of both men and women compare unfavourably with their Western counterparts, it is East European men, rather than women, who are dying more frequently at younger ages. So far, this systematic contrast between the two parts of Europe has defied explanation. The present paper seeks to provide a conceptual framework within which the phenomenon may be understood. It does this by addressing four fundamental questions. First, how far is it possible to identify dimensions of health relevant experience which distinguish Eastern Europe as a whole from the rest of Europe? Second, how is one to account for the fact that the divergence in mortality trends began when it did, that is to say, around the mid-1960s? Third, how is it possible to account for the fact that the Eastern European experience has affected the health of men more dramatically than the health of women? And finally, why is the gradient of change of adult male mortality in Eastern Europe in general opposed to the gradient of change of that of children and young people in those countries?

Those attempts which have been made hitherto to explain rising mortality in Eastern Europe have typically pointed to a number of factors such as smoking, diet, environmental pollution, standard of living, work-related hazards and quality of health care, which individually or severally might hold the key to the East–West divide. The paper considers how far available evidence supports the view that such factors are actually capable of accounting for diverging mortality trends in Eastern and Western Europe. The conclusion is that the probability of identifying a combination of such factors capable of providing a satisfactory answer to each of the four questions posed above is small. It seems clear from the available evidence that the specific features of the East–West health divide cannot be adequately explained in terms of 'healthiness of lifestyle', level of environmental pollution, 'absolute' standard of living, 'objective' working conditions or quality of health care. No single 'objective' health risk factor or coherent set of such factors, I argue, can be identified which would adequately account for the East–West divide. That, of course, is not to argue that they have little relevance for health. It is to say, rather, that they are incapable in themselves of providing an answer on the level of explanation which is required to address the phenomenon in hand. I argue that this is because the East–West mortality divide can *only* be fully understood when it is viewed in relative terms which make reference to a concrete social context, and for this a broader, sociological perspective is required.

Thus, rather than seek an explanation of the East–West health divide in terms of specific 'health variables' which are typically measured along a socially uncalibrated scale, the present paper attempts to identify the specific characteristics of the social context which have given rise to a particular *quality* of experience in Eastern Europe. Increasing mortality is understood as a consequence of a specific social process which developed not simply as a result of the immanent characteristics of state socialism, but rather as a result of the fact that state socialist society existed within a globalizing context which increasingly shaped aspirations which state socialism itself was unable to meet. This process may be viewed in terms of an evolving interaction between the 'objective' and 'subjective' factors which together determine the nature of everyday experience. The distinction between what is objective and subjective is conceptually an important one. It allows us to identify the crucial psychosocial dimension of the deterioration of everyday life in Eastern Europe, to recognise the importance of 'cumulated frustrations' and an increasing sense of helplessness and hopelessness under 'objective' economic and political conditions which until the 1980s at least, were not changing for the worse. However, it is also important to recognise that subjective and objective factors can in practice never be viewed in isolation from each other. Material factors do influence health in a direct way; they also prompt subjective responses and shape individual motivation and action, as a consequence of which the 'objective' world and 'objective experience' are themselves altered.

The explanatory account of rising male mortality in Eastern Europe which is put forward in the present paper has three main elements. First, it stresses the importance of a pervasive sense of relative deprivation which is defined in terms of ideas of Western 'normality'. This dissatisfaction is exacerbated by the perceived lack of scope for effective autonomous action in the public sphere. It is interesting, for example, that premature death rates among adults in Albania, the only European state socialist country to have been effectively isolated from the West, and not to have followed the 'market socialism' pattern of development, are only about half the level found elsewhere in Eastern Europe, although infant mortality and child death rates are higher there [2]. Elsewhere, the raising of the Iron Curtain and political liberalization meant that as the frame of reference for evaluating living conditions shifted from the ruination of war, the backwardness of the pre-war era and the life lived by one's parents (yielding positive comparisons) it was replaced by a picture of an ever more dynamic West (yielding negative comparisons). The growing perception of economic irrationality and the lack of the rule of law, accompanied by the state's manufacture of a sham reality, where individuals were powerless to act to improve a situation increasingly perceived as unsatisfactory—these are other important factors which lent economic frustrations a peculiarly moral, emotional and ultimately debilitating force.

Second, the paper highlights the heightened importance of the family under state socialism as the core characteristic of the 'neo-traditional' organization of social life under conditions of systemic exclusion. Although state socialist societies were industrially modern, they mimicked traditional society insofar as individuals were unable to engage reflexively with formal institutions, which were essentially fixed [3]. The way people came to creatively adapt to this form of rule also has features reminiscent of traditional society. This traditional form of adaptation to state socialism was the only way for a society to make sense of the world, to organize social life and to create 'coherence', to use Antonovsky's term, when it was prevented from articulating itself through its own formal institutions. Neo-traditionalism is essentially oriented towards self-protection and survival, towards 'keeping going' within an essentially alien institutional environment. The significance of the family is reflected in the fact that marriage rates were universally higher in Eastern Europe than in the West. Importantly, there is now evidence from a number of Eastern European countries showing that the post-war rise in adult male mortality has been largely confined to the non-married population.

Finally, the paper points to the way in which neo-traditionalism, even though it was oriented to survival, in a sense also contributed to the 'hidden injuries' of state socialism. First, in valorizing 'insider' status in the public sphere (do you belong to my family, my informal network?), by the same token this form of cultural adaptation also increased the negative significance of 'outsider' status. Thus 'ordinary people' actively contributed to the alienation which they themselves experienced in the public sphere. Secondly, this form of cultural adaptation entrenched a fixed and traditional notion of masculine identity in a political and economic context which thwarted traditional masculinity by precluding autonomous activity outside the private sphere. Similar objective conditions of work and public life did not wound women in the same way. That is because traditional gender identity tended to value the qualities of a good subordinate in a woman, but the qualities of a boss or a highly skilled worker in a man, as has been demonstrated in Poland [4]. At the same time it is the competent and resourceful execution of the traditional feminine family-oriented role (at home and at work), the 'successful coping' of women, which has been central to neo-traditional survival strategies under state socialism.

MORTALITY TRENDS IN EASTERN AND WESTERN EUROPE 1970–1990

During the first 20 years following the end of the Second World War, mortality rates fell across the

board in Eastern Europe (as indeed they did in Western Europe), a decline which, for men, stopped in the 1960s. By 1970, adult male mortality rates in Eastern Europe as a whole were not yet inevitably higher than Western European rates (see Fig. 1). For example, the mortality rates of Bulgarian men were exceeded in that year by as many as 13 of the Western European countries considered. Male mortality rates in West Germany were higher than those in East Germany. However, as Fig. 1 shows, between 1970 and 1990 Eastern and Western Europe were characterized by opposing trends in adult male mortality. While all Western European countries showed reduced mortality rates for men, all of the Eastern European countries showed increasing mortality rates for men. The exception is Yugoslavia (not a member of the Soviet Bloc) which showed a minimal decline in adult male mortality. The net effect of these opposing gradients of change has been that mortality rates for men were uniformly higher in 1990 in the ex-Soviet Bloc than in the rest of Europe, with Hungary showing the greatest increase and highest rate in this regard. This pattern of change exhibited by East European men is not shared by East European women. With the exception of Hungary, where mortality rates for women showed an 11% increase (as opposed to a 57% increase in the case of men) women's mortality rates improved in both parts of Europe between 1970 and 1990 (see Fig. 2). Although the degree of improvement was generally less than in the West, women's death rates in Eastern Europe were not inevitably higher than those in Western European countries in 1990. For example, women's death rates in Scotland and Denmark were higher than in a number of East European countries. The differential mortality trends for men and women in Eastern Europe is encapsulated by the German

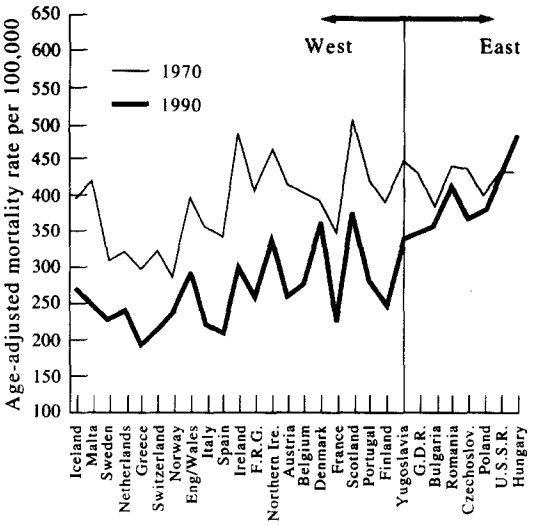

Fig. 2. Female mortality rates in Europe (1970 and 1990, 25–64 years). Source: *World Health Statistics Annuals.* Standardized with respect to total female population aged 25–64 years in 28 European countries.

experience. Before Germany was split into East and West, the mortality differentials between men and women in the East and the West were comparable. By the time Germany was reunified in 1990, the mortality differential between women and men was significantly larger in the G.D.R. than in the F.R.G. [5]. Neither is the Eastern European mortality trend for adult men shared by children and young people of either sex. Figures 3 and 4 show that death rates for males and females aged 1–24 years continued to fall between 1970 and 1990, as they did in the West.

This improvement is particularly noticeable in Czechoslovakia, and to a lesser extent in Poland and

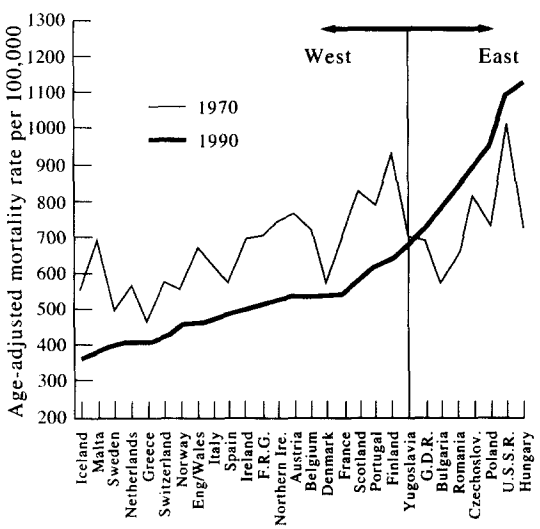

Fig. 1. Male mortality rates in Europe (1970 and 1990, 25–64 years). Source: *World Health Statistics Annuals.* Standardized with respect to total male population aged 25–64 years in 28 European countries.

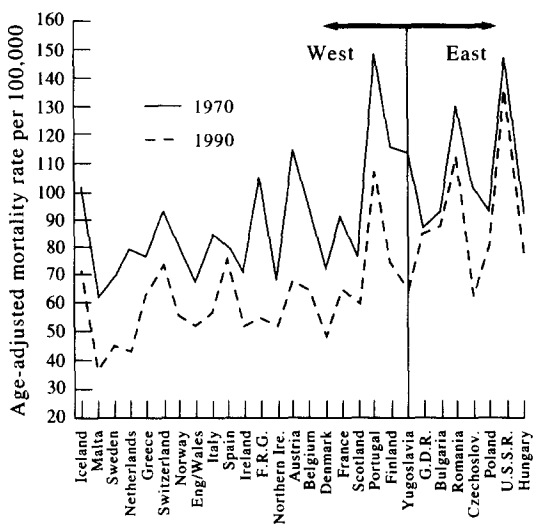

Fig. 3. Male mortality rates in Europe (1970 and 1990, 1–14 years). Source: *World Health Statistics Annuals.* Standardized with respect to total male population aged 1–24 years in 28 European countries.

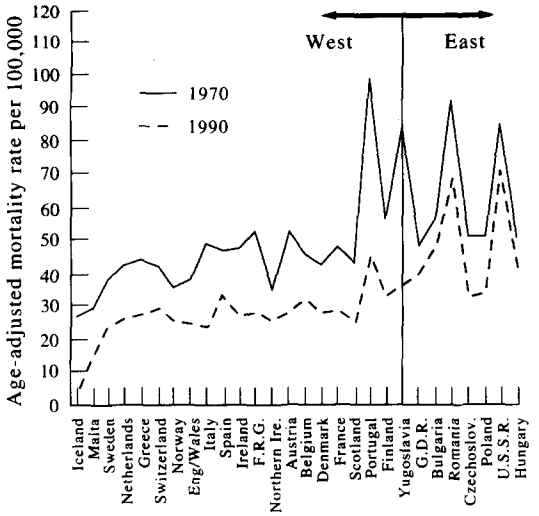

Fig. 4. Female mortality rates in Europe (1970 and 1990, 1–24 years). Source: *World Health Statistics Annuals*. Standardized with respect to total female population aged 1–24 years in 28 European countries.

Rumania also. This pattern suggests that, in line with rising standards of living, there has been a general improvement in Eastern European health, to which the adult male mortality pattern stands in stark contradiction. Apart from a period during the 1970s in the U.S.S.R., infant mortality rates have also generally fallen, while Polish evidence on trends in the height of young adults, a sensitive indicator of socioeconomic conditions, shows that it increased rapidly during the period of study (1955–1978), and while social disparities in height did not decrease during this period, neither did they increase [6].

CAUSES OF DEATH

In general, the mortality increase among Eastern European men can be accounted for by increases in deaths due to a number of causes. A rise in deaths due to circulatory diseases [7, 8] and cancers account for a significant part of this mortality increase. But notable increases have also been observed in deaths due to a number of other causes. For example, in a study of mortality change in Hungary between 1966 and 1980, Compton has shown that the age specific death rate due to circulatory disease rose by 30% during this period, accounting for about 56% of the total observed mortality increase among men [9]. Mortality due to cancer rose by 23% and explained about 20% of the mortality increase among men. Deaths due to respiratory disease almost doubled and accounted for about 20% of the mortality increase among men between 1966 and 1980. Mortality due to injuries and poisonings rose by almost 50%, and contributed about 18% to the total mortality increase for men, while disease of the digestive system rose by just over 60%, and contributed about 18% of the total mortality increase. In the case of Hungarian women, the two causes of death showing any substantial mortality increase during the same period were diseases of the respiratory system (a rise of 55%), and injuries and poisonings (a 41% increase) [9] (p. 79, Table 4).

For Poland, Kaczorowski has analysed the 18 most frequent causes of deaths among Polish men in an attempt to establish those causes for which mortality increase had been greatest and most consistent over the period 1960–1989 [10]. This group of causes included artherosclerosis, chronic inflammation of the bronchus, some cancers, including cancer of the lung and bronchus, ischaemic heart disease, cirrhosis of the liver and vehicle accidents. The rate of increase varied from a factor of 2.5 in the case of ischaemic heart diseases to a factor of 30 in the case of chronic inflammation of the bronchus. This latter increase was mainly observed in older age groups; for example, over the entire period 1960–1989 a 15-fold increase in mortality was observed among men in the 50–54 year age group. In older age groups, the increase was still higher. In the case of ischaemic heart disease, the increases affected men from the age of 25 onwards. Between 1965 and 1989, the mortality rate for this cause increased by 250% in the 25–29 year age group, and by 358% in the 45–49 year age group [10] (p. 74).

For the former U.S.S.R., mortality increases between 1970 and 1990 were evident in the case of diseases of the circulatory system (men over 35, and to a much lesser extent women over 45) and cancers (men, and to a lesser extent women, over 45). The less prominent causes of death where mortality increased during this period included accidents and adverse effects, bronchitis, emphysema and asthma and diabetes [11].

'LIFESTYLE FACTORS' AS AN EXPLANATION OF THE EAST–WEST DIVIDE

Attempts to account for the different mortality trends in Eastern and Western Europe have quite commonly made reference to the role of 'lifestyle' factors in this regard. For example, the World Bank has stated in a recent report that differences "in lifestyle and harmful health practices—such as unhealthy eating habits, smoking, excessive drinking, a sedentary way of life, and to some extent accidental injury and deaths—are (...) responsible for this remarkable divergence between Eastern and Western Europe" [12]. Similar points have also been made by Feachem [13]. In a recent article on the poor health status of the Czechoslovak population, Janeckova and Hnilicova [14] claim that the situation "is above all due to the critical ecological situation and persistent stereotypes of unhealthy lifestyles". Finally, Murray and Chen [15] quote Eberhardt as attributing the rise in adult male mortality in Eastern Europe to "enormous increases in smoking and other cardiovascular risk factors".

However, the popularity of such views is belied by the empirical evidence. First, there are general weaknesses in the scientific evidence, particularly in the case of animal fats, linking level of consumption to length of life (see Refs [16, 17]). Secondly, the risk factor approach cannot address the question of the timing of mortality changes in Eastern Europe, when smoking levels, for example, were still quite low [17]. Thirdly, the existing data do not actually support the view that East Europeans universally eat more animal fats, smoke more cigarettes or drink more alcohol than their Western European counterparts. They may well eat, smoke and drink more than is good for their health—the point is that they do not seem to be unique in this respect.

Statistical data for 1986–88 show that the average level of cigarette and alcohol consumption was actually lower in Eastern Europe than in OECD countries [12]. These figures show that Poland has the highest level of cigarette consumption among East European countries, but that the highest level of consumption in Europe as a whole is in Greece. Hungary comes a close second to Poland among East European countries for smoking, but has the same level of cigarette consumption as Japan, a country noted—in contrast to Hungary—for the longevity of its inhabitants. The difficulty in properly accounting for mortality solely in terms of smoking levels has also emerged in a recent study by Peto *et al.* [18] where it was noted that "smoking appears to be even more dangerous in Eastern Europe than elsewhere". Analogous findings concerning variations in the dose–response relationship for cigarette consumption and cardiovascular mortality and lung cancer (in a number of countries outside Eastern Europe) have led Hertzman [17] to conclude that "it might be expected that the dose-response relationship between cigarette smoking and both lung cancer and cardiovascular mortality would be much steeper in the East than the West because of factors related to those societies as a whole, and not attributable to cigarette smoking per se" (Annex 1, p. 19). The findings of the World Health Organisation's 'MONICA project', a study which compared smoking levels and other cardiovascular risk factors in a number of sites in Western and Eastern Europe in the 1980s, showed generally high levels of smoking in Eastern Europe, although there was no clear dichotomy between East and West in this regard [19].

The MONICA study significantly failed to show a correlation between cardiovascular mortality and level of blood cholesterol and blood pressure in the East European centres, again leading to the conclusion that the data "do not support a view that the East–West life expectancy gap can be accounted for primarily by differences in diet, obesity, or lack of blood pressure control" [17]. Dietary evidence shows that although the consumption of fats has been rising in Eastern Europe, this is also true of other European countries. Moreover, figures for 1989 show that Eastern European countries were still either well below or very close to the European average (where fats account for 34.3% calorific intake) in this regard [20]. European leaders in the consumption of fats were Belgium (47.3%), Luxembourg (45.5%), Denmark (45.3%), Switzerland (42.5%) and France (41.4%) (ibid.). In fact, the highest level of fats consumption in Eastern Europe is found in East Germany, where they account for 35.1% of calorific intake—still 3.3 percentage points less than in West Germany [20]. It is true that these figures do not differentiate between types of fat consumed. However, a recent German study has provided further and more detailed evidence of slightly 'healthier' eating habits among East Germans than among West Germans [21]. On the basis of the data cited by the World Bank and Wojtyniak and Kopczyński, then, it emerges that the Romanians smoke less, drink much less and eat less fat than the French, the Czechs smoke the same amount, drink much less and eat much less fat than the Belgians, while the East Germans smoke fewer cigarettes, drink about the same amount of alcohol and eat less fat than West Germans. Thus the difficulty of accounting for increasing male mortality in Eastern Europe in terms of these behavioural risk factors is if anything even greater than difficulties which are encountered in trying to explain class differences in health in the West. In fact, it is the very hopelessness of such an endeavour in the East European context which has led one recent commentator to wryly observe that: "it is difficult to establish any causal relationship between Stalinism and high chloresterol levels" [22].

ENVIRONMENTAL FACTORS AS AN EXPLANATION OF RISING MALE MORTALITY IN EASTERN EUROPE

What then of environmental factors? How adequately can the 'environmental crisis in Central Europe' [23] account for the East–West mortality divide? The answer is 'not very', for again, it is by no means the case that the 'environmental crisis' is exclusively an Eastern European one. Eastern European countries have had lower levels of nitrogen oxide (of which vehicle emissions are a major source) than Western Europe, although they tend to have relatively high levels of sulphur dioxide (from coal-burning) [23–25, 17]. Rates of sulphur dioxide deposition have not, however, been inevitably higher in Eastern Europe. For example, figures for 1982–1983 show that while Czechoslovakia and East Germany both had higher rates than West Germany (22.6, 35.0 and 14.5 tons per km^2, respectively), the rate for Poland (12.0 tons) was lower [23]. More recently, a joint survey carried out in 1992 by the EC and the UN Economic Commission found that although several East European had a relatively high proportion of damaged trees as a result of poor air quality, many, including Hungary, did not. The

highest levels of tree damage were in fact found in Britain [26].

Hertzman [17] has pointed to the fact that Eastern European countries who have environmental 'hotspots', such as Poland or Czechoslovakia share high mortality rates with those, such as the Baltic countries, which do not. Other evidence suggests that regions which suffer particularly high levels of environmental pollution do not necessarily have the highest mortality rates in a given country. Some areas of Slovakia have low life expectancy despite relatively favourable air quality, while in the Czech Republic, East Bohemia has relatively good life expectancy in spite of poor air quality [17]. In Poland, it is clear that the government's four non-marine 'ecological disaster' regions indicated by the World Bank [12]: namely Katowice, Kraków, Legnica-Głogów and the Elbląg voivodeship, do not necessarily have higher mortality rates than other regions in Poland. For example, although the standardised all-cause mortality rate for urban areas in the Katowice voivodeship is very high, standing at 1153 per 100,000 in 1991, this rate was exceeded in the rural areas of the Szczecin (1165), Piła (1161) and Koszalin (1176) voivodeships—all non-disaster areas [27]. Furthermore, in 1991 the urban area of Kraków had a standardized all-cause morality rate which was lower than the national average for urban areas, and also lower than the rural areas in the same voivodeship. The Polish figures also show that the age-specific mortality of men aged 35–65 increased more rapidly in rural areas than in urban areas during the period 1970–1988 [4] (p. 112, Table 3). A separate study carried out by Andryszek [28] has attempted to relate level of environmental pollution to mortality rate in Poland. This study rated classified voivodeships in terms of a composite measure of pollution based on level of industrial and communal effluent, air pollution, cumulated industrial waste, soil quality and tree damage, and compared this rating with the age-standardized mortality rate in each voivodeship. The study found that seven of the high-mortality (990–1066 deaths/100,000) voivodeships had also been rated as 'ecologically threatened', but three further high mortality voivodeships had been rated 'unpolluted'. Low-mortality (855–906 deaths/100,000) voivodeships were generally unpolluted, although there were counter-examples here too, notably the Kielce voivodeship which was rated as being under ecological threat, yet whose mortality rate was low. Again, in the Kraków voivodeship which rated second to Silesia in terms of pollution risk, and where 89% of the population were estimated to be living under such conditions of risk, mortality levels were in the second lowest category (906–942 deaths/100,000).

Any association between mortality and level of pollution is likely to be confounded by high levels of manual employment and high levels of divorce in polluted urban areas. A related study carried out by Andryszek and Dziankowska [29] found that the voivodeships ascertained to have high levels of pollution were also characterized by high levels of divorce. Although no attempt was made to correlate mortality levels with divorce rate in this study, in fact there was a more consistent association between these two variables than between mortality and pollution, with high divorce areas with one exception (the Piła voivodeship) also being high mortality areas.

Taking gender into account makes an environmental explanation of the East–West health divide even more difficult to sustain. Evidence from the rural areas of the U.S.S.R. and Poland, where health is less likely to be damaged by pollution, shows that the gender gap in health is even greater there than it is in towns (for the U.S.S.R. see Ref. [30]; for Poland see Ref. [20]). This cannot be accounted for in Poland in terms of the prevalence of the peasant worker household in some rural areas, whereby men have combined paid industrial employment with work on the smallholding: Polish mortality figures show that male mortality is also high in rural areas with state farms, and that gender differences are also greater in these rural areas than in the regional towns.

The fact that post-war mortality trends for adult men and women have diverged, and have diverged in both rural and urban areas in Poland and the U.S.S.R. at least, militates against an explanation of the East–West health divide in terms of a range of other factors too. These include objective work experience, occupational hazards, quality of health services and objective level of wealth. Further evidence against objective work-related factors as a significant determinant of the East–West mortality divide comes from Lódź. Until recently this town had a large and unmodernized textile industry and a large female proletariat working in very poor conditions. Mortality rates in this town are high for both women and men, but here too, the differential between the sexes is maintained.

THE WIDER CONTEXT

It is not strictly true to say that the health crisis in Eastern Europe is wholly contained within the logic of the socialist vision itself, as has been recently suggested [31]. Rather, I would suggest that it is the outcome of socialism's ultimately (unsuccessful) struggle to modernize in an increasingly global context. It is significant, for example, that in Albania, the only Eastern European socialist country to be effectively sealed off from the West during the post-war period, the mortality rates for adults aged 40–59 years was 3.81 per 1000 in 1989, substantially less than in all other Eastern European countries where the corresponding rate varied from 6.68 (Czech Republic) to 9.67 (Hungary), and only about half that of its Southern neighbour, Bulgaria [2] (p. 88). Furthermore, although mortality rates were lower for

adults in Albania, they were noticeably higher for infants and children.

Nor did mortality rates rise systematically throughout the period of socialist rule in Eastern Europe; on the contrary, they fell during the first twenty years of this period, primarily, but not exclusively, due to a reduction of deaths due to infectious diseases. In Poland, for example, the 1950s saw a significant drop in deaths due to heart disease among men of all ages, a trend which was reversed in the 1960s [32]. This fall in heart disease took place in spite of the fact that Stalinist modernization had involved rapid social change—the extensive mobilization of labour power for heavy industry, hard manual work in poor conditions for little pay and the threat of physical repression. The period compared favourably in a number of respects, however, with what came before and after. Where the 1950s had been a period of dynamic economic growth, in the 1960s there was an atmosphere of "nothing happening" [33]. In the Stalinist period entire populations were mobilized to achieve national goals; large-scale social mobility, universal education and health care contributed to a (relatively) inclusive sense of social advancement. The modernization of the 1950s, however, itself played a role in reshaping individual goals. From the 1960s onwards this individualized, consumption-oriented and more family-centred way of living increasingly came to be modelled on an ever more visible West, while at the same time the socialist economies had lost dynamism and were not able to meet the new Western-style aspirations in a responsive and effective way. Eventually external standards adopted from what could be seen of the West, came to be the main criterion for self-evaluation. The daily frustrations caused by this mismatch or 'incongruity' between aspirations and economic performance were, moreover, fused with deep political resentment and a sense of helplessness.

THE HIDDEN INJURIES OF STATE SOCIALISM

The Stalinist period had according to Narojek [34] been clearly characterized, at least in Poland, by a climate of psychological ambivalence. This was because state propaganda set out its intention with regard to social transformation, at the same time making clear the boundaries which it did not intend to cross. As the transformation petered out, ambivalence went with it. Economic frustrations *were* now political frustrations, not only because the public perceived the political sphere both as the basic mechanism for the distribution of all economic goods and the source of prosperity [35], but also because the experience of economic problems was infused with a sense of political injustice and moral outrage. "Even the minor irritations of everyday life under socialism were highlighted against a gloomy background of hopelessness" [34, p. 99]. It is the particular *way* objective conditions were perceived, the social construction of that perception, which is important for understanding rising mortality in Eastern Europe, for such perceptions constitute a kind of relative deprivation (*cf* Ref. [36]). As Runciman [37] has pointed out, the extent of such subjectively experienced deprivation—relative deprivation—does not stand in a direct and immutable relation with objective inequalities. It must be established empirically and sociologically.

In many ways the burdens of state socialism are like the "hidden injuries of class" eloquently described by Sennett and Cobb [38] "the feeling of not getting anywhere despite one's efforts, the feeling of vulnerability in contrasting oneself to others at a higher social level (read: the *nomenklatura*, the West—P.W.), the buried sense of inadequacy that one resents oneself for feeling". There is a sense of this burden, and the injurious emotions associated with it, in the responses of the DiP discussion group which reported shortly before the emergence of Solidarity:

> Polish society seems to be experiencing a state of extreme exhaustion, the result primarily of economic stagnation in which prospects for advancement and prompt improvement in the material situation have become non-existent, and frustration is deep ... The lack of social energy has been noticeable for some time ... Hostility between groups and classes is growing [39].

What made economic/political frustrations all the more potent in Eastern Europe was the fact that people could do little to remove their perceived causes. The system, based as it was on comprehensive exclusion, precluded autonomous non-state activity in the public sphere:

> the state monopoly of the basic institutions of public life deprived the individual of the opportunity of changing a situation which he or she did not accept and of substituting another. The lack of such organisations as free trade unions and the frequent violations of the rule of law meant that people saw their situation very clearly as being one from which there was no way out, and where there was no way of defending themselves from possible threats. This sense of being locked in was aggravated by an inability to control events at grass-roots level, a lack of self-management and the blocking of spontaneous activity both within and outside the enterprise [40].

There is some evidence that the "cumulated frustrations" which derived from living in state socialism and in a globalizing world, had important emotional and motivational consequences, and that these had implications for health. Take, for example the universality of the 'divided self' in Eastern Europe—another parallel with the 'hidden injuries' of class. This phenomenon refers to a split between the real self and the performing individual, and occurs because "people who are subjected to the power of others, and who feel their dignity compromised by that limitation of freedom, have a tremendous fear of exposing themselves" [38].

> The divided self is like most other kinds of conscious defenses human beings erect for themselves; it stills the pain

in the short run but it does not remove the conditions that made a defense necessary in the first place. If the defense fails finally to make men happy, or even reconciled, the failure is at worst a sign ... that despite an extraordinarily subtle rebalancing of their feelings they cannot escape the influence of a destructive social order [38].

Throughout Eastern Europe, hostility and vulnerability expressed itself in high levels of social intolerance (for comparative indices of social intolerance in Eastern and Western Europe see Ref. [41]). In Poland these emotions were expressed in high levels of authoritarianism [40] and, for example, in attacks against people with HIV in that country [42]. Further evidence of the psychological climate is provided by the changes in behaviour which took place during 1980–1981, the time of the Solidarity breakthrough. Figure 5 shows how suicide rates for middle-aged men plummeted in Poland in 1981 (and again to a lesser extent in 1989, the year of the first free elections in Eastern Europe). At the same time, the consumption of alcohol (as reflected in numbers of cases of alcohol-induced psychosis) fell significantly, while there was a sharp rise in the non-traditional use of recreational drugs [43]. These changes were correlated with sudden rises in measures of social optimism. In July 1980, just before the emergence of Solidarity, only 21% of Poles were 'optimists' in that they expected some kind of material improvement in their lives; after the signing of the Agreements in September 1980, this proportion rose to 70%, although it fell back to 47% in October [44]. In the light of this it is conceivable, perhaps, that the mortality decline seen in the U.S.S.R. during the period 1985–86/87—contradicting the trend since the mid-1960s—had something to do with the fact that this was also a period which saw new, and briefly sustained, hope and a 'tremendous release of tension' with coming to power of Gorbachev and the introduction of *glastnost* [45]. Certainly suicides fell sharply between 1985 and 1986 in the U.S.S.R., as they had done in Poland a few years earlier, remaining lower in 1991 than they had been in the first half of the 1980s [46].

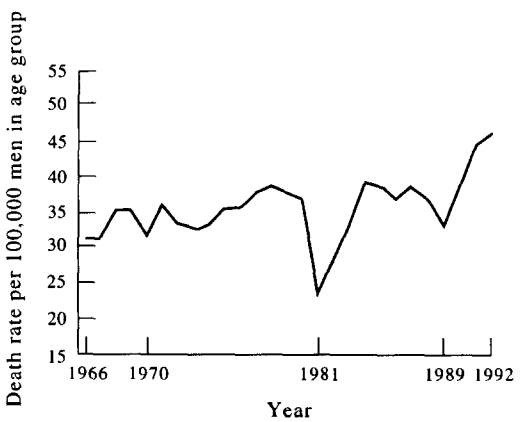

Fig. 5. Suicide in Poland: men aged 45–54. Source: *World Health Statistics Annuals* and *Polish Central Statistical Agency*.

The difficulties in being able to live what was regarded as a 'normal' life in Eastern Europe did not simply entail negative emotional consequences, important though these undoubtedly were. 'Normal' aspirations, crucially shaped through messages from the West, informed action and thus surely influenced health in 'objective' ways too—take, for example, the tiring 2 hr queue for a deodorant. Survival in Eastern Europe, then, did not simply mean keeping body and soul together, for basic shelter and basic foodstuffs were not at issue. Survival meant expending a great deal of physical and mental energy patching together a 'normal' existence, and never wholly succeeding in doing so.

NEO-TRADITIONALISM: SOCIAL ADAPTATION TO SYSTEMIC EXCLUSION

Insofar as state socialism was based on the systemic exclusion of individuals from the public life of society, it resembled the fixed institutional framework of traditional life. Indeed, it is interesting to note how political and economic changes were experienced as something depending on the whim of the Gods—the lack of goods in the shops has been compared, for example, to the poor harvests of traditional society [34]. The DiP report expresses a similar idea as follows:

The Polish citizen experiences the meanderings of politics and planning more or less as he or she experiences changes in the weather, that is, as important changes to which one has to adapt, but whose causes, which are wholly external, it is not worth trying to fathom since there is no way it is possible to influence them [39].

Research carried out in 1984 by Titkow [44] found that as many as 75% of respondents were convinced that the effects of their actions were subject to forces outside their personal control. It is for these reasons that the concept of 'learned helplessness' has found such an echo in Polish writings (see, for example, Refs [47, 48, 34, 44]). It is precisely the context of exclusion and powerlessness which explains the contrast between the survival-oriented attitude of "I won't give in—whatever happens" (*Ja i tak się nie dam*) [49]—the defiant voice of the embattled victim, with the "I will overcome" attitude which Antonovsky [50] identifies as the essence of the salutogenic sense of coherence.

The neo-traditional exclusion of state socialist rule, brilliantly analysed by Jowitt [51], itself perpetuates a neo-traditional (counter)culture, shaping perception and motivation in a fundamental and enduring way. Thus the family and household became of crucial importance in making a life and assuring survival, given the problems of supply and the low level of institutional responsiveness to needs which were not predefined by the state. In Eastern Europe it was marriage itself which offered the golden key to coping

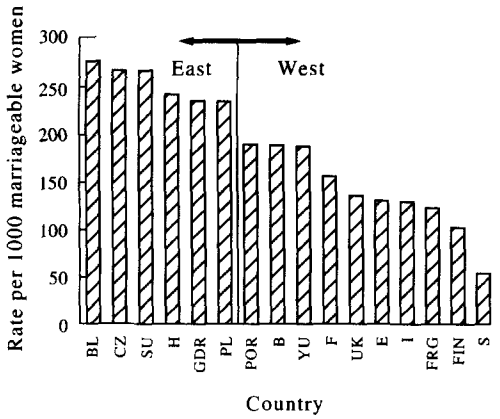

Fig. 6. Marriage in Eastern and Western Europe: women aged 20–24 years (*ca* 1980). Source: *UN Demographic Yearbook*, 1990.

with life (rather than, as has been noted for the West, the job providing the golden key for marriage [52]). Marriage data confirm this view and provide evidence of an East–West 'nuptuality divide'. This is illustrated, for example, by the fact that, although East and West share a long-term decline in marriage rates, all Eastern European countries have shown a consistently higher, 'neo-traditional' rate of marriage among marriageable people aged 20–24 than in the rest of Europe as is shown in Fig. 6. The contrast with Southern Europe is of particular significance because traditionally, Eastern and Southern Europe shared a pattern of early marriage [53].

The *modus vivendi* which developed between state and society in Eastern Europe in the 1960s and culminated in a range of pro-family policies in the early 1970s was one whereby state authorities accepted the primacy of family life (and the partial subversion of public roles to this end) while society did not fundamentally challenge state socialist rule. In fact, the family became the *modus vivendi* in a very literal sense in Eastern Europe, since there are consistent data which indicate that increasing mortality has been in the main confined to the non-married population. For example, the death rates of married and divorced men in Poland developed quite differently between 1970 and 1988 (see Fig. 7). During this period, mortality rates for divorced men rose dramatically for all age groups—for men in their early sixties, there was an almost 3-fold increase in mortality rate (but more than a 6-fold increase in number of deaths, due to the increase in divorce). For married men aged 20–44 years, on the other hand, mortality rates fell. For married men aged 45–64 years they rose, but much more modestly than in the case of divorced men (8% among men in their early sixties). In the case of women (Fig. 8), there was also an increase in death rates for divorced women of all ages, accompanied by a decline in death rates for married women. In sum, then, it is clear that all of the rise in premature male mortality among men up to 45 years of age and a disproportionate amount of that among men over 45, can be accounted for by a rise in the proportion of the population who are non-married and by a rise in the death rates in all these groups, especially among the divorced. Mortality rises among divorced (and to a lesser extent among widowed) women are counterbalanced by a fall among all married and single women. Figures presented by Gärtner [5] similarly show that in East Germany in 1989, mortality for married men in all age groups was actually lower than it had been in 1980. The same was not true for non-married men. For Hungary, it has been shown that practically the entire rise in death rates among adult men between 1982 and 1990 was among the non-married, with the highest rates being among the divorced but the greatest rate of increase among the widowed. Death rates among married Hungarian men remained almost constant during the same period [54]. Selection effects are unlikely to be responsible for much of this pattern. For Hungary, Hajdu *et al.* quote Hu

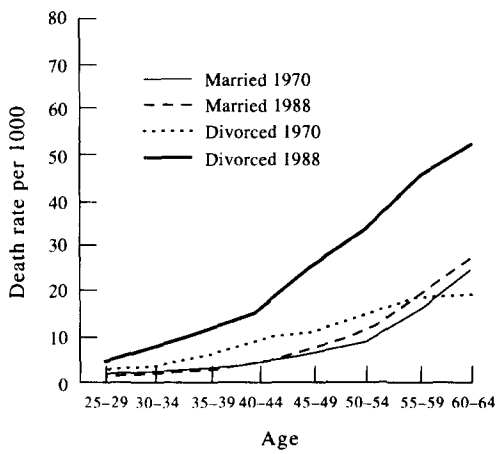

Fig. 7. Mortality change among married and divorced men. Poland: 1970 and 1988. Source: *Polish Central Statistical Agency*.

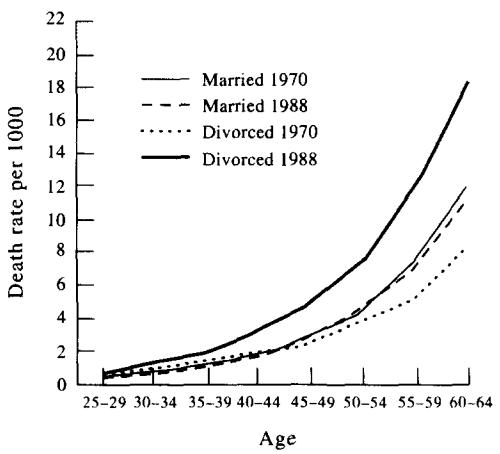

Fig. 8. Mortality change among married and divorced women. Poland: 1970 and 1988. Source: *Polish Central Statistical Agency*.

and Goldman who found evidence of selection for a number of Western countries, but not for Hungary (or Scandinavia) [54]. Furthermore, the class distribution of divorcing couples may not be the same as in the West. In Poland the divorce rate has been consistently about twice as high among people with higher education as among those with only primary education [55], contrary to the pattern in the U.K. Further evidence of the heightened importance of family status for health in Eastern Europe comes from a Polish study which found that non-married status and marital problems were the two factors where the relative risk of premature mortality diverged most among 'exposed' men on the one hand, and 'exposed' women on the other [56].

THE VULNERABILITY OF MEN UNDER STATE SOCIALISM

'Keeping going' in Eastern Europe thus meant (and often still means) keeping the family going, where this depends crucially on the paid and unpaid work of women. It is 'learned resourcefulness', then, rather than 'learned helplessness' or 'passivity' that has generally applied to women in the pursuance of family-oriented goals. The multiple burdens of women reflected in time-budget studies are not wholly negative in effect; in line with Western findings, Polish research shows that women who combine domestic responsibilities with paid work experience less stress than women who either have no family responsibilities or are not employed [57]. Despite the physical demands it makes, a woman's family role under state socialism (given that she was also employed) was also a resource and a way of creating meaning; it was *the* way of coping. In the words of a Polish clerical worker interviewed in 1993, "If I'm upset when I come home, I do a washing—a hand-washing you know. But what can a man do? He can just sit there".

However, in a state-controlled public sphere which precludes individual initiative and is often perceived to be the site of 'senseless' activity, the opportunities for realising traditional masculinity are strictly limited. Indeed research has shown that men more frequently miss a meaningful role at work—the opportunity to show initiative and demonstrate their ability, while women feel they have a meaningful role (in the family) for which they do not have enough time given that they are also employed [58]. For men under state socialism, then, one might say that there is a specific 'incongruity' between gender expectation and outcome. State socialism thus fosters a pattern of fixed coping strategies based on a traditional gender identity which is (within limits) adaptive for women and their families, but ultimately maladaptive for men as men.

DISCUSSION

Any persistent analysis of the East–West health divide is, I think, bound sooner or later to oblige us to confront the extent to which health is a social phenomenon which cannot be properly understood purely in terms of socially-abstract 'health variables'. For as the evidence considered here indicates, however many of these variables are taken into consideration in comparing East with West, they do not add up to the explanation we are looking for.

What I have attempted to do in this paper is to indicate a number of dimensions where social experience in the two parts of Europe has radically diverged during the post-war period, and to show the way in which the specific nature of the East European experience might be linked to what could be termed the 'neo-traditional' pattern of health transition which has been observed there. The framework which I have put forward stresses the importance of psychosocial factors for declining health among East European men. In very general terms, this framework rests on the notion of social exclusion, and the neo-traditional forms of adaptation to which such exclusion gives rise. The article points to the frustrations of state socialism as likely to be important influences on health, and has indicated the way in which these frustrations are likely to be greater for men than women. It points to the effort which has gone into making a 'normal' life, the way this effort has been centred on the household and has made use of informal ties to get round an unresponsive institutional system. In a context of economic and political dissatisfaction, institutional exclusion, and the need to 'do something', it was the family which defined the scope of what could be done, and the way it could be done. The Polish data in particular show that men have been more vulnerable than women in Eastern Europe regardless of marital status, but equally, rising premature mortality among men has been overwhelmingly concentrated in the (increasing) non-married section of the population.

A comparison of Eastern and Western Europe also underlines the social nature of health by demonstrating the limitations of viewing 'individual' and 'social' factors as mutually exclusive determinants of health. It is no accident that the idea of 'lifestyle' had no currency in Eastern Europe, or that Eastern European doctors, despite the knowledge available to them, did not until the end of the 1980s begin to attempt to modify their smoking behaviour, for example [7]. The 'individual lifestyle' is a quintessentially social phenomenon associated with a particular set of historical changes, as Giddens makes clear:

> In modern social life, the notion of lifestyle takes on a particular significance. The more tradition loses its hold . . . the more individuals are forced to negotiate lifestyle choices among a diversity of options . . . Because of the openness of social life today, the pluralisation of contexts of action and the diversity of 'authorities', lifestyle choice is increasingly

important in the constitution of self-identity and daily activity. [59].

However, under state socialism, as I have argued, tradition in some ways was not losing hold, but on the contrary was becoming further entrenched. Coping strategies were fixed and family based, and the options which are the prerequisite of 'life-planning' or lifestyle choices, of creating 'A New Stage, A New Life' [60], were all—bar emigration— unavailable. Everyday life in Eastern Europe was overwhelmingly encased in the present [33]. If the future was 'colonized' at all, then it was in terms of lifecycle, rather than lifestyle. Choices made at the level of the individual were socially structured by the resources and options available, and the perceptual frameworks to which such arrangements gave rise. These choices were oriented towards making the best of life as it presented itself, rather than devising the kind of life one wished to have. The orientation towards 'keeping going' is focused on difficulties experienced in the present, and implies traditional attitudes to health maintenance within the family (regular hot meals; wrapping up warmly), where the family is the primary resource. As such this orientation has implications for perceptions of, and attitudes to, risk—with little time, energy or facility for the optimization of a hypothetical future.

Even after the end of state socialism, mortality rates in Eastern Europe have continued to rise dramatically. It has not been the aim of this paper to focus on these latest developments. However, it is possible to point to a number of factors which may be contributing to this phenomenon. These include, firstly, falling absolute standards of living for many, coupled with a ubiquitous increase in the scale of social inequalities. Secondly, there is reduced scope for family coping, given the fall in incomes and the reduced extent to which jobs may be used for household advantage. Thirdly, there is a resurgent sense of helplessness and disenfranchisement, embodied in an apparent disillusionment with politicians and the political process. Finally, there is a much higher level of insecurity and uncertainty connected with the widespread rise of unemployment and the limited nature of income support schemes. In the context of an undeveloped civil society in Eastern Europe, unemployment there is likely to be more damaging to health than we already know it to be in the West.

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