

Chapter 13

Conclusion

France Meslé and Jacques Vallin

Over the course of the twentieth century, Ukraine was confronted with two very different types of major health crises. Firstly, in the 1930s and 1940s it experienced very heavy losses as a result of famine, war and political turmoil. The immediate consequences of these appalling setbacks were so severe that life expectancy at birth in some years fell to unimaginably low levels: in 1933, at the height of the Great Famine, 11 years for females and just 7 years for males. Yet, each time, these large-scale crises remained very circumstantial in nature, like those of the more remote past. Once the crisis had ended, health trends followed their previous course again and, in the twentieth century, mortality declined steeply. In contrast, from the mid-1960s onwards, a new type of crisis arose, bringing a lasting reversal of past trends: the increase in life expectancy for females came to a complete halt, and male life expectancy declined strongly year on year.

As we have seen, the major fluctuations of the 1980s and 1990s were merely additional manifestations around this new, generally unfavourable trend, since they were entirely due firstly to the anti-alcohol campaign and then to the abrupt transition to a market economy. On the other hand, the new reduction in life expectancy noted over the very last years of the century indicates that – despite the confusion resulting from these fluctuations – the long-term trend remains a deteriorating one.

Our cause-of-death analysis in the third part of the book amply demonstrates the dominant role played in this long-term deterioration by alcoholism, diseases of the circulatory system and deaths from injury and poisoning. In reality, Ukraine, like the other countries of the former USSR, has been as yet incapable of moving beyond control of infectious diseases. As far as the latter are concerned, in three decades Ukraine succeeded in completely catching up with Northern Europe and Western

F. Meslé (✉) • J. Vallin

Institut National d'Études Démographiques, Bd. Davout 133, 75980 Paris Cedex 20, France
e-mail: mesle@ined.fr; vallin@ined.fr

Europe, which it had lagged behind since the beginning of the century; in doing so, it was following exactly the epidemiologic transition pattern put forward by Abdel Omran (1971). But from the mid-1960s, it seems to have continued to conform to this pattern, whereas Western countries were contradicting Omran's theory. At the end of the 1960s, he thought that health improvements would hit two major barriers. Firstly, the dramatic fall in infectious diseases placed degenerative diseases (mainly cancer and diseases of the circulatory system) squarely in the foreground, and any reduction in these in the near future seemed improbable. Secondly, a certain number of perverse effects resulted from economic development and social changes, leading to the rise of what Abdel Omran called "man-made diseases": alcoholism, smoking, road traffic accidents, etc. But, contrary to this theory, from the late 1960s Western countries entered a period in which they not only brought 'man-made' diseases under control but also reduced diseases of the circulatory system and even some cancers, thus creating a new transition phase that was totally absent from Omran's theory. We believe it is preferable to refer to this as "the second stage of the health transition" (Vallin 1993; Meslé and Vallin 2000; Vallin and Meslé 2004) – rather than as a "fourth stage of the epidemiologic transition", as Jay Olshansky and Brian Ault (1986) do; and it is this new stage that Ukraine, like its neighbours in the former USSR, has as yet been unable to embark upon.

The new stage requires – much more than the previous one, in fact – a health strategy based not only on technological progress and its dissemination (as was the case with vaccines or antibiotics) but also on populations themselves taking responsibility for their health, notably through behavioural changes – for example, in the area of food or in monitoring risk factors. Quite obviously, Soviet society, which was hypercentralized and had almost completely quashed the spirit of initiative, was not prepared to adopt this type of strategy, and this probably explains the crisis in the Soviet health system from the mid-1960s onwards, at a time when Ukraine no longer had any cause to envy Western countries their victory over infectious diseases. One might expect that, with the fall of the Soviet empire and the transition to a market economy, health policies would start to move in this direction and that life expectancy trends would take an upward turn, at least after a certain length of time.

This is certainly what happened in several Central European countries, though it is true that they had seen a less severe long-term decline. In the Czech Republic and Poland from the early 1990s, then in Hungary and Slovakia from the middle of the same decade, life expectancy started to rise again (Vallin and Meslé 2001). And, at least in Poland and the Czech Republic, this revival derived very significantly from the reduction in mortality from diseases of the circulatory system, which heralded a new era of lasting improvements (Meslé and Hertrich 1997; Meslé 2004). Within the countries of the former USSR itself, it seems that the Baltic states might have recently entered a similar phase (Hertrich and Meslé 1999; Meslé 2004). On the other hand, no such pattern is as yet on the horizon in Ukraine, and even less in Russia (Meslé et al. 1998). Both these countries obviously still face a major challenge for the future: will they continue to see life expectancy decline, or will they finally succeed in starting to improve again by creating not only an

environment in which new ways of combating 'man-made' and chronic diseases will be able to develop, but also the behavioural changes required for these to succeed?

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