

THE GORBACHEV ANTI-ALCOHOL CAMPAIGN AND RUSSIA'S MORTALITY CRISIS

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Political and economic transition is often blamed for Russia's 40% surge in deaths between 1990 and 1994 (the "Russian Mortality Crisis"). Highlighting that increases in mortality occurred primarily among alcohol-related causes and among working-age men (the heaviest drinkers), this paper investigates a different explanation: the demise of the 1985-1988 Gorbachev Anti-Alcohol Campaign. We use archival sources to build a new oblast-year data set spanning 1970-2000 and find that: (1) The campaign was associated with substantially fewer campaign year deaths, (2) Oblasts with larger reductions in alcohol consumption and mortality during the campaign experienced larger transition era increases, and (3) Other former Soviet states and Eastern European countries exhibit similar mortality patterns commensurate with their campaign exposure. The campaign's end explains between 32% and 49% of the mortality crisis, suggesting that Russia's transition to capitalism and democracy was not as lethal as commonly suggested.

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1. Introduction

Crude death rates in Russia soared by 40% between 1990 and 1994, climbing from 11 to nearly 15.5 per thousand.¹ By 2009 standards, the decline in male life expectancy at birth (by nearly 7 years, to 57.6) would tie Russian men with their counterparts in Bangladesh, falling short of male longevity in less-developed countries with troubled population health histories (Botswana, Haiti, North Korea, and Yemen, for example). The magnitude of this surge in deaths – coupled with the Soviet Union’s international prominence – has prompted observers to term this demographic catastrophe “the Russian Mortality Crisis.”

The underlying cause of the mortality crisis has been hotly debated, but most accounts implicate Russia’s political and economic transition.² Specific transition-related explanations include: a decline in economic output and employment (Cornia and Panizza 2000, Brainerd 2001), rapid privatization (Stuckler, King, and McKee 2009), physiological and psychological stress (Shapiro 1995, Bobak and Marmot 1996, Kennedy, Kawachi, and Brainerd 1998, Leon and Shkolnikov 1998, Gavrilova et al. 2001), rising inequality (Lynch, Smith, Kaplan, and House 2000, Denisova 2010), reductions in the relative price of vodka (Treisman 2010), and deterioration of the medical care system (Ellman 1994).³

The proximate cause of the crisis is less controversial: alcohol consumption soared in Russia between 1990 and 1993 (Leon et al. 1997, Treml 1997, Shkolnikov et al. 1998, Walberg

¹ Throughout this paper we use the term “Russia” to refer to the Russian state of the Soviet Union (until December 1991) and the Russian Federation (after December 1991).

² In response to Stuckler, King, and McKee’s (2009) article in *The Lancet* suggesting that privatization was responsible, see Jeffrey Sachs’ rebuttal in the *Financial Times* on January 19, 2009 (“‘Shock Therapy’ Had No Adverse Effect on Life Expectancy in Eastern Europe”), the subsequent reply by the authors in the *Financial Times* on January 22, 2009 (“Rapid Privatisation Worsened Unemployment and Death Rates”), and a recapitulation in *The Economist* on January 22, 2009 (“Mass Murder and the Market”). See also Earle and Gehlbach’s (2010) re-analysis.

³ Brainerd and Cutler (2005) provide a thorough review of this literature.

et al. 1998).⁴ The types of deaths that increased most during the transition were related to alcohol, either directly (alcohol poisonings and violent deaths) or indirectly (heart attacks and strokes) (Leon et al. 1997, Gavrilova et al. 2000, Brainerd and Cutler 2005). Although most diseases disproportionately kill the young and the old, crisis deaths were also concentrated among working age men – the demographic group that drinks the most.⁵

Recognizing the central role of alcohol, we investigate a different explanation for the Russian mortality crisis. Rather than the transition to capitalism and democracy, we study the coincident demise of the (reputedly successful) 1985-1988 Gorbachev Anti-Alcohol Campaign (Leon et al. 1997, Shkolnikov and Nemtsov 1997, Cockerham 1999).⁶ The campaign was unprecedented in scale and scope, simultaneously raising the price of drinking and subsidizing substitutes for alcohol consumption. In practice the campaign lasted longer – restarting state alcohol production required time, and elevated alcohol prices lingered. Figure 1 depicts our basic logic (Demoscope 2009). Crude Russian death rates increased linearly between 1960 and 1984, plummeted abruptly with the start of the campaign in 1985, remained below the pre-campaign trend throughout the latter 1980s, rose rapidly during the early 1990s to a temporary peak in 1994, and then largely reverted back to Russia’s long-run trend. The crisis could therefore be the combined result of lagged ‘catch-up’ mortality (as relatively weak marginal survivors saved by the campaign die at higher rates) together with reversion to the long-run trend.

⁴ Exceptions are Bobak et al. (1999) and Bobak and Marmot (1999), who use survey data to question the role of alcohol consumption in explaining the mortality crisis.

⁵ Death rates among males ages 35-44 rose by 74% between 1989 and 1994, for example.

We begin by establishing the association between the Gorbachev Anti-Alcohol Campaign and Russian mortality during the latter 1980s.⁷ To do so, we have digitized and harmonized numerous Russian data sources to create a new panel data set of Russian oblasts spanning years 1970-2000. At the height of the campaign, official alcohol sales had fallen by as much as two-thirds (Russians responded by increasing home-production of alcohol called *samogon* – although our estimates suggest not by enough to offset the reduction in state supply).⁸ The accompanying decline in crude death rates was about 12%, implying roughly 665,000 fewer deaths in total. Alcohol poisonings varied in the same way, with percentage point reductions among men about twice as large as those among women. These relationships appear robust and are not easily explained by unrelated shifts in alcohol supply or demand. We also employ a supplemental instrumental variables strategy, instrumenting for campaign intensity using interactions between each oblast’s Muslim population share prior to the campaign and campaign year dummies (changes in alcohol policy should matter less for Muslims). Our results are generally consistent across a variety of estimation strategies.

To study the link between the Gorbachev Anti-Alcohol Campaign and Russia’s mortality crisis, we then relate variation in campaign intensity to subsequent mortality over the next decade. Russian oblasts with more intense campaigns (and larger campaign-year mortality declines) experienced systematically larger mortality crises during the 1990s. This relationship peaked in the middle of the decade and matches temporal patterns predicted by independent simulations.⁹ Causes of death more closely related to alcohol consumption (circulatory disease,

⁷ This relationship has previously been studied only qualitatively or using aggregate national-level data – see White (1996), Tremblay (1997), Avdeev et al. (1998), and Nemtsov (2000). Balan-Cohen (2007) finds superior health indicators among children born during the campaign.

⁸ Throughout the paper, we use the term “*samogon*” to mean illegal alcohol generally.

⁹ Using Framingham Heart Study data, we find temporal relationships that are consistent with the lagged pattern of mortality we observe after the end of the anti-alcohol campaign (see Appendix 3).

accidents and violence, and alcohol poisoning) also increased relatively more in these oblasts during the 1990s. Overall, our estimates explain between 32% and 49% of the Russian mortality crisis.

We conclude by documenting broad patterns of mortality commensurate with campaign exposure in other former Soviet States and Eastern European countries. Former Soviet states in the West and in the Baltics exhibit similar mortality declines during the late 1980s followed by similar surges during the early 1990s. This pattern is also present – but attenuated – in former Soviet states with large Muslim populations for whom alcohol policy matters less (in the Caucasus and Central Asia). Mortality patterns in Eastern European countries undergoing political and economic transitions but not subjected to the campaign (the Czech Republic, Hungary, Poland, and the Slovak Republic) are starkly different. These cross-national patterns are consistent with the demise of the Gorbachev Anti-Alcohol campaign playing an important role in the Russian Mortality Crisis. Taken together, our results suggest that Russia’s transition to capitalism and democracy was not as lethal as often suggested.

2. Drinking in Russia and the Gorbachev Anti-Alcohol Campaign

2.1 Alcohol Consumption in the Soviet Union and the Russian Federation

The Soviet Union – and Russia in particular – historically ranks among the world’s heaviest drinking countries. Alcohol consumption rose steadily between 1950 and 1985 – between 1960 and 1979 alone, alcohol sales nearly quadrupled (with disposable household income spent on alcohol reaching 15-20%) (Trembl 1982, Segal 1990, Tarschys 1993, White 1996, McKee 1999). Just prior to the anti-alcohol campaign, annual consumption of pure alcohol in the Soviet Union was 14.2 liters per capita (compared to 8 liters in the United States)

(Nemtsov 2000). This figure is roughly equivalent to adult males consuming half a liter of vodka every two days (Ryan 1995).¹⁰ Given lower levels of drinking in Soviet states with more Muslims (in the Caucasus and Central Asia, for example), the counterbalancing rate for Russia alone was presumably much higher (Shkolnikov and Nemtsov 1997).

2.2 The Gorbachev Anti-Alcohol Campaign

By the early 1980s, alcohol abuse was widely recognized as a major cause of death, absenteeism, and low labor productivity in the Soviet Union.¹¹ Although difficult to estimate, observers suggest that alcohol's cost to the Soviet economy during the 1980s totaled about 10% of national income (Trembl 1987, Segal 1990; Tarschys 1993, White 1996).

In response, the Politburo and the Central Committee passed resolutions entitled "Measures to Overcome Drunkenness and Alcoholism" in May of 1985 (shortly after Mikhail Gorbachev became Secretary General). These decrees and subsequent directives of the Central Committee and the Presidium of the Supreme Soviet ushered in the country's most stringent anti-alcohol policies since its 1919-1925 prohibition. Given tight state control of social and economic affairs, rapid implementation and rigid adherence to campaign mandates were possible.

¹⁰ In addition to the quantity consumed, the type and pattern of alcohol consumption in Russia (compared to other heavy-drinking countries like France) has important implications for mortality. A disproportionate amount of consumption can be characterized as 'binge drinking' (defined as three or more measures of alcohol within 1 to 2 hours), especially on weekends and holidays (Bobak et al. 1999, Chenet et al. 1998, Malyutina et al. 2001, McKee and Britton 1998). Alcohol abuse and binge drinking are linked not only to accidents and violent deaths, but more quantitatively important, they are key risk factors for heart attacks and cardiovascular disease (McKee and Britton 1998; McKee et al. 2001, O'Keefe et al. 2007, Rehm et al. 2009, Tolstrup et al. 2006). Recent estimates suggest that alcohol abuse is responsible for more than half of all deaths in Russian cities among those ages 15-54 (Leon et al. 2007, Zaridze et al. 2009).

¹¹ Alcohol played a central role in violent crimes and traffic accidents as well. According to then Interior Minister Vitalii Fedorchuk, two-thirds of all murder, battery, and rape as well as 70-80% of "hooliganism" were committed under the influence of alcohol (Reid 1986, Trembl 1991).

The Gorbachev Anti-Alcohol Campaign consisted of seven broad measures designed to raise the price of drinking and subsidize substitute activities. Four were clearly supply-oriented. First, state production of alcohol was drastically reduced. Between June 1985 and May 1986 alone, state production of vodka and hard liquor declined by 30-40% (Segal 1990) and cognac production fell by 44% (White 1996). Second, substantial new restrictions were placed on alcohol sales. Liquor stores were not allowed to sell vodka or wine before 2pm on business days, restaurants were no longer permitted to sell hard liquor, and the official drinking age rose from 18 to 21. Sales near factories, educational institutions, hospitals, and airports were prohibited. Third, the government increased alcohol prices substantially. In 1985 alone, the price of vodka, liqueurs, and cognac rose by 25% (McKee 1999), and prices were increased by about 25% more in 1986 (White 1996). Fourth, heavy new sanctions for public drunkenness and other alcohol-related offenses were introduced. Fines for workplace intoxication were one to two times the mean weekly wage, and both home production of alcohol and possession of homebrew equipment were punishable by large fines or imprisonment.

Three other measures focused on reducing the demand for alcohol. One was heavy subsidization of substitute activities; all Soviet oblasts were required to build and modernize leisure facilities (like parks and sport clubs) and to promote cultural activities. Another was media propaganda and health education programs together with bans on glamorous media depictions of drinking. To encourage sober lifestyles, the government also created a national temperance society (the “All-Union Voluntary Society for the Struggle for Temperance”) – within three years, the society had 428,000 branches and more than 14 million members (White 1996). Finally, the government made large efforts to improve the treatment of alcoholism.

Health care system responsibility for compulsory treatment of alcoholism was expanded, and physician supervision of treatment was required for up to five years.

Aggregate state alcohol sales fell by more than 50% between 1984 and 1988 (White 1996). Official figures overstate the decline in alcohol consumption, however, because they do not capture the “moonshining” response to the campaign. Russians have a long-standing tradition of producing *samogon* (literally, “distillate made by oneself,” a generic term for illegal alcoholic beverages made from sugar as well as corn, beets, and potatoes among other ingredients) – and did so more vigorously during the campaign (as Appendix Figure A1 shows).¹²

Reductions in alcohol consumption varied across the Soviet Union. Across republics, for example, Latvia’s decline in alcohol consumption was roughly seven times greater than in wine-oriented Armenia (Trembl 1982). Within Russia, vodka sales in Kirov, Kamchatka, Karelia, and Sakhalin (in the east) fell four times more than in Southern areas. Some of these regional differences were due to heterogeneity in application of campaign laws and regulations – heavy-drinking Baltic and Slavic regions were slated to receive ‘special attention’ during the campaign, for example (Reid 1986). Ethnic and religious differences were another source of variation. Prior to the campaign, predominantly Slavic areas in the north and northeastern parts of the Soviet Union drank more than areas with substantial Muslim populations in the south and southwest.¹³

¹² A fictitious type of *samogon* called *tabouretovka* is made from wooden stools (or “tabourets”) (Petrov, Dovich, and Il’f 1997). There were more extreme efforts to obtain alcohol as well: sales of alcohol-based glue increased from 760 to 1000 tons between 1985 and 1987; sales of glass cleaners rose from 6,500 to 7,400 tons over the same period; and there was large-scale theft of industrial alcohol (Trembl 1997).

¹³ Sections 5.1 and 5.2 find little evidence that (a) independent shifts in alcohol supply or demand or (b) campaign targeting to oblasts with pre-campaign trend differences in mortality explain our main findings.

2.3 The Demise of the Anti-Alcohol Campaign

The Soviet Central Committee officially ended the anti-alcohol campaign in October 1988 (because of its unpopularity and the loss of revenue from alcohol sales).¹⁴ In practice, however, the campaign extended beyond its official end for several reasons. First, increasing state production of alcohol required time; vodka production did not reach pre-campaign levels until 1993, for example (White 1996). Second, some campaign sales restrictions (against vodka sales on Sundays, for example) remained in place (White 1996). Third, alcohol prices remained high – 75% higher in 1989 than at the beginning of the campaign in 1985 (authors’ calculations). Overall, the result was that the campaign lingered – both official and total alcohol consumption rates (including *samogon*) did not return to pre-campaign levels until the early 1990s. Appendix Figure A1 shows this slow recovery in our own data, concurring with Nemtsov’s (2000) suggestion that 1991 was the campaign’s *de facto* end date.

3. Data

We used a variety of archival sources to create a new panel data set covering 77 Russian oblasts between 1970 and 2000.¹⁵ Table 1 presents descriptive statistics from this data set by study period. In this section we summarize our key sources and variables; Appendix 1 provides greater detail about each source (the intersection of all key variables is generally years 1970, 1979, 1980, 1984, 1985-1987, and 1989-2000).

¹⁴ The campaign was also politically divisive within the communist party, and two important proponents of the campaign (Yegor Ligachev and Mikhail Solomentsev) retired from the Politburo at the end of 1987.

¹⁵ All data compiled for this project are available upon request. In addition to true administrative oblasts, our dataset contains 22 *krai* and autonomous republics as well. For simplicity, we generically refer to all of these regions as oblasts. We exclude autonomous *okrugs* from our analysis because information about them is not available for a number of years; we also exclude Chechnya and Ingushetia (typically reported together as Chechnya-Ingush prior to 1991) because of war-related inconsistencies in the data.

3.1 Economic, Demographic, and Alcohol Data from *Goskomstat* and *Rosstat* Yearbooks

We obtained core demographic and alcohol variables from several types of statistical yearbooks compiled by *Goskomstat* (the Soviet national statistical agency) and *Rosstat* (the Russian Federation's national statistical agency). Some yearbook data is available through East View Information Services, a provider of Eurasian archival source materials. We obtained the remainder from the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives (available in hard-copy format in Russian).¹⁶ To fill gaps in the coverage of these sources, we also used archival records published by scholars outside of the Soviet Union (New World Demographics 1992, Treml and Alexeev 1993, Vassin and Costello 1997, Vallin et al. 2005, Heleniak 2006).

Vital Records. Our core mortality variables are crude death rates per 1,000 population, and alcohol poisoning death rates by gender per 100,000 population. Russian death certificates are certified by physicians (or in less than 10% of the cases, by paramedics), and evaluations of Russia's mortality statistics generally conclude that they are satisfactory in quality with modest under-reporting rates (Andreev 1999, Bennett et al. 1998, Leon et al. 1997, and Norton et al. 1999).¹⁷

Causes of death in the Soviet Union were classified using a Soviet system with 175 categories; these categories were later harmonized with codes from the World Health Organization's International Classification of Diseases, Ninth Revision (ICD-9).¹⁸ *Goskomstat's*

¹⁶ We are grateful to Irina Erman and Emily Singer for outstanding Russian language assistance.

¹⁷ Exceptions are Tuva's statistics and regions in the North Caucasus, where reports suggest that infant mortality under-reporting was as high as 25% during the 1980s (Blum and Monnier 1989). These specific oblasts are Tuva, Dagastan Republic, Ingushitya Republic, Chechen Republic, Kabardino-Balkarskaya Republic, Karachaevo-Cherkesskaya Republic, North Osetiya-Alaniya Republic, Krasnodarskiy Krai, and Stavropolski Krai. We repeat the analyses shown in Table 2 excluding these oblasts – Appendix Table A1 shows that the results are similar.

¹⁸ The Russian Federation used the Soviet cause of death classification system until 1999 but also began using the WHO International Classification of Diseases (ICD) system in parallel in 1993. Cause of death records are

and *Rosstat's* statistical yearbooks contain little cause-specific mortality data at the oblast level, however. Given our focus, we have compiled information on deaths directly linked to alcohol consumption (cardiovascular disease, alcohol poisoning, and accident/violent deaths), deaths more indirectly related to alcohol (digestive and respiratory disease deaths), and deaths not closely alcohol-related (cancer deaths) (Vallin, Andreev, Mesle, and Shkolnikov 2005). We obtained data on alcohol poisoning deaths for additional years from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research (Shkolnikov et al. 2005).

Alcohol Sales. As the sole legal producer and distributor of alcohol in the Soviet Union, the government maintained records of alcohol sales (in liters) for principal alcoholic beverages (vodka, beer, wine, cognac, and champagne).¹⁹ Sales by type of beverage are reported in liters of pure alcohol for some years and in thousands of dekaliters in other (partly-overlapping) years. We converted sales data for all years into liters of pure alcohol, following Andrienko and Nemtsov (2006) by assuming each type to have the following alcohol content: vodka: 40%; wine: 14.4%; cognac: 18%; champagne: 22.8%; beer before 1995: 2.85%; beer between 1995 and 1999: 3.37%; and beer after 2000: 3.85%.²⁰ For each oblast-year, we divide liters of pure alcohol by the corresponding population estimate, yielding rates of pure alcohol consumption per person for years 1970, 1980-1992, and 1996-2002. White (1996) uses retrospective survey data to demonstrate that sales data during campaign years were generally not manipulated by politically-motivated officials.

generally less reliable than other types of mortality data, so we emphasize our crude death rate analyses but supplement them with analyses of cause-specific mortality.

¹⁹ This data excludes information about alcohol sold on military bases. Beginning in 1992, it also excludes alcohol sales at private trade outlets and restaurants. Data for cognac and champagne sales data are only available beginning in the late 1990s (although they constitute a small share of total sales). Finally, it does not measure quality. According to the Russian Trade Committee, the share of alcoholic beverages rejected as substandard was 5.6% in 1991, rising to 12.4% in 1992, 25.6% in 1993, and 30.4% in 1994 (Nemtsov 2002).

²⁰ For years possible, we verify the validity of our calculations through direct comparison with data on sales measured in pure alcohol.

Muslim Population Share. To implement a supplemental instrumental variables strategy (described in Section 4), we obtained each oblast's Muslim population share in the 1979 Soviet population census provided by Heleniak (2006).

Other Covariates. Some of our analyses control for other determinants of mortality and for other factors proposed to explain the Russian mortality crisis. We assembled oblast-year data on health care infrastructure and workforce (the number of hospitals and the number of doctors per capita) and crude birth rates using *Goskomstat* and *Rosstat* Yearbooks. We also collected data on employment rates and employment rates in private manufacturing from Brown, Earle, and Gehlbach (2009) and Earle and Gehlbach (2010); income per capita from Trembl and Alexeev (1993); and immigration and emigration flows from Andrienko and Guriev (2004).²¹

3.2 Estimating Total Alcohol Consumption (Including *Samogon*)

Official alcohol sales data do not accurately reflect total alcohol consumption because many Russians make *samogon* at home. Because comprehensive estimates of oblast-year *samogon* production are not available, we extend the work of Nemtsov (2000) to estimate it for the 1980s and early 1990s. Sugar is a critical ingredient in *samogon*, so one approach is based on sugar sales that exceed estimated dietary consumption (Nemtsov 1998). However, this method fails for years 1986 and later when sugar was rationed (Trembl 1997).

Nemtsov (2000) therefore developed an alternative indirect technique using forensic records. Both the Soviet Union and the Russian Federation mandate that each oblast's forensic bureau perform autopsies for all violent and accidental deaths as well as deaths with unclear causes. Importantly, these mandatory autopsies systematically document blood alcohol content

²¹ Other work (such as Stillman and Thomas 2008) investigates the health consequences of Russia's economic crisis late in the 1990s.

(albeit in a non-random sample of Russians).²² Nemtsov (2000) used these records to estimate the association between blood alcohol concentrations and total alcohol consumption, recovering implied *samogon* consumption. Using these estimates, he then predicted *samogon* consumption for twenty-five oblasts between 1980 and 1992 (Nemtsov 2000).²³ Despite their imperfections, the autopsy-based estimates closely match sugar-based estimates in overlapping years and outperform other methodologies (based on hospital admissions for alcohol-induced psychosis, cirrhosis deaths, and pancreatitis deaths, for example) (McKee 1999, Nemtsov 2000, Balan-Cohen 2007).

We use estimates published in Nemtsov (2000) – together with some algebraic manipulation – to recover underlying parametric relationships (Appendix 2 describes the details of these calculations and their validation). We then use these parameters to predict oblast-year *samogon* consumption and calculate total alcohol consumption as the sum of official sales and *samogon* for years 1980-1992.²⁴ As Appendix Figure A1 shows, *samogon* consumption rose sharply as official alcohol sales fell during the campaign, closely matching aggregate relationships reported by others (Nemtsov 2000). In our analyses, we use both official alcohol sales and total alcohol consumption estimates in parallel.

3.3 Measuring Anti-Alcohol Campaign Intensity

²² The autopsy records used by Nemtsov were not made public during the Soviet era, so manipulation for external political purposes is likely not a concern.

²³ These oblasts are Altai krai, Amur, Bashkiria, Ekaterinburg, Ivanova, Khabarovsk, Kaluga, Karelia, Kemerov, Kursk, Leningrad, Moscow city, Moscow oblast, Murmansk, Novgorod, Novosibirsk, Omsk, Orel, Rostov, Samara, Saratov, Sakhalin, St. Petersburg city, and Yaroslav.

²⁴ In short, Nemtsov (2000) provides an unadjusted OLS regression coefficient for the relationship between *samogon*/illegal alcohol (IA) and official alcohol sales (OS) in 1990, and he also reports correlation coefficients between official sales and *samogon* for years 1983, 1985 and 1990 (years preceding, during, and after the campaign). The regression coefficient is equal to $\text{Cov}(\text{IA}, \text{OS}) / \text{Var}(\text{OS})$, and the correlation coefficient $r = \text{Cov}(\text{IA}, \text{OS}) / (\text{Var}(\text{IA})^{1/2} \times \text{Var}(\text{OS})^{1/2})$. Using the variance of official alcohol sales for years in our dataset and assuming the variance of *samogon* to remain constant over time, we calculate implied regression coefficients for each year 1980-1992. We then use these year-specific regression coefficients and our oblast-year official sales data to predict total alcohol consumption (including *samogon*).

As Section 2.2 describes, the anti-alcohol campaign was multifaceted, complicating the measurement of campaign intensity. Moreover, comprehensive records documenting campaign activities are unavailable. We therefore measure oblast-year campaign intensity as the percent change in campaign year alcohol consumption relative to mean consumption in that oblast between 1980 and 1984.²⁵ Differences in intensity across oblasts could therefore be due to differential supply shifts (linked to restrictions on alcohol sales, for example), differential demand shifts (as substitutes for drinking are subsidized), or differences in price elasticities of demand. We highlight that these multiple sources of variation in intensity are all useful to us given our overarching objective. Our campaign intensity measures are also strongly correlated with independent measures of campaign enforcement such as court sentencing for *samogon* production and drunk driving arrests.

We build two campaign intensity measures: one using official sales of pure alcohol and the other using total consumption (including *samogon*). We term these measures “official sales” and “total consumption,” respectively. Figure 2 shows the distribution of these two campaign intensity variables across campaign years. At its height, official sales were as much as 60% below pre-campaign levels, and total consumption had fallen by 25-30%.

3.4 Graphical Evidence

Before turning to econometric analyses, we use our new data set to examine graphical relationships between the anti-alcohol campaign and Russian crude death rates. Figure 3 shows death rates over time by pre-campaign drinking rates. To construct this figure, we calculate mean total alcohol consumption in each oblast for years 1980-1984. We then graph crude death

²⁵ Section 5.2 explores the sensitivity of our results to alternative definitions of campaign intensity and also considers possible campaign targeting to pre-campaign trends in alcohol consumption or mortality.

rates between 1970 and 2000 for the top and bottom quartiles of the distribution of pre-campaign alcohol consumption. Consistent with an effective anti-alcohol campaign, oblasts in the top quartile experienced larger crude death rate reductions in the latter 1980s during the campaign. Then, during Russia's subsequent political and economic transition, this relationship reverses. Between 1990 and 1994, larger crude death rate increases occurred among oblasts with more pre-campaign drinking – and oblasts with less pre-campaign drinking experienced smaller increases.

Figure 4 shows a similar temporal pattern using oblasts in the top and bottom quartiles of the distribution of mean campaign intensity. High and low intensity oblasts have similar crude death rates (in level and trend) prior to the campaign. With the start of the campaign in 1985, mortality in high intensity oblasts falls relative to low intensity oblasts, and this gap remains as the campaign progresses. Crude death rates in the two groups then converge with the end of the campaign, narrowing to the pre-campaign gap during Russia's political and economic transition. Overall, both figures are consistent with the campaign's end playing an important role in the mortality crisis.

4. Empirical Strategy

4.1 The Gorbachev Anti-Alcohol Campaign and Mortality in Russia during the 1980s

We first study the relationship between the Gorbachev Anti-Alcohol Campaign and Russian mortality during the latter 1980s. Specifically, we use sample years prior to 1990 to estimate the association between campaign intensity and different measures of mortality in oblasts o and years y :

$$(1) \quad mortality_{oy} = \alpha + \beta(intensity_{oy}) + \delta_o + \delta_y + \varepsilon_{oy},$$

where *mortality* is a death rate (crude death rates per 1,000 or alcohol poisoning death rates per 100,000 among males and females), *intensity* is the percent change in alcohol consumption relative to the 1980-1984 mean (measured using either total alcohol consumption or official sales), and δ_o and δ_y represent oblast and year fixed effects. We also estimate variants of equation (1) that include oblast-specific linear time trends, and we study temporal mortality patterns during the campaign by including more flexible interactions between intensity and campaign year dummy variables.

We also use a supplementary instrumental variables strategy. Given Islam’s prohibition of intoxicants, we exploit variation in the concentration of Muslims across Russia’s oblasts (ranging from negligible amounts to about 85%), instrumenting for oblast-year campaign intensity using interactions between population share Muslim in 1979 and campaign year dummies. The underlying logic is that areas with relatively more Muslims should experience smaller absolute declines in alcohol consumption during the campaign.²⁶ Appendix Figure A3 shows the difference in total alcohol consumption between oblasts in the top and bottom deciles of the distribution of Muslim population share in 1979. In areas with the lowest concentration of Muslims, annual alcohol consumption during the campaign fell by nearly 2.5 liters per person more than in areas with the highest concentration.²⁷

4.2 The Relationship between the Anti-Alcohol Campaign and the Russian Mortality Crisis

²⁶ Appendix Figure A2 shows the distribution of Muslims across Russian oblasts in 1979 (Heleniak 2006); the highest concentrations were in the Caucasus and Central Asia. Because we use population share Muslim in 1979, we minimize the influence of any campaign-era migration along religious lines. Adherence to Islam implicates other health behaviors related to mortality (dietary restrictions, for example), but we are unaware of any policy changes that vary in the same temporal pattern as the anti-alcohol campaign (or that disproportionately affected Muslims).

²⁷ Specifically, instrumenting for *intensity* in equation (1) using interactions between 1979 population share Muslim and campaign year dummies, the first-stage relationship is: $intensity_{oy} = \alpha + \sum_i \gamma_i [(1979 \text{ pop share Muslim})_o \times (campaign \text{ year})_{yt}] + \sigma_o + \sigma_y + \xi_{oy}$; all variables are defined as in equation (1). The relationship between campaign intensity and the instruments appears sufficiently strong (Staiger and Stock 1997).

After establishing the relationship between the anti-alcohol campaign and Russian mortality during the 1980s, we then investigate how the end of the campaign was related to the mortality crisis. Specifically, we relate mean campaign intensity to time-varying mortality during the 1990s by using sample years 1990-2000 to estimate equations of the following form:

$$(2) \quad mortality_{oy} = \alpha + \sum_i \beta_i [(mean\ intensity)_o \times (transition\ year)_{yt}] + \delta_o + \delta_y + \varepsilon_{oy},$$

where *mortality* is a death rate (the crude death rate as well as cause-specific rates with varying relatedness to alcohol), *mean intensity* is average campaign intensity in each oblast, *transition year* is a vector of year dummy variables, and all other variables are defined as before.²⁸ The pattern of β s over time allows us to study systematic relationships between the end of the campaign and the subsequent evolution of mortality during Russia's political and economic transition. (To study the temporal relationship between alcohol consumption and lagged mortality more closely, we also simulate it using hazard rates that we estimate with data from the Framingham Heart Study – see Section 7.2 and Appendix 3 for details.)

5. Results: The Anti-Alcohol Campaign and Mortality during the 1980s

5.1 Campaign Intensity and Mortality during the 1980s

Table 2 Panel A presents campaign intensity estimates obtained from equation (1). Because our intensity variables are percent changes constructed as fractions, the estimates shown can be interpreted as changes in crude death rates per 1,000 associated with a 100% increase in alcohol consumption.²⁹ The first column shows that a 100% increase in total alcohol consumption is associated with a 5.9 per 1,000 rise in the crude mortality rate. Using mean intensity across campaign years, the implied decline in death rates linked to the campaign is 1.25

²⁸ We focus on estimates for years prior to the start of Russia's financial/economic crisis in 1998.

²⁹ We find very similar results using log deaths or log death rates as the dependent variable.

deaths per 1,000 – a reduction of about 12%. In the 1984 Russian population, this implies approximately 166,000 deaths averted per year, totaling about 665,000 throughout the campaign.³⁰ The second column re-estimates equation (1) including oblast-specific linear time trends. The resulting campaign intensity estimate is smaller but is statistically indistinguishable from the estimate in the first column. The third and fourth columns report results using official alcohol sales to measure campaign intensity. These estimates are smaller than those in the first two columns, but because the reduction in official sales during the campaign was greater than the reduction in total alcohol consumption (due to *samogon* production), they imply roughly the same decline in mortality (about 17%).³¹ Appendix Table A2 shows that these estimates are robust to the inclusion of oblast-year controls for other determinants of mortality for which data is available (crude birth rates, doctors per capita, and hospitals per capita).³²

The last three columns of Table 2 Panel A study changes in alcohol poisoning during the campaign, re-estimating equation (1) using total and gender-specific alcohol poisoning death rates per 100,000 as dependent variables. The estimates in the first row imply that oblasts with more intense campaigns experienced larger reductions in alcohol poisoning death rates during campaign years. These declines are large, and they are considerably larger for men than for women (17.8 and 9.8 fewer deaths per 100,000, respectively).³³

³⁰ Mean campaign intensity (using total alcohol consumption) across campaign years is -0.213; $5.886 \times -0.213 \approx -1.25$ per 1,000 population. Prior to the anti-alcohol campaign, the Russian crude death rate was approximately 10.5 per 1,000; $1.25/10.5 \approx 0.12$. The 1984 Russian population was roughly 132,631,000; $1.25 \times 132,631 \approx 166,282$ averted deaths per year and 665,127 averted deaths over four years.

³¹ Mean campaign intensity using official alcohol sales is -0.490. Using the third column in Table 2 $3.601 \times -0.49 \approx -1.76$ per 1,000 population. With a pre-campaign crude death rate of 10.5 per 1,000, $1.76/10.5 \approx 0.17$.

³² Appendix Figure A4 shows that the geographic pattern of mean campaign intensity does not closely match patterns of mean annual changes among these determinants of mortality between 1985 and 1989.

³³ The male alcohol poisoning rate estimate of 83.45 deaths per 100,000 multiplied by a mean campaign intensity (using total alcohol consumption) across campaign years of -0.213 implies $83.45 \times -0.213 \approx 17.8$ deaths fewer per 100,000. The female alcohol poisoning rate estimate of 46.04 implies $46.04 \times -0.213 \approx 9.8$ fewer deaths per 100,000.

Table 2 Panel B then examines temporal mortality patterns throughout the campaign by interacting our intensity measures with campaign year dummy variables. The marginal relationship is largest in 1985 and declines in each subsequent year. However, campaign intensity peaks in 1986 before tapering-off, so implied death rates fall for the first two years and then rise again later in the campaign.³⁴

5.2 Targeting of Campaign Intensity

We then test for targeting of campaign intensity to oblasts with differentially changing mortality or alcohol consumption prior to the anti-alcohol campaign – and evaluate the implications of any targeting for the interpretation of our main results. Focusing first on mortality, we estimate variants of equation (1) that include interactions between mean campaign intensity and pre-campaign year dummies (1978 and 1980 – the years closest to the campaign for which we have mortality data). The first two columns of Table 3 show these results (with and without linear oblast time trends). The interaction terms suggest differential mortality by campaign intensity further back in time (in 1978) but not closer to the campaign (in 1980). As the first row of Table 3 shows, controlling for these interactions directly does not substantially alter our main campaign intensity estimates.

We next use two strategies to study the role of any pre-campaign trend differences in alcohol consumption. First, we construct an alternative campaign intensity measure that explicitly accounts for them. Specifically, we use each oblast's 1980-1984 alcohol consumption trend to construct counterfactual linear predictions of consumption during the campaign - and

³⁴ We do not have crude death rate data for 1987. Two other forces also work in the opposite direction. Those saved at the beginning of the campaign are likely the easiest to save, implying a relatively large initial marginal relationship that declines over time. However, some mortality benefits also occur with a lag, flattening the otherwise steeper temporal gradient of this association.

measure oblast-year campaign intensity as the percent change in actual alcohol consumption relative to predicted consumption. The third column of Table 3 shows that using this alternative definition of intensity does not meaningfully change our main finding. Second, we re-estimate equation (1) controlling directly for alcohol consumption prior to the campaign. As the last two columns of Table 3 show, our campaign intensity estimates are robust to doing so.

Finally, we use a supplemental instrumental variables approach to further assess the influence of any targeting. Appendix Table A3 reports estimates obtained by instrumenting for campaign intensity using interactions between 1979 Muslim population share and campaign year dummies.³⁵ Both columns (with and without oblast-specific trends) show patterns of mortality change that are consistent with our main findings.

6. Results: The Anti-Alcohol Campaign and Russia's Mortality Crisis

6.1. Campaign Intensity and Mortality during the 1990s

Having established a relationship between the anti-alcohol campaign and mortality declines during the 1980s, we then investigate how the end of the campaign shortly prior to Russia's political and economic transition may have contributed to the mortality crisis. Relating the evolution of crude death rates during the 1990s to mean campaign intensity, Table 4 shows OLS results obtained by estimating equation (2) (with and without oblast-specific trends). In general, oblasts that had more intense campaigns experienced disproportionately large increases in mortality during the first half of the 1990s which peaked mid-decade. This temporal pattern of results is consistent with the end of campaign explaining an important part of the mortality crisis.

³⁵ Relative to pre-campaign years, the first stage estimates suggest smaller average declines in alcohol consumption (or less intense campaigns) in areas with more Muslims.

To calculate the share of mortality crisis explained by these estimates, we define excess mortality during crisis years as each year's increase relative to 1991 (Nemtsov 2000). We then calculate crude death rate increases predicted by the end of the campaign by multiplying estimates from Table 4 (conditional on linear oblast time trends) by mean campaign intensity. Finally, we divide each year's predicted increase by observed excess mortality in that year, yielding the share of the crisis explained in each year. On average, the campaign explains 49% of the mortality crisis between 1992 and 1995 and 32% of the crisis between 1993 and 1995.³⁶

6.2. Campaign Intensity and Cause-Specific Mortality during the Crisis

We then investigate changes in three groups of cause-specific death rates with differential relatedness to alcohol consumption. Those most closely related to alcohol are alcohol poisonings, deaths due to cardiovascular disease, and accidents/violent deaths. Causes more indirectly linked to alcohol are respiratory diseases and digestive diseases. Finally, cancer deaths are most weakly related to alcohol (and occur only after a long period of time).

Figure 5 shows cause-specific death rates predicted by estimating equation (2) using each as a dependent variable and multiplying the resulting estimates by mean campaign intensity. Alcohol poisonings, circulatory disease deaths, and accidents/violent deaths rise considerably during the early 1990s in proportion to intensity of the Gorbachev Anti-Alcohol Campaign, and their temporal pattern generally matches the changes in crude death rates implied by Table 4 (as well as our simulation results in Appendix 3). Alcohol poisonings rise much more for men than for women – and do so early in the 1990s as drinking rates returned to their pre-campaign levels. The most quantitatively important increases occur among cardiovascular disease deaths and

³⁶ Excess crude death rates per 1,000 were 0.31 in 1992, 2.53 in 1993, 3.70 in 1994, and 3.01 in 1995. For the period 1992-1995, $[((-0.213 \times -2.70)/0.31) + ((-0.213 \times -3.15)/2.53) + ((-0.213 \times -3.55)/3.70) + ((-0.213 \times -6.90)/3.01)]/4 \approx 0.49$. For the period 1993-1995, $[((-0.213 \times -3.15)/2.53) + ((-0.213 \times -3.55)/3.70) + ((-0.213 \times -6.90)/3.01)]/3 \approx 0.32$.

accidents/violence. Consistent with evidence that heavy alcohol consumption results in substantial lagged cardiovascular mortality, these deaths peak in the middle of the decade.³⁷ Predicted respiratory and digestive disease mortality is relatively low (consistent with their weaker relationship to alcohol consumption), and the profile of predicted cancer deaths is essentially flat throughout the 1990s.³⁸

7. Robustness, Simulations, and Cross-Country Evidence

7.1 Robustness to the Inclusion of Additional Controls for Alternative Crisis Explanations

To consider the possibility that other explanations proposed for the mortality crisis account for the estimates in Table 4, we re-estimate equation (2) with controls for them. Specifically, we assess the sensitivity of our results to the inclusion of doctors and hospital beds per capita (measuring health care system functioning), internal emigration and immigration (measuring changes in population composition), employment in private manufacturing (measuring privatization), and income per capita and employment rates (measuring local economic conditions).³⁹ Table 5 reports these results. Overall, the association between campaign intensity and mortality rates throughout the 1990s is robust to their inclusion, suggesting that these factors proposed by others are not closely related to the phenomenon we study.⁴⁰

³⁷ The medical literature suggests that cardiovascular disease deaths should be most important (with a lag) (Chenet et. al. 1998; Britton and Mckee 2000; Corrao et. al. 2000; Hemström 2001; McKee, Shkolnikov, and Leon 2001; Corrao et. al. 2002; Ramstedt 2009).

³⁸ Similarly, infant mortality is not associated with campaign intensity during the transition era.

³⁹ We also find few meaningful relationships between these controls and campaign intensity.

⁴⁰ Alcohol price reductions during the 1990s could be an important factor related to the end of the campaign that contributed to the mortality crisis (Treisman 2010). We investigated this possibility using data that Daniel Treisman generously shared with us. Although limited only to vodka prices and years 1992 and later, we found that vodka prices fell relatively less during crisis years in oblasts that had more intense campaigns. Moreover, controlling for vodka prices during crisis years increases the magnitude of our main anti-alcohol campaign estimates (results available upon request).

7.2 Estimation and Simulation of the Temporal Relationship between Alcohol Consumption and Mortality Using Framingham Heart Study Data

Although the anti-alcohol campaign lingered for several years after its official repeal (alcohol consumption did not reach its pre-campaign levels until the early 1990s), the Russian mortality crisis followed the campaign's end by several years. This temporal relationship is unsurprising given that the consequences of drinking become manifest over time (as subsequent heart attacks and strokes, for example). To investigate more carefully the timing of deaths following a sharp decrease and subsequent resumption of drinking, we use unique longitudinal data from the Framingham Heart Study to estimate mortality hazards associated with alcohol consumption. Using these estimates, we then simulate reductions in drinking analogous to those under the anti-alcohol campaign followed by increases in drinking observed during Russia's political and economic transition. Overall, we find strikingly similar temporal patterns of mortality, with excess deaths emerging 2-3 years after the resumption of pre-campaign drinking and lasting for more than a decade. Appendix 3 presents these analyses in more detail.

7.3 The Anti-Alcohol Campaign across Other Former Soviet States and Eastern Europe

Finally, if the Gorbachev Anti-Alcohol Campaign explains an important part of the Russian Mortality Crisis, then temporal patterns of mortality commensurate with campaign exposure should be present across other Eastern European countries. Other former Soviet states also experienced the campaign, and the campaign's impact should vary systematically with ethnic/religious composition (with larger campaign-year reductions and larger transition-year increases in countries with higher concentrations of Muslims). Alternatively, non-Soviet Eastern

European countries had no anti-alcohol campaign – and therefore should have different temporal patterns of mortality despite experiencing similar political and economic transitions.

Figure 6 shows crude death rate comparisons between Russia and three groups of countries: former Soviet states with a small share of Muslims (Latvia, Lithuania, Estonia, Ukraine, Belarus, and Moldova), former Soviet states with a larger share of Muslims (Armenia, Azerbaijan, Georgia, Uzbekistan, Kazakhstan, Kyrgyzstan, and Turkmenistan), and non-Soviet Eastern European countries (the Czech Republic, the Slovak Republic, Hungary, and Poland). Each panel shows de-trended crude death rate means for one of these country groups (and Russia for comparison), plotting residuals obtained by regressing country-year crude death rates on a linear year variable (Demoscope 2009, World Bank 2010). Former Soviet states with low Muslim concentrations exhibit both crude death rate decreases during the latter 1980s and death rate increases during the early 1990s similar to those in Russia. Alternatively, former Soviet states with higher Muslim concentrations experienced campaign year reductions and transition year-increases that are muted considerably. Finally, death rates over time in non-Soviet Eastern European countries appear unrelated to those in Russia (see also Mesle 2004). These patterns of mortality during the 1980s and 1990s across former Soviet States and Eastern European countries are consistent with our oblast-level findings for Russia.

8. Conclusion

This paper demonstrates an important but under-recognized link between the Gorbachev Anti-Alcohol Campaign and Russia's mortality crisis. Intervening on a variety of margins, the campaign simultaneously raised the cost of drinking and subsidized substitute activities. Alcohol consumption declined markedly, and Russia's crude death rate fell by 12%, implying roughly

665,000 fewer deaths during the latter 1980s. However, the campaign's unpopularity and public finance impact led to its repeal shortly before the collapse of the Soviet Union. The Russian death rate subsequently climbed rapidly – and the increase associated with the campaign's end explains between 32% and 49% of the Russia's Mortality Crisis. Former Soviet States and the rest of Eastern Europe also experienced similar temporal patterns of mortality commensurate with their exposure to the Anti-Alcohol Campaign.

A key implication of these findings is that Russia's transition to capitalism and democracy was not as lethal as commonly suggested (Stuckler, King, and McKee 2009). However, our findings also do not necessarily imply that alcohol prohibition raises welfare (in Russia or elsewhere), even if it saves lives. Health is only one argument of welfare, so health-improving restrictions on individual choices can cause harm as well as do good.⁴¹

⁴¹ Negative externalities and the role of addiction introduce ambiguity into welfare evaluations of alcohol policies and are beyond the scope of our paper (Becker and Murphy 1988; Becker, Grossman, Murphy 1994; Gruber and Koszegi 2001).

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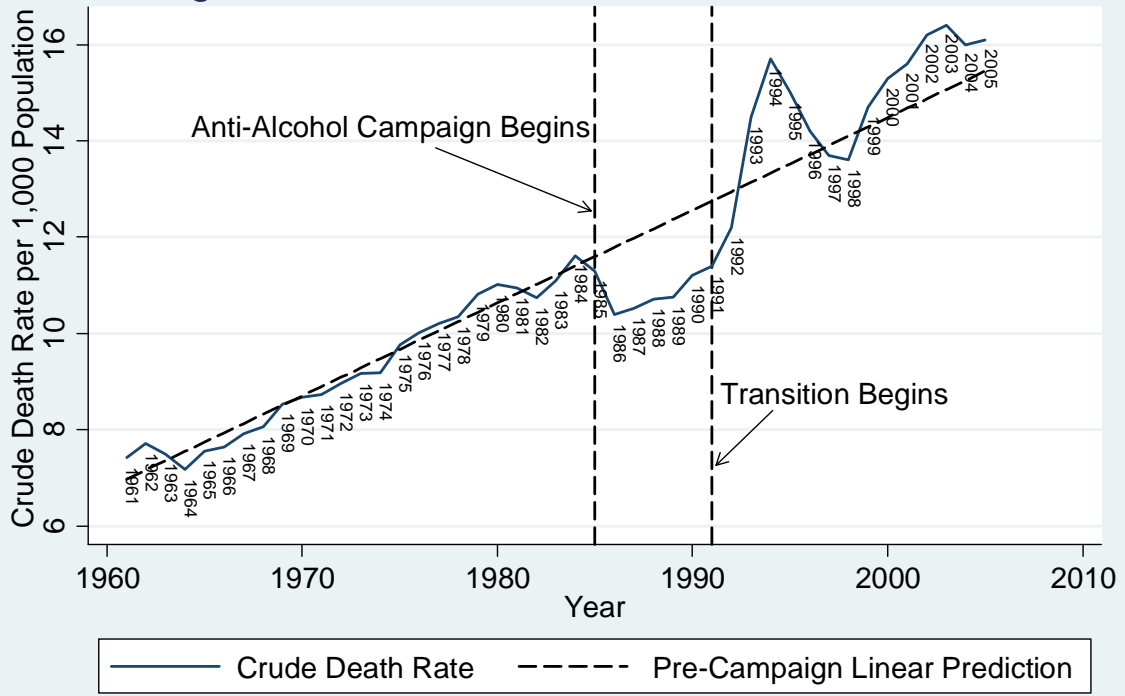
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Figure 1: Russian Crude Death Rates, 1960-2005



Source: <http://www.demoscope.ru>

Figure 2: The Distribution of Anti-Alcohol Campaign Intensity by Type of Alcohol Measure, 1985-1989

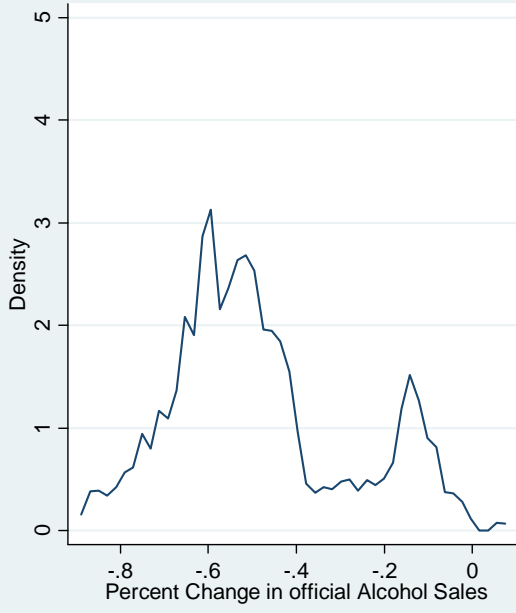
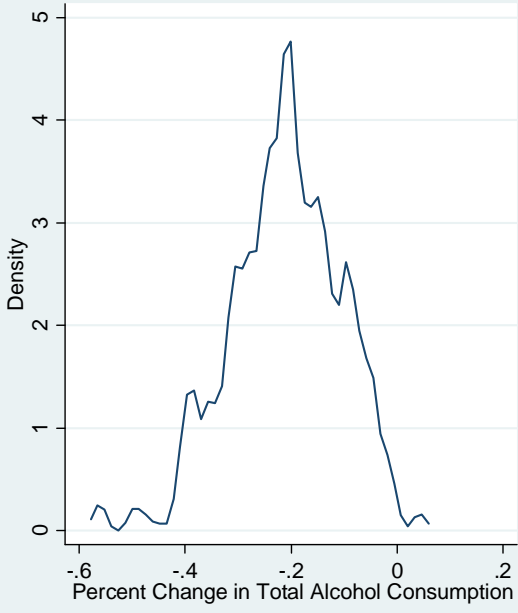


Figure 3: Crude Death Rates by Quartile of Pre-Campaign Total Alcohol Consumption, 1970-2000

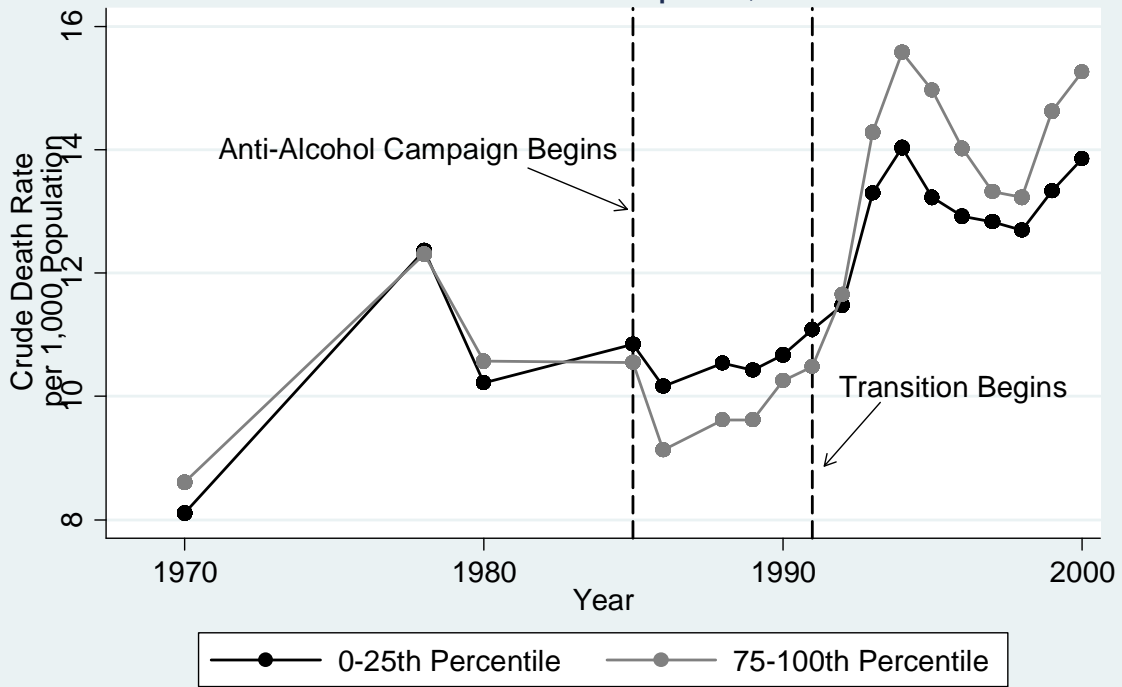


Figure 4: Crude Death Rates by Quartile of Mean Campaign Intensity, 1970-2000

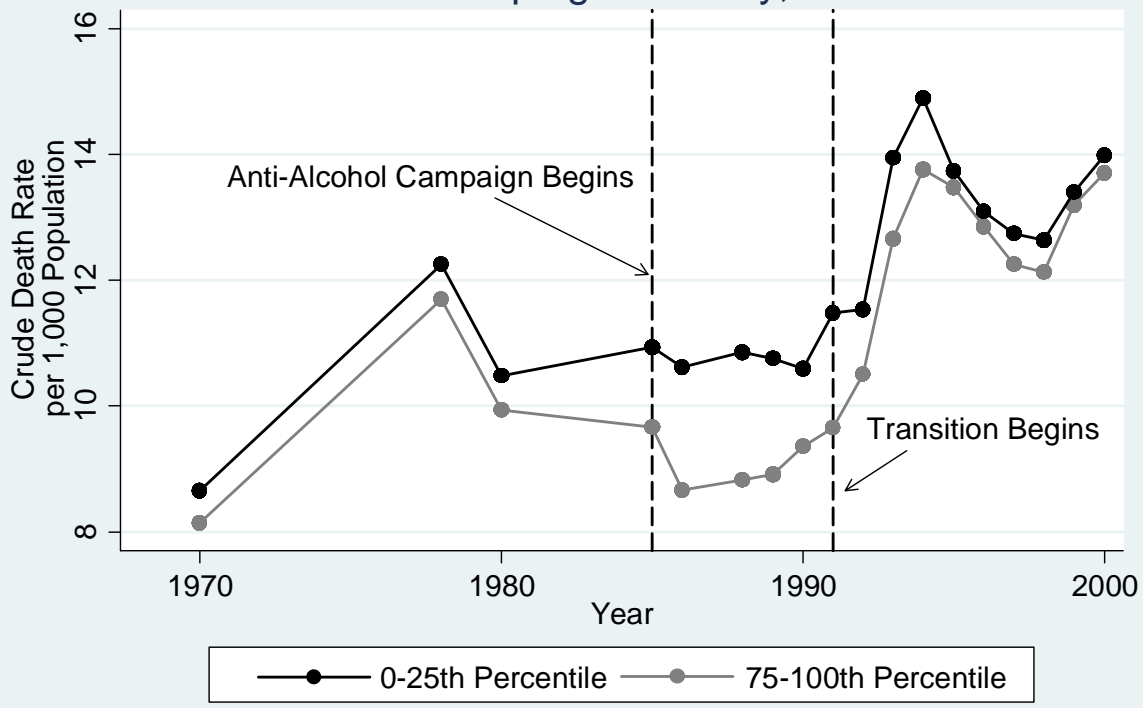


Figure 5: Cause-Specific Death Rate Increases during the Mortality Crisis Predicted by Mean Anti-Alcohol Campaign Intensity

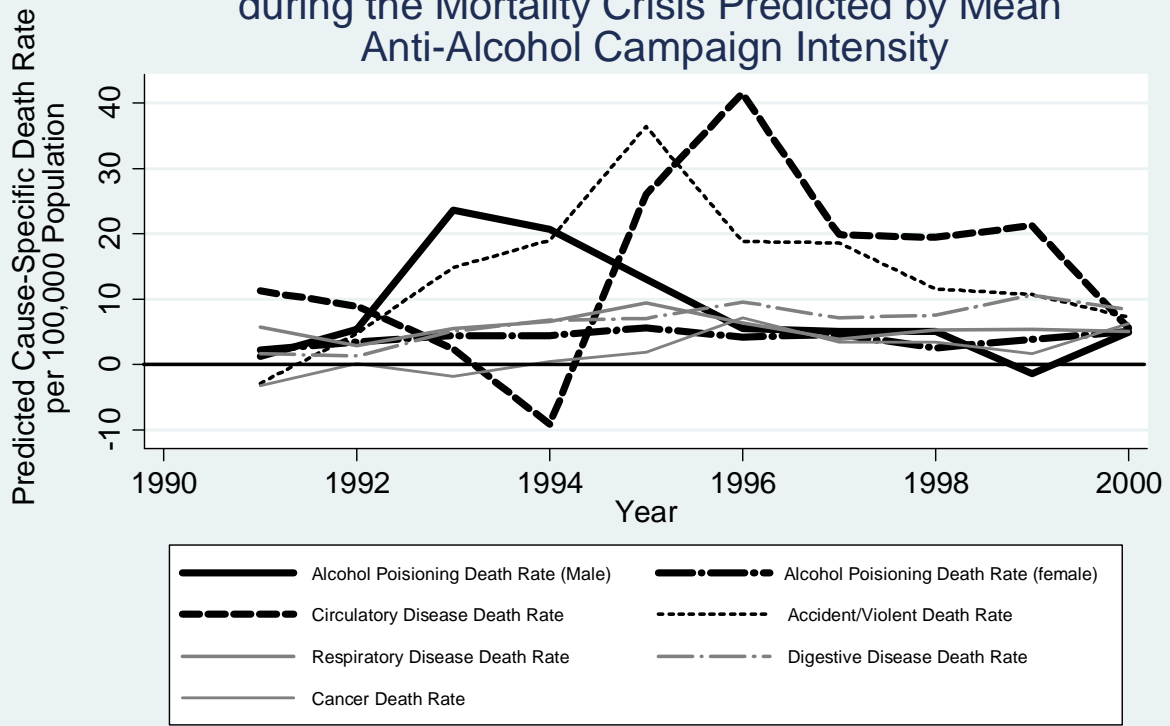


Figure 6: De-Trended Crude Death Rates in Former Soviet and Non-Soviet States, 1960-2005

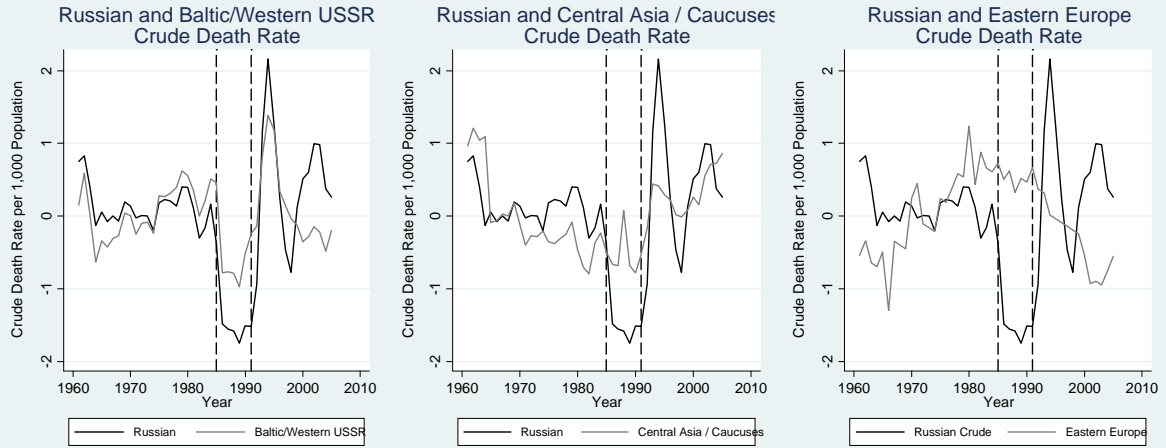


TABLE 1:
DESCRIPTIVE STATISTICS

Years:	Pre-Campaign Years (Prior to 1985)			Campaign Years (1985-1989)			Transition Period (1990-2000)			All Years		
	N	Mean	SE	N	Mean	SE	N	Mean	SE	N	Mean	SE
Crude Death Rate	219	10.27	(0.16)	306	10.42	(0.14)	955	13.04	(0.10)	1480	12.09	(0.08)
Official Alcohol Sales	454	9.97	(0.11)	376	5.28	(0.16)	549	5.92	(0.08)	1379	7.08	(0.08)
Total Alcohol Consumption	376	14.56	(0.11)	376	11.46	(0.09)	234	12.96	(0.07)	986	12.99	(0.07)
Campaign Intensity (Official Alcohol Sales)	454	0	0	376	-0.48	(0.01)	--	--	--	830	-0.22	(0.00)
Campaign Intensity (Total Alcohol Consumption)	376	0	0	376	-0.21	(0.01)	--	--	--	752	-0.11	(0.00)
Alcohol Poisoning Death Rate	73	29.46	(2.14)	151	9.91	(0.48)	864	26.43	(0.67)	1088	24.34	(0.58)
Alcohol Poisoning Death Rate (Male)	73	46.54	(3.21)	151	15.92	(0.76)	864	41.47	(1.01)	1088	38.26	(0.88)
Alcohol Poisoning Death Rate (Female)	73	12.38	(1.28)	151	3.89	(0.25)	864	11.39	(0.38)	1088	10.41	(0.33)
Circulatory Disease Death Rate	77	509.63	(20.22)	78	555.92	(23.59)	959	675.92	(7.71)	1114	656.02	(7.13)
Accident/Violent (and other External Cause) Death Rate	77	166.96	(5.54)	78	116.76	(3.08)	959	210.08	(2.28)	1114	200.57	(2.15)
Respiratory Disease Death Rate	77	97.19	(4.08)	78	66.31	(3.30)	959	68.03	(0.82)	1114	69.93	(0.83)
Digestive Disease Death Rate	77	28.42	(1.46)	78	28.69	(1.55)	959	37.40	(0.37)	1114	36.17	(0.36)
Cancer Death Rate	77	142.76	(4.87)	78	167.93	(5.73)	959	181.14	(1.57)	1114	177.56	(1.47)
Doctors Per Capita	258	3.03	(0.06)	423	4.39	(0.14)	959	5.38	(0.22)	1640	4.75	(0.14)
Hospital Beds Per Capita	258	12.80	(0.18)	423	14.25	(0.12)	956	13.21	(0.09)	1637	13.41	(0.07)
Emigration (in 1,000s)	--	--	--	--	--	--	800	38.64	(0.93)	800	38.64	(0.93)
Immigration (in 1,000s)	--	--	--	--	--	--	800	38.64	(0.99)	800	38.64	(0.99)
Privatized Manufacturing Employment Rate	--	--	--	--	--	--	894	0.53	(0.01)	894	0.53	(0.01)
Average Monthly Income Per Capita (Deflated, in Rubles)	--	--	--	--	--	--	753	266.73	(5.50)	753	266.73	(5.50)
Employment Per 1,000 Population	--	--	--	71	68.09	(9.90)	888	49.04	(0.80)	959	50.45	(1.05)

Data on death rates, official alcohol sales, doctors, hospital beds, internal immigration and emigration, income, and employment are available in annual statistical yearbooks compiled by Goskomstat and Rosstat. We obtained this statistical yearbook data through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Trembl and Alexeev (1993), Vassin and Costello (1997), Vallin et al. (2005), and Heleniak (2006) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research. Data on employment in private manufacturing are from Brown, Earle, and Gehlbach (2009) and Earle and Gehlbach (2010); data on emigration and immigration is from Andrienko and Guriev (2004). We constructed estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production. See Appendices 1 and 2 for details.

**TABLE 2:
CHANGES IN DEATH RATES UNDER THE GORBACHEV ANTI-ALCOHOL CAMPAIGN**

Alcohol Measure:	Total Alcohol Consumption		Official Alcohol Sales		Total Alcohol Consumption		
	Crude Death Rate	Crude Death Rate	Crude Death Rate	Crude Death Rate	Alcohol Poisoning Death Rate	Alcohol Poisoning Death Rate (Male)	Alcohol Poisoning Death Rate (Female)
Panel A: Mean Change across Campaign Years							
Campaign Intensity	5.886*** (1.083)	3.496*** (0.889)	3.601*** (0.928)	1.972*** (0.777)	64.75** (28.85)	83.45** (41.29)	46.04** (17.83)
Year Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oblast Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oblast-Specific Linear Trends	No	Yes	No	Yes	No	No	No
N	513	513	513	513	214	214	214
R ²	0.943	0.977	0.938	0.976	0.810	0.818	0.765
<hr style="border-top: 1px dashed black;"/>							
Panel B: Year-Specific Changes during the Campaign							
Campaign Intensity × 1985	8.256*** (1.272)	5.273*** (0.989)	5.112*** (0.944)	2.985*** (0.710)			
Campaign Intensity × 1986	5.661*** -0.985	3.673*** -0.819	3.305*** (0.802)	1.936*** (0.639)			
Campaign Intensity × 1988	5.711*** -0.934	2.940*** -0.858	3.335*** (0.843)	1.196* (0.742)			
Campaign Intensity × 1989	5.144*** (0.932)	1.824** (0.890)	2.913*** (0.846)	0.1976 (0.774)			
Year Fixed Effects	Yes	Yes	Yes	Yes			
Oblast Fixed Effects	Yes	Yes	Yes	Yes			
Oblast-Specific Linear Trends	No	Yes	No	Yes			
N	513	513	513	513			
R ²	0.944	0.978	0.938	0.977			

Data on death rates and official alcohol sales were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Treml and Alexeev (1993), Vassin and Costello (1997), Vallin et al. (2005) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research; estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details). Campaign intensity estimates were obtained by estimating equation (1) (and variants with interactions between campaign intensity and campaign year dummy variables). Crude death rates are per 1,000 population; alcohol poisoning death rates are per 100,000 population; campaign intensity variables were constructed using alcohol measures shown at the top of each column. All oblast-year samples are restricted to years prior to 1990 (for crude death rate regressions: 1970, 1978, 1980, 1985, 1986, 1988, and 1989; for alcohol poisoning death rate regressions: 1978, 1988, 1989). Standard errors clustered at the oblast level shown in parentheses. *p<0.10, **p<0.05, and ***p<0.01.

**TABLE 3:
ANALYSIS OF DEATH RATE TRENDS PRIOR TO THE ANTI-ALCOHOL CAMPAIGN**

Campaign Intensity Definition:	Change from 1980-1984 Mean	Change from 1980-1984 Mean	Change from 1980-1984 Linear Trend	Change from 1980-1984 Mean	Change from 1980-1984 Mean
Campaign Intensity	5.541*** (1.281)	2.664*** (0.899)	4.761*** (0.993)	5.886*** (1.083)	3.496*** (0.889)
Mean Campaign Intensity × 1980	0.697 (1.193)	-0.657 (1.056)			
Mean Campaign Intensity × 1978	-3.285** (1.563)	-3.357** (1.335)			
Pre-Campaign Alcohol Consumption				-0.0002 (0.0002)	0.0002 (0.0002)
Year Fixed Effects	Yes	Yes	Yes	Yes	Yes
Oblast Fixed Effects	Yes	Yes	Yes	Yes	Yes
Oblast-Specific Linear Trends	No	Yes	No	No	Yes
N	503	503	497	513	513
R ²	0.942	0.977	0.941	0.943	0.977

Data on death rates and official alcohol sales were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Treml and Alexeev (1993), Vassin and Costello (1997), Vallin et al. (2005) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research; estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details). All estimates were obtained by estimating variants of equation (1) (with interactions between 1979 and 1980 dummies in the first two columns, with pre-campaign alcohol consumption in the last two columns). The dependent variable in all regressions is crude death rates per 1,000 population; all campaign intensity variables are constructed using total alcohol consumption. In the first two and last two columns, campaign intensity is measured as percent change in campaign year alcohol consumption relative to mean consumption between 1980 and 1984; in the third column, campaign intensity is measured as the percent change in actual alcohol consumption relative to consumption predicted by each oblast's 1980-1984 alcohol consumption trend. All oblast-year samples are restricted to years prior to 1990 (1970, 1978, 1980, 1985, 1986, 1988, and 1989). Standard errors clustered at the oblast level shown in parentheses. *p<0.10, **p<0.05, and ***p<0.01.

TABLE 4:
THE GORBACHEV ANTI-ALCOHOL CAMPAIGN AND RUSSIA'S MORTALITY CRISIS

Mean Campaign Intensity × 1991	-0.1458	(1.752)	0.5538	(1.504)
Mean Campaign Intensity × 1992	-2.633**	(1.247)	-2.699***	(0.732)
Mean Campaign Intensity × 1993	-2.623	(1.810)	-3.154**	(1.524)
Mean Campaign Intensity × 1994	-2.512	(2.189)	-3.558**	(1.687)
Mean Campaign Intensity × 1995	-5.128**	(2.249)	-6.899***	(2.017)
Mean Campaign Intensity × 1996	-5.484***	(1.501)	-7.623***	(1.064)
Mean Campaign Intensity × 1997	-3.985***	(1.444)	-6.491***	(0.606)
Mean Campaign Intensity × 1998	-3.543***	(1.233)	-6.417***	(0.838)
Mean Campaign Intensity × 1999	-4.218*	(2.221)	-7.378***	(0.507)
Mean Campaign Intensity × 2000	-3.526	(2.366)	-7.038***	(0.922)
Year Fixed Effects	Yes		Yes	
Oblast Fixed Effects	Yes		Yes	
Oblast-Specific Linear Trends	No		Yes	
N	865		865	
R ²	0.957		0.974	

Data on death rates and official alcohol sales were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Treml and Alexeev (1993), Vassin and Costello (1997), Vallin et al. (2005) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research; estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details). All estimates were obtained by estimating equation (2). The dependent variable in all regressions is crude death rates per 1,000 population; all campaign intensity variables are constructed using total alcohol consumption. All oblast-year samples are restricted to years 1990 and later (1990-2005). Standard errors clustered at the oblast level shown in parentheses. *p<0.10, **p<0.05, and ***p<0.01.

TABLE 5:
THE GORBACHEV ANTI-ALCOHOL CAMPAIGN AND RUSSIA'S MORTALITY CRISIS
WITH ADDITIONAL CONTROLS FOR ALTERNATIVE EXPLANATIONS

Mean Campaign Intensity × 1991	0.554 (1.504)	-0.248 (1.177)	-0.927 (0.716)	-0.135 (1.584)	-1.923*** (0.751)	-2.053** (0.892)
Mean Campaign Intensity × 1992	-2.699*** (0.732)	-3.422*** (0.957)	-3.226*** (0.811)	-4.096*** (0.507)	-3.306*** (1.303)	-3.978** (1.826)
Mean Campaign Intensity × 1993	-3.154** (1.524)	-3.913** (1.646)	-3.549** (1.520)	-4.910*** (1.581)	-3.132 (2.293)	-4.106 (3.058)
Mean Campaign Intensity × 1994	-3.558** (1.687)	-4.314** (1.889)	-3.332* (1.709)	-5.696*** (2.186)	-3.084 (2.901)	-4.290 (3.877)
Mean Campaign Intensity × 1995	-6.899*** (2.017)	-7.546*** (2.031)	-7.833*** (1.800)	-10.251*** (2.573)	-8.554** (3.612)	-9.625** (4.853)
Mean Campaign Intensity × 1996	-7.623*** (1.064)	-8.223*** (1.033)	-8.853*** (0.855)	-11.971*** (2.314)	-9.316*** (2.910)	-11.415*** (4.351)
Mean Campaign Intensity × 1997	-6.491*** (0.606)	-7.037*** (0.668)	-7.424*** (0.551)	-11.252*** (2.936)	-8.092*** (3.005)	-10.653** (4.489)
Mean Campaign Intensity × 1998	-6.417*** (0.838)	-6.911*** (0.777)	-7.556*** (0.701)	-12.354*** (3.226)	-8.245*** (3.177)	-11.335** (4.828)
Mean Campaign Intensity × 1999	-7.378*** (0.507)	-7.831*** (0.669)	-8.055*** (0.795)	-12.875*** (3.769)	-9.727*** (3.524)	-11.906** (5.499)
Mean Campaign Intensity × 2000	-7.038*** (0.922)	-7.462*** (0.772)		-13.443*** (4.112)	-9.992** (4.012)	
Doctors per Capita	No	Yes	No	No	No	Yes
Hospital Beds per Capita	No	Yes	No	No	No	Yes
Internal Emigration	No	No	Yes	No	No	Yes
Internal Immigration	No	No	Yes	No	No	Yes
Employment in Private Manufacturing	No	No	No	Yes	No	Yes
Income per Capita	No	No	No	No	Yes	Yes
Employment per Capita	No	No	No	No	Yes	Yes
N	865	855	757	833	809	714
R ²	0.974	0.973	0.973	0.973	0.976	0.973

Data on death rates, official alcohol sales, doctors, hospital beds, internal immigration and emigration, income, and employment were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Trembl and Alexeev (1993), Vassin and Costello (1997), Andrienko and Guriev (2004), Vallin et al. (2005), Brown, Earle, and Gehlbach (2009), and Earle and Gehlbach (2010) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research; estimates of total alcohol consumption are from extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details). All estimates were obtained by estimating equation (2). The dependent variable in all regressions is crude death rates per 1,000 population; all campaign intensity variables are constructed using total alcohol consumption; all regressions include oblast and year fixed effects and oblast-specific linear time trends. All oblast-year samples are restricted to years 1990 and later (for regressions with number of doctors, number of hospital beds, income, and employment: 1990-2000; for regressions with emigration and immigration: 1990-1999; for regressions with employment in private manufacturing: 1990-2000). Standard errors clustered at the oblast level shown in parentheses. *p<0.10, **p<0.05, and ***p<0.01.

APPENDICES:

“The Gorbachev Anti-Alcohol Campaign and Russia’s Mortality Crisis”

APPENDIX 1: Data

APPENDIX 2: Estimation of Total Alcohol Consumption (Official Alcohol Sales and *Samogon* Production)

APPENDIX 3: Estimation and Simulation of the Temporal Relationship between Alcohol Consumption and Mortality in the Framingham Heart Study

APPENDIX FIGURES A1-A7

APPENDIX TABLES A1-A7

APPENDIX 1: Data

This appendix describes the sources used to construct our new oblast-year panel data set spanning 1970-2000 that includes mortality rates, official alcohol sales, and socio-economic and demographic characteristics. We use the term “oblast” throughout, but geographic areas also include several krajs (Altayskii, Krasnodarskiy, Krasnoyarskii, Khabarovskii, Primorskii, Stavropolski) and autonomous republics (Altai, Bashkortostan, Buryatiya, Chuvash, Dagastan, Kabardino-Balkarskaya, Kalmykaya, Karachaevo-Cherkesskaya, Karelia, Khakasiya, Komi, Marii-El, Mordovaya, North Osetiya-Alaniya, Sakha, Taatarstan, Tuva, Udmurtskaya). We exclude autonomous okrugs (Aginsky, Eventsky, Chukotsky, Khanty-Mansiisk, Komi-Permiatsky, Koryaksky Nenets, Nenetsky, Taimyrskii (or Dolgano-Nentsky), Usy-Ordynsky, Yamalo-Nenetsky) from the analysis because we do not have information about them for several key years. Overall, our analyses therefore generally include 77 oblasts (including krajs and republics).

From the 1960s until 1986, statistics on deaths, alcohol production/consumption, and crime were collected but not made publicly available for political purposes. Under Glasnost and Mikhail Gorbachev’s leadership, however, the Central Statistical Office of the Soviet Union (*Goskomstat*) resumed publication of oblast-level mortality statistics in annual demographic yearbooks in 1986 (publication of official alcohol sales data and crime statistics resumed shortly thereafter – in 1987 and 1988, respectively). Since the 1980s, an estimated 94% of all deaths in Russia have been medically certified (with the remainder certified by trained paramedics called *feldshers*) (Shkolnikov et al. 1996). Oblast governments then use these death records to construct oblast-level mortality statistics by age, sex, and cause. In principle, these oblast-year statistics are available from *Goskomstat* (and its successor *Rosstat*). Obtaining these records is not easy in practice, so we also conducted a comprehensive search of all Russian and English language publications with statistics on mortality, alcohol, and crime in constructing our data set.

Vital Statistics

Our primary dependent variable is the crude death rate (CDR), which is defined as the number of deaths per 1,000 people. The CDR is calculated as the number of deaths from all causes in a calendar year divided by the mid-year *de facto* population (the official inter-censal population estimate) and is available for years 1970, 1978, 1980, 1985, 1986, and 1988-2000 (Goskomstat SSSR 1987; New World Demographics 1992; Goskomstat Rossii 1992; 1993a; 1995; 1996b-2005b).

We also study death rates (per 100,000 population) by several categories of causes. In the Soviet Union, cause-specific deaths were reported using a Soviet classification system containing 175 categories. These were later reclassified according to the World Health Organization’s International Classification of Diseases (ICD) (see below). Given the focus of our study, an important cause of death is alcohol poisoning (a marker for a broader set of alcohol-related deaths). The Soviet Union and Russian Federation require that sudden, unexpected deaths be investigated (by autopsy). Cases of alcohol poisoning are identified when blood alcohol concentrations exceed 250 mg/dl and in the absence of other apparent causes. Alcohol poisoning deaths are reported separately for men and women and are available for years 1978/9 and 1988-2000. These data were graciously provided by Vladimir Shkolnikov. To convert alcohol poisoning deaths (which are reported by age group for years 1989-2000) into

overall death rates (per 100,000), we use the 1998 European Standard Population. Alcohol poisoning death rates are then the weighted average of the age-specific rates (using standardized population shares as weights).

In addition to alcohol poisonings, we study data on deaths by other major causes: neoplasms/cancers (group 2, codes 140-239), circulatory diseases including cardiovascular diseases (group 7, codes 390-459), acute respiratory infections (group 8, codes 460-519), diseases of the digestive system (group 9, codes 520-579) and accidental/violent deaths (accidents, other poisonings, homicide, and suicide (group 17, codes 800-999). About half of deaths in the last category are thought to be alcohol-related (Nemtsov 1998; 2000). These data are available for 1978/8, 1988/9 and annually since 1990 (Goskomstat Rossii 1993b; Goskomstat Rossii 1996b-2005b; Vallin et al. 2005).

Evaluations of Russia's mortality statistics generally conclude that they are acceptable in quality with relatively little under-reporting. Exceptions are Tuva and regions in the North Caucasus (Dagastan Republic, Ingushitya Republic, Chechen Republic, Kabardino-Balkarskaya Republic, Karachaevo-Cherkesskaya Republic, North Osetiya-Alaniya Republic, Krasnodarskiy Krai, and Stavropolski Krai) where studies of infant mortality under-reporting suggest rates as high as 25% during the 1980s (Blum and Monnier 1989). The cause of death statistics appear somewhat less reliable as many alcohol related deaths seem to be classified as cardiovascular disease or cause unknown (Andreev 1999, Gavrilova et. al. 2005, Zaridze et al. 2009).

Between 1969 and 1991, the Soviet cause-of-death classification system was changed three times (in 1970, 1981 and 1988). The Soviet system from 1965 to 1970 was similar to WHO ICD-8 codes, and the revisions in 1981 and 1988 closely resembled WHO ICD-9 codes (Goskomstat created a key matching the two) (Shkolnikov et al. 1996). The analyses of Vallin et al. (1996) suggest that the changes in 1970 and 1981 did not influence the registration of deaths from major causes (at least at ages up to age 65) (Vallin et al. 1996). The 1988 revision simply merged the previous classification's 'employment-related' and 'non-employment-related' alcohol poisoning subgroups into a single category. A comparison of data from Russia and the three Baltic countries (Estonia, Latvia, and Lithuania which shifted before 1999) shows no discontinuity, suggesting that data before and after the coding change are roughly comparable (Mesle et al. 1996).

Population Measures

Population estimates used to convert deaths into death rates are based on the Soviet censuses of 1970, 1979, and 1989 Soviet censuses and the 2002 census of the Russian Federation. These censuses were conducted on January 15, 1970; January 17, 1979 and 1989; and between October 9 and 16, 2002. Using census population counts, *Goskomstat* produced official population estimates for January 1 of each census year. For inter-census years, oblast statistical offices estimated their populations using information on births and deaths as well. Population estimates were also adjusted using data on internal migration collected by the Ministry of the Interior. Mid-year *de facto* populations used as denominators for constructing rates are calculated as arithmetic means of population estimates at the beginning of a given year and the subsequent year (Goskomstat SSSR 1990; New World Demographics 1992; Goskomstat Rossii 1993c; Goskomstat 1996a-2005a).

Alcohol Sales

As a monopolist, the government of the Soviet Union decided official alcohol production, pricing, foreign trade, and domestic distribution. *Goskomstat* collected statistics on alcohol sales from reports of government retail trade networks across the country (but do not alcohol sold on military bases). After Russia's political and economic transition, *Rosstat* continued collecting data in the same way, although data after 1992 do not include legal private trade and restaurant sales. More importantly, official sales statistics also do not include illegal home production of alcohol (*samogon*).

Data on official sales are reported in billions of rubles and in volume of pure alcohol for years 1970, 1980, 1985 and 1989. In addition, official sales data are reported in liters of pure alcohol per person for 1970, 1980, 1984, 1985 and 1989-1992. We also have information on sales of specific types of alcoholic beverages (vodka, wine, beer, champagne, and cognac). The numbers for individual beverages sales are reported in liters per person and are available for years 1970, 1980-1992, and 1997-2000. Sales data for cognac and champagne were available since 1999 only. We converted the sales data for specific types of beverages into total sales of pure alcohol using the following assumptions about alcohol concentrations for each type of beverage (from Andrienko and Nemtsov 2006): Russian vodka 40%; wine 14.4%; cognac 18%; champagne 22.8%; beer 2.85% (before 1995), 3.37% (between 1995 and 1999), and 3.85% (after 2000). To summarize, we calculate alcohol consumption per capita in liters of pure alcohol from sales of different types of alcoholic beverages using the following formula:

$$\begin{aligned} \text{Liters of Pure alcohol} = & 0.144 * \text{wine} + 0.4 * \text{vodka} + 0.228 * \text{champagne} + 0.18 * \text{cognac} \\ & + 0.285 * \text{beer} * 1(1970-1994) + 0.337 * \text{beer} * 1(1995-1999) + 0.389 * \text{beer} * 1(2000-2005). \end{aligned}$$

We thus generate a panel of oblast-level total alcohol sales data from 1970 to 2000 (with data missing between 1971 and 1979). The data prior to 1997 (when both official sales and sales of specific beverages types are reported) show that our calculations using beverage-specific data closely matches the *Goskomstat* official data on pure alcohol sales.

Other Covariates

To control for other factors influencing mortality in Russia, we assembled oblast-year data on employment, income, health care infrastructure, fertility, and migration. Employment is measured as the number of people employed per 1000 population and is available for 1985 and all years beginning in 1990 (*Goskomstat Rossii* 1997f, 2002j, 2006j). We also use data on the share of employment in private manufacturing, which is available for all years beginning in 1992 (Brown, Earle and Gehlbach 200, Earle and Gehlbach 2010). Income is measured as average income per month in real Rubles and is available for years 1970, 1980, 1985, 1989-1992, and all years beginning in 1994 (*Goskomstat Rossii* 1992, 1993a, 1996a-2005a, Trembl and Alexeev 1993). Our health care infrastructure and workforce measures are the number of hospital beds per capita and the number of doctors per capita; these variables are available for years 1970, 1975, 1980 and all years beginning in 1985 (*Goskomstat Rossii* 1994, 1997f-2001f, 2002i-2005i, *Goskomstat SSSR* 1990b). Crude birth rate data (defined as the number of births per 1,000 population) is available for years 1970, 1980, 1985-1986, and all years beginning in 1988 (*Goskomstat SSSR* 1987, *Goskomstat Rossii* 1992, 1993a, 1995, 1996b-2005b, New World Demographics 1992). Finally, data on immigration and emigration flows are available for all

years beginning in 1989 (Andrienko and Guriev 2004, Goskomstat SSSR 1990a, Goskomstat Rossii 1993b, 1995, 2002i-2005i).

Additional Data Source References:

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APPENDIX 2:

Estimation of Total Alcohol Consumption (Official Alcohol Sales and *Samogon* Production)

Official alcohol sales data measure sales of state-produced alcoholic beverages. However, anecdotal evidence suggests that illegal production of alcoholic beverages – especially *samogon* – increased during the Gorbachev Anti-Alcohol campaign. Because comprehensive oblast-year estimates of illegal alcohol production are not available, we extended the work of Nemtsov (2000) to estimate illegal alcohol production and consumption for the 1980s and early 1990s.

Nemtsov (1998, 2000) developed two indirect methods for estimating illegal alcohol consumption. First, Nemtsov (1998) exploits the fact that sugar is the main ingredient required for *samogon* production. For Moscow prior to 1986 (when the Soviet Union began to ration sugar), he used sugar sales data to estimate excess sugar sales by subtracting standard dietary requirements of sugar from total sugar sales.¹ Excess sugar sales are then converted into *samogon* production estimates with information about the sugar concentration of *samogon*.

To estimate *samogon* production for years after 1986, Nemtsov (2000) used forensic records to develop a second indirect technique. Both the Soviet Union and the Russian Federation require each oblast's forensic bureau to perform autopsies for all violent and accidental deaths as well as for deaths with unclear causes. All autopsies report blood alcohol content, effectively providing a non-random sample of Russians with measures of alcohol concentration in the blood. Nemtsov (2000) calculates the ratio of autopsies with positive blood alcohol content (excluding alcohol poisoning deaths) to the number of autopsies with no blood alcohol content and parametrically relates this ratio to total alcohol consumption. He then uses this estimated parametric relationship to predict total (including illegal) alcohol consumption for 25 oblasts between 1980 and 1992, allowing him to recover implied *samogon* consumption (Nemtsov 2000).² Autopsy-based estimates closely match sugar-based estimates for Moscow between 1983 and 1986 and outperform other methodologies (based on hospital admissions for alcohol-induced psychosis, cirrhosis deaths, and pancreatitis deaths, for example) (McKee 1999, Nemtsov 2000, Balan-Cohen 2007).

To generate oblast-year estimates of total alcohol consumption for key years in our data set, we use statistical relationships between official alcohol sales and estimated *samogon* consumption reported in Nemtsov (2000). Specifically, Nemtsov (2000) uses data from 25 oblasts in 1990 to regress *samogon* consumption on official alcohol sales, estimating the following relationship: $samogon = 12.38 - 1.02 \times \text{official sales}$. He also reports the correlation coefficient between official sales (OS) and *samogon*/illegal alcohol (IA) for years 1983, 1985 and 1990. Because the regression slope is equal to $\text{Cov}(IA, OS) / (\text{Var}(OS))$ and the correlation coefficient $r = \text{Cov}(IA, OS) / (\text{Var}(IA)^{1/2} \times (\text{Var}(OS)^{1/2})$, we can use the observed variance of official sales in 1990 to calculate the implied variance of *samogon* production in 1990. Assuming the variance of *samogon* production to remain constant over time, we then use the observed variance of official sales in 1983 and 1985 to calculate implied regression coefficients

¹ Nemtsov (1998) uses the minimum amount of sugar sold (per person and month) in the state retail network during the period 1983 to 1986. The figure he uses – 24.3 kg of sugar (recorded for September of 1985) – is close to the average sugar consumption (24 kg) in the Soviet Union as reported by the Institute of Nutrition of the Soviet Union in the Academy of Medical Sciences.

² These oblasts were Altai krai, Amur, Bashkiria, Ekaterinburg, Ivanova, Khabarovsk, Kaluga, Karelia, Kemerov, Kursk, Leningrad, Moscow city, Moscow oblast, Murmansk, Novgorod, Novosibirsk, Omsk, Orel, Rostov, Samara, Saratov, Sakhalin, St. Petersburg city, Yaroslavl.

for years 1983 and 1985. We assign the slope in 1983 to pre-campaign years 1980-1984, the 1985 slope to campaign years 1985-1989, and the 1990 slope to post-campaign years 1990-1992.

We then calculate year-specific regression constants. To do so, we subtract observed annual national-level official alcohol sales from annual national-level total alcohol consumption reported by Nemtsov (2000), yielding annual national-level *samogon* consumption. With observed official alcohol sales and annual *samogon* consumption, we are then able to calculate implied year-specific regression constants.

Finally, we use these year-specific regression constants and slopes together with our oblast-year data on official alcohol sales to predict oblast-year *samogon* consumption. We then calculate total alcohol consumption as the sum of official sales and *samogon* consumption for years 1980-1992. To validate these predictions, we calculate mean total consumption for the same 25 oblasts studied in Nemtsov (2000), and we then compare annual means with those provided by Nemtsov (2000) for Russia's six regions (North and Northwest Region, Central Region, Northern Caucasus Region, Urals and Volga Region, Western Siberia Region, and Russian Far East Region). Appendix Table 4 shows that our calculations generally match these published figures.

APPENDIX 3:

Estimation and Simulation of the Temporal Relationship between Alcohol Consumption and Mortality in the Framingham Heart Study

Many consequences of alcohol consumption occur over time. Specific examples include cirrhosis, hypertension, heart attacks, and strokes. There are suggestive reports that moderate alcohol consumption may increase longevity as well. However, given the magnitude of the decline in alcohol consumption under the Gorbachev Anti Alcohol Campaign, we would expect a reduction in mortality on balance. Similarly, we hypothesize that the relaxation of constraints to drinking at the end of the campaign increased mortality. The precise temporal relationship between contemporaneous alcohol consumption and subsequent mortality is unclear, however. The objective of this appendix is to examine this temporal relationship with data from the Framingham Heart Study, a large longitudinal study uniquely suited for this purpose.

The Framingham Heart Study

Spanning 1948 to the present, the Framingham Heart Study has collected unusually detailed high-frequency cohort health data from three generations of individuals. At its inception, the study enrolled 5,209 randomly selected subjects from the population of Framingham, Massachusetts. Sampling children of the original participants, it then added an additional cohort of 5,124 individuals (and their spouses) in 1971 and a third generation of grandchildren (and their spouses) in 2002. Our analyses use individuals from the first cohort observed during years 1948-2000.

Investigators visit each member of all three cohorts every two years to administer a detailed questionnaire and medical examination. The study follows every participant until death, using death certificates to verify dates of death. Beginning with the seventh wave (which was conducted between 1960 and 1964), the study began collecting information about alcohol consumption. Specifically, the questionnaires ask respondents how many cocktails, glasses of beer, and glasses of wine (with a standard drink size specified) they consumed during the past month.

Using responses to these questions, we computed total alcohol consumption (grams per day) by multiplying the number of each type of drink consumed with its average alcohol content (and summing across the three products). Following the Framingham investigators, we define a standard drink to be 13.7 grams (0.018 liters) of pure alcohol. This amount of pure alcohol is found in 12-ounces (0.36 liters) of beer, 5-ounces (0.15 liters) of wine, or 1.5-ounces (0.04 liters) of 80-proof liquor such as gin, rum, vodka, or whiskey. We adjust for changes during the late 1960s in the alcohol content of liquor (from 100% to 80% proof), the type of wine consumed (from fortified to table wine), and changes in average serving sizes in calculating total ethanol consumption. Between waves, we impute alcohol consumption at the level reported in the preceding wave.

The Framingham Heart Study provides an excellent source of information about alcohol consumption and mortality and is distinguished from other longitudinal data sets by its longevity and data quality. Hence, the Framingham Heart Study is well suited for estimating the temporal relationship between alcohol consumption and subsequent mortality.

Estimation

Our analysis proceeds as follows. Let $i = 1 \dots N$ denote each of the N individuals in the study and let $k = 1 \dots K$ represent survey wave. Individual i is surveyed first at age_{i0} years of age and again at $age_{i1} \dots age_{iK}$ assuming that the individual survives to those ages. While interview waves were generally separated by two years, there was considerable variation in exact interview dates, and the survey was fielded every single calendar year after the start of the study. The Framingham sample cohort at wave 1 consists entirely of adults over the age of 28.

Let t_{ik} be the time elapsed between initial entry into the study and wave k . We normalize $t_{i1} = 0$ for each individual. Let $dead_i$ be the date (measured relative to t_1) that individual i dies if he/she dies during the observation period, and let $dead_i = \infty$ if the individual does not die during the observation period. So an individual will not be observed in wave k if $t_{ik} > dead_i$.

Let $alc_{it} = \{none_{it}, light_{it}, moderate_{it}, heavy_{it}\}$ represent a vector of mutually exclusive and collectively exhaustive dummy variables indicating computed alcohol consumption category. We assign these dummies based on the amount of alcohol that individual i reports drinking at time t over the previous four weeks. We assign to $none_{it} = 1$ to individuals reporting no alcohol consumption over the past month, $light_{it} = 1$ to individuals in the 0-25th percentiles of the alcohol consumption distribution (measured in grams of alcohol conditional on positive consumption), $moderate_{it} = 1$ to those between the 25th and 75th percentiles, and $heavy_{it} = 1$ to people above the 75th percentile. In addition to alcohol consumption, we observe education ($educ_{it}$), which we divide into six mutually exclusive groups: 8th grade or less, some high school, high school graduate, some college, college graduate, and post-graduate. We also observe the sex of the respondent, coded as a dummy variable, $male_i$.

Appendix Table A5 shows means and standard deviations of our key variables in waves 1, 7 (the first wave asking alcohol consumption questions), 17, and 23. In the initial wave, there were 5,209 individuals in the cohort. As the sample ages, the number people in the sample decreases, due mainly to deaths. The proportion of females increases at successive ages because males have higher mortality rates at these ages. The proportion of the population that never attended high school decreases substantially over time because those with lower educational attainment have higher mortality hazards. In wave 7, 59% of the population reported some alcohol consumption during the preceding month; 17% reported heavy drinking (that is, $heavy_{it} = 1$). By wave 23, the proportion of the cohort reporting some alcohol consumption falls to 39%, and the share of heavy drinkers drops to 7%. This is due to both differential mortality (as we will show) and less drinking with age.

We first estimate a Cox proportional hazards model of the determinants (including alcohol consumption) of time to death from entry into the study. Let $\lambda_i(t)$ be the hazard rate of mortality for individual i at time t . We model the mortality hazard as follows:

$$(A1) \quad \lambda_i(t) = \lambda_0(t) \exp(\beta_1 age_{it} + \beta_2 educ_{it} + \beta_3 male_i + \beta_4 alc_{it})$$

Here, $\lambda_0(t)$ is the baseline hazard rate. Appendix Table A6 shows the coefficient estimates (and robust standard errors) from the Cox proportional hazards regression. The results are intuitive. Males face a substantially higher mortality hazard than females, with a hazard ratio greater than 1.5; each year of age increases the hazard rate by about 8 percent. Those with education beyond high school have lower mortality hazards. Finally, heavy drinking increases the mortality hazard

by about 11 percent relative to complete abstinence. Mild or moderate drinking is associated with a lower but statistically insignificant mortality hazard.

Simulation Analysis

We next use estimates from the Cox model above to conduct simulation analyses. Specifically, we analyze temporal patterns of mortality rates for three different counterfactual scenarios. *Scenario 1*: we study the evolution of mortality rates over time following a hypothetical change from heavy drinking to abstinence in the entire population. *Scenario 2*: we model an event analogous to the Gorbachev Anti-Alcohol Campaign in which heavy drinkers become light drinkers and moderate and light drinkers abstain from drinking for five years. At the end of the five-year “campaign” period, all individuals return to their previous alcohol consumption path. *Scenario 3*: we repeat scenario 2 but also include a temporary two-year increase in alcohol consumption (to levels above the path prior to the campaign) at the end of the “campaign.” During these two years, previously heavy drinkers return to heavy drinking, previously moderate drinkers become heavy drinkers, previously light drinkers become moderate drinkers, and previous abstainers become light drinkers.

Formally, let \widehat{alc}_{it}^j be the j^{th} counterfactual path of alcohol consumption followed by individual i . Using our estimates and equation (A1), we calculate the mortality hazard path predicted by the counterfactual alcohol consumption path:

$$(A2) \quad \hat{\lambda}_i^j(t) = \hat{\lambda}_0(t) \exp(\hat{\beta}_1 age_{it} + \hat{\beta}_2 educ_{it} + \hat{\beta}_3 male + \hat{\beta}_4 \widehat{alc}_{it}^j)$$

$\hat{\lambda}_i^j(t)$ is the predicted mortality hazard path for the j^{th} counterfactual alcohol consumption path, $\hat{\lambda}_0(t)$ is the observed baseline hazard function, and $\hat{\beta}_1 \dots \hat{\beta}_4$ are the Cox regression coefficient estimates.

To simulate the three scenarios that we describe above, we need predictions for four counter-factual paths. We need four counter-factual paths for three scenarios because *Scenario 1* compares two distinct counter-factual paths, while Scenarios 2 and 3 use one counter-factual path each and compare against the actually observed mortality path. For $j = 1$, we set \widehat{alc}_{it}^1 such that $\widehat{none}_{it}^1 = 1 \forall i, t$.¹ For $j = 2$, we set \widehat{alc}_{it}^2 such that $\widehat{heavy}_{it}^2 = 1 \forall i, t$. For $j = 3$ and $j = 4$, we set \widehat{alc}_{it}^3 and \widehat{alc}_{it}^4 according to Appendix Table A7.

The j^{th} counterfactual survivor function for individual i implied by this hazard rate formula is:

$$(A3) \quad S_i^j(t) = \exp\left(-\int_0^t \hat{\lambda}_i^j(u) du\right)$$

We calculate a discrete version of (3) for each individual in the population and for each counterfactual path.

For our simulations, we draw $k = 1 \dots K$ independent uniform random numbers, $z_{ik} \sim U[0,1]$, for each individual in the population. k counts over the number of iterations in our simulation, and we set $K = 1,000$. For a given iteration, we calculate the time of death in the simulation for each individual as follows:

¹ $\widehat{none}_{it}^1 = 1$ is a shorthand notation here for $\widehat{alc}_{it}^1 = \{\widehat{none}_{it}^1 = 1, \widehat{light}_{it}^1 = 0, \widehat{moderate}_{it}^1 = 0, \widehat{heavy}_{it}^1 = 0\}$. We use similar shorthand throughout the remainder of this appendix.

$$(A4) \quad dead_{ik}^j = \inf\{t | S_i^j(t) \leq z_{ik}\}$$

It should be clear that $\lim_{\epsilon \rightarrow 0} P(t < dead_{ik}^j < t + \epsilon) = S_i^j(t) \forall k$.

Using draws of time to death, we calculate the number of people who die in each year, $d_k^j(t)$, as well as the size of the cohort alive, $pop_k^j(t)$:

$$(A5) \quad d_k^j(t) = \sum_{i=1}^N 1(t < dead_{ik}^j < t + 1)$$

$$(A6) \quad pop_k^j(t) = \sum_{i=1}^N 1(dead_{ik}^j > t)$$

Here, $1(\cdot)$ is the indicator function. The death rate in year t is:

$$(A7) \quad rate_k^j(t) = \frac{d_k^j(t)}{pop_k^j(t)}$$

Using our four counterfactual alcohol consumption paths, we examine the mortality time path for each of our three thought experiments. We calculate the following quantities:

$$(A8) \quad \begin{aligned} effect_1(t) &= \text{median}_k \{rate_k^1(t) - rate_k^2(t)\} \\ effect_2(t) &= \text{median}_k \{rate_k^3(t) - rate_k(t)\} \\ effect_3(t) &= \text{median}_k \{rate_k^4(t) - rate_k(t)\} \end{aligned}$$

Results

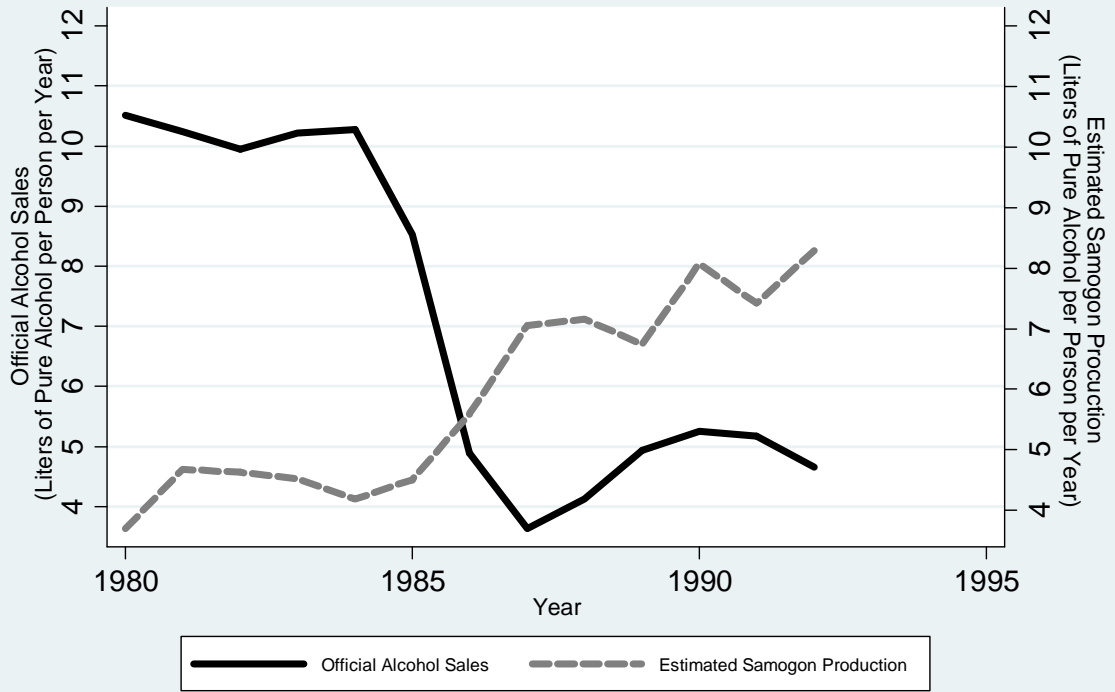
The following figures plot $effect_1(t) \dots effect_3(t)$. Appendix Figure A5 shows the mortality rate difference over time for *Scenario 1* (which compares a counterfactual scenario in which everyone is a heavy drinker against one in which everyone is an abstainer). In the Framingham study cohort, the move from heavy drinking to abstinence would have lowered mortality rate for a seventeen-year period. But mortality rates would have risen during the following seventeen years. This happens because a move to abstinence would preserve alive some part of the population. This part of the population is presumably at a higher risk of mortality than other parts because a move to abstinence makes a difference in whether this part stays alive. In later years, as the population ages and mortality rates necessarily rise, this part of the population begins to die at higher rates. This compositional effect is analogous to what we term “catch-up” mortality in Russia after the end of the Gorbachev Anti-Alcohol Campaign.

Appendix Figure A6 shows the mortality rate difference over time for *Scenario 2* (which compares mortality rates in a counterfactual scenario in which there is a five-year period during which heavy drinkers become light drinkers and moderate and light drinkers abstain against observed mortality). This “campaign” changes heavy drinkers into light drinkers and moderate and light drinkers into abstainers, and all individuals then revert to their pre-campaign drinking path. Given the results from *Scenario 1*, it is unsurprising to see an initial reduction in mortality during the campaign followed by an increase leading to excess mortality beginning three years after the campaign’s end.

Appendix Figure A7 shows the mortality rate difference over time for *Scenario 3* (which compares mortality rates in a counterfactual scenario in which the “campaign” from Scenario 2 is followed by two years of excessive drinking, and then a return to the pre-campaign drinking path, against observed mortality). The results are qualitatively similar to the previous graph – a decline in mortality during the “campaign” followed by an increase leading to excess mortality (larger in magnitude and longer lasting than in Scenario 2) about two years after the end of the campaign.

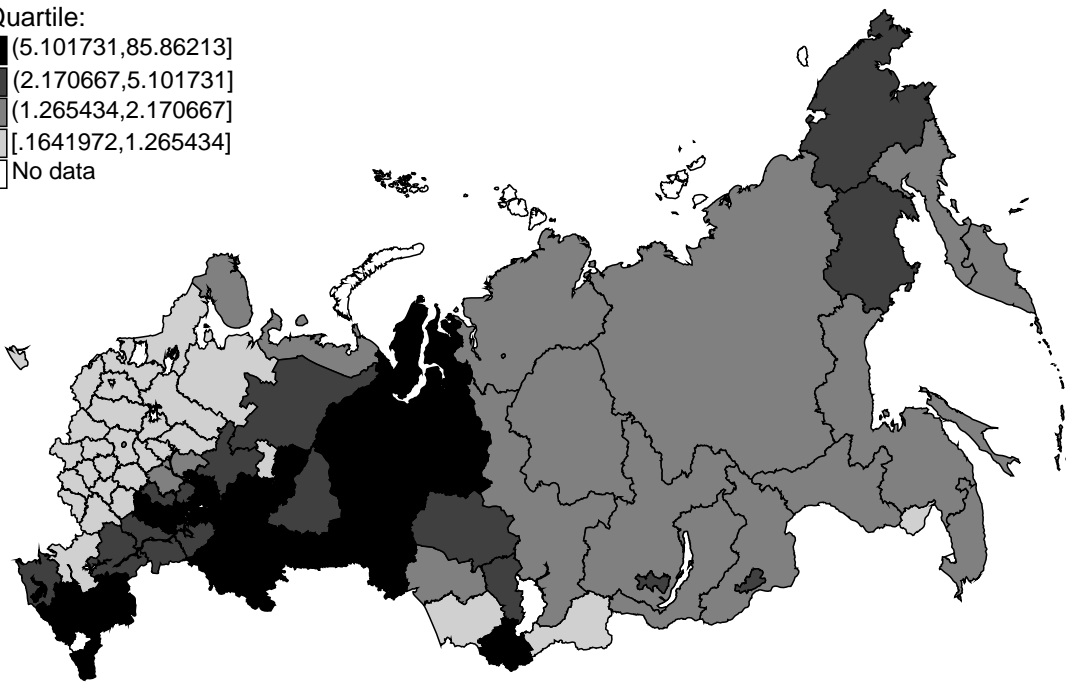
The magnitudes, patterns, and composition of alcohol consumption in the United States and Russia differ markedly. Our simulations using Framingham Heart Study data are nevertheless informative about mortality patterns in Russia assuming alcohol consumption and mortality have an approximately linear (or even convex) relationship. More generally, our primary objective is simply to establish general temporal relationships between alcohol consumption and mortality consistent with those observed in Russia during the latter 1980s and early 1990s.

Appendix Figure A1: Official Alcohol Sales and Indirect Estimates of Samogon Production

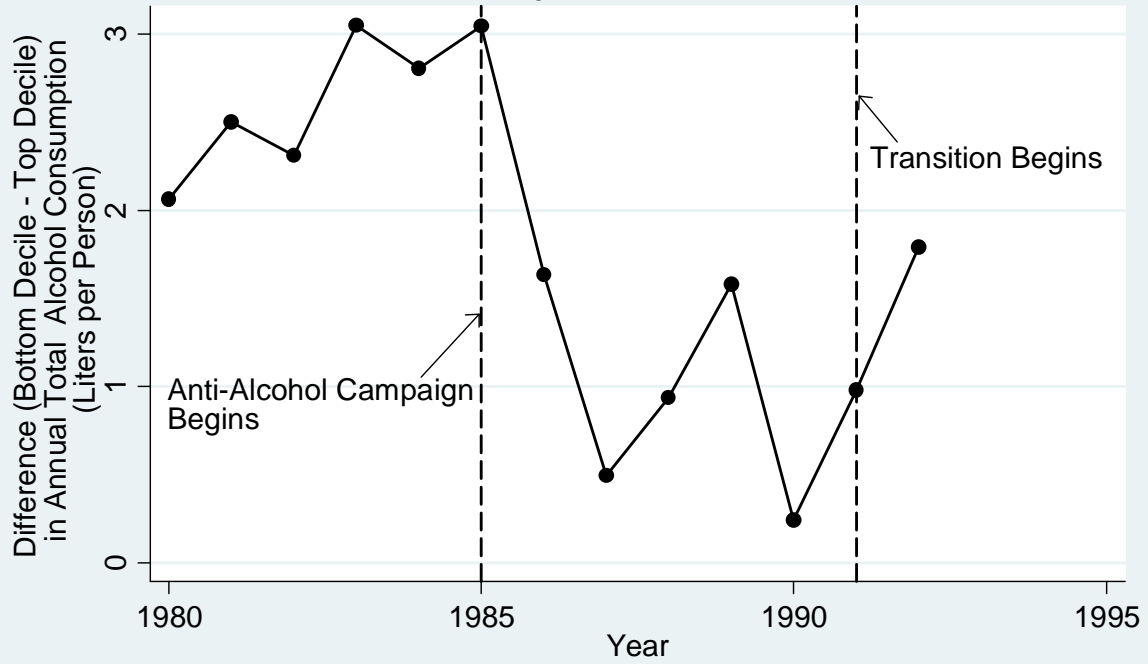


Appendix Figure A2: Muslim Concentration across Russia's Oblasts in 1979

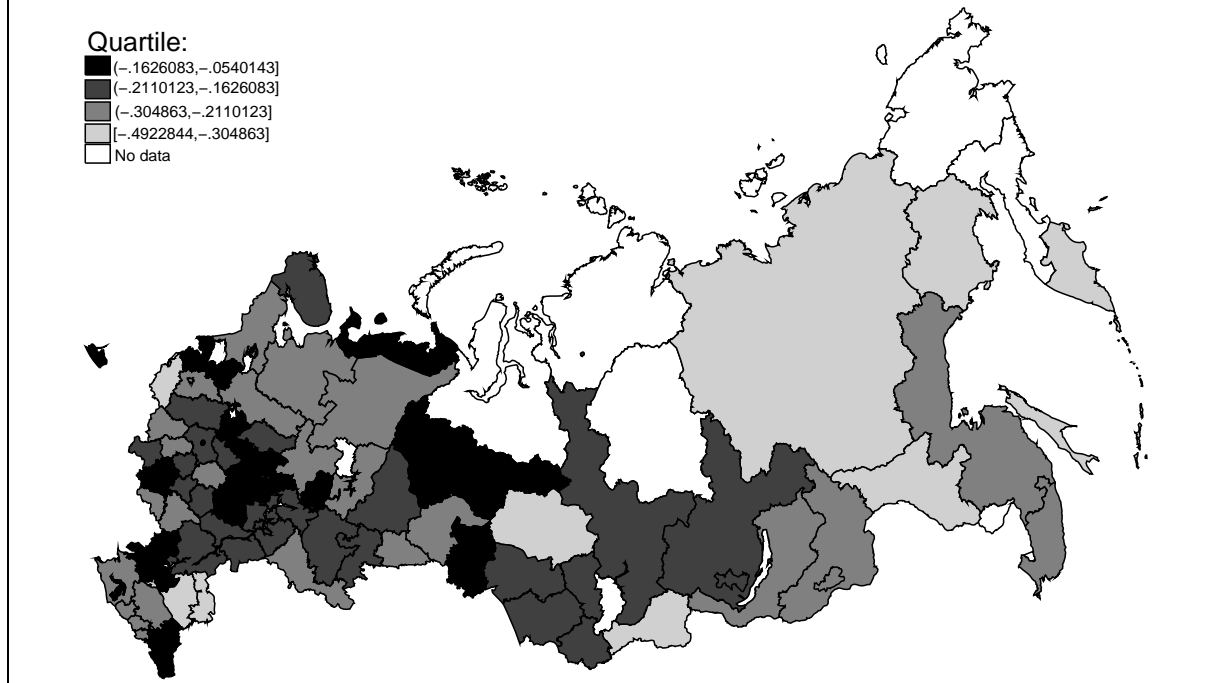
Quartile:
■ (5.101731,85.86213]
■ (2.170667,5.101731]
■ (1.265434,2.170667]
■ [.1641972,1.265434]
□ No data



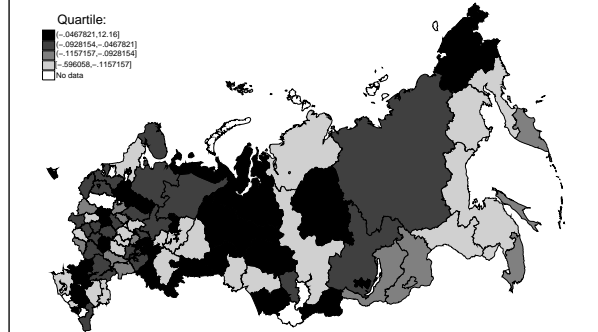
Appendix Figure A3: The Difference in Total Alcohol Consumption between Bottom and Top Deciles of Muslim Population Share in 1979



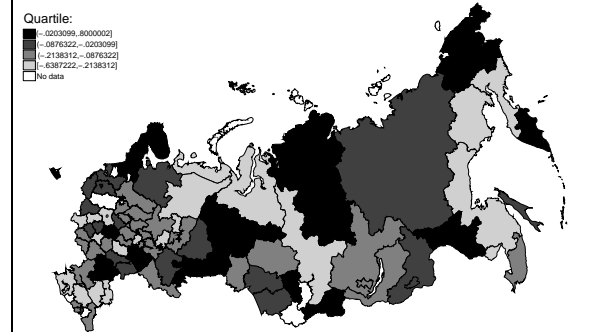
Appendix Figure A4–a: Mean Campaign Intensity across Russia's Oblasts, 1985–1989



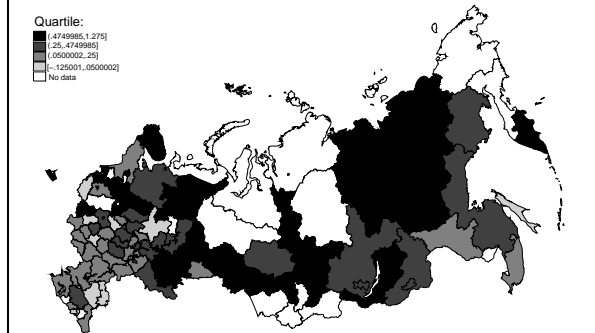
Appendix Figure A4–b: Mean Annual Change in Doctors per Capita across Russia's Oblasts, 1985–1989



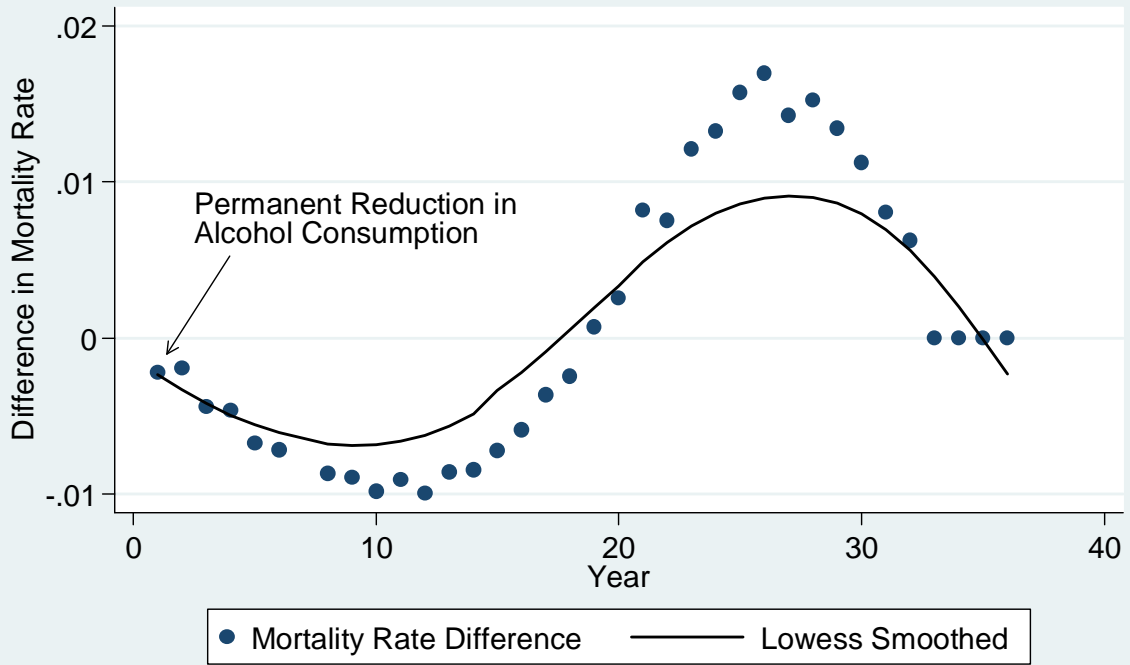
Appendix Figure A4–c: Mean Annual Change in Hospital Beds per Capita across Russia's Oblasts, 1985–1989



Appendix Figure A4–d: Mean Annual Change in Birth Rates across Russia's Oblasts, 1985–1989

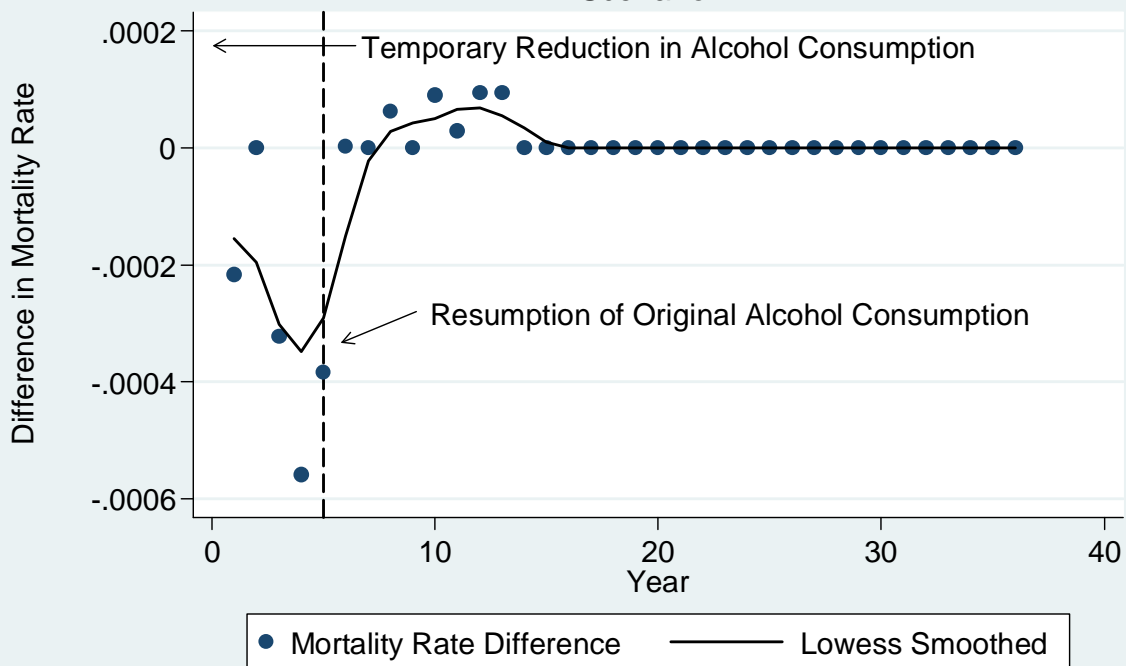


Appendix Figure A5: Heavy Drinkers Become Abstainers
Scenario 1



Note: t=1 is the first year of the permanent reduction in alcohol consumption

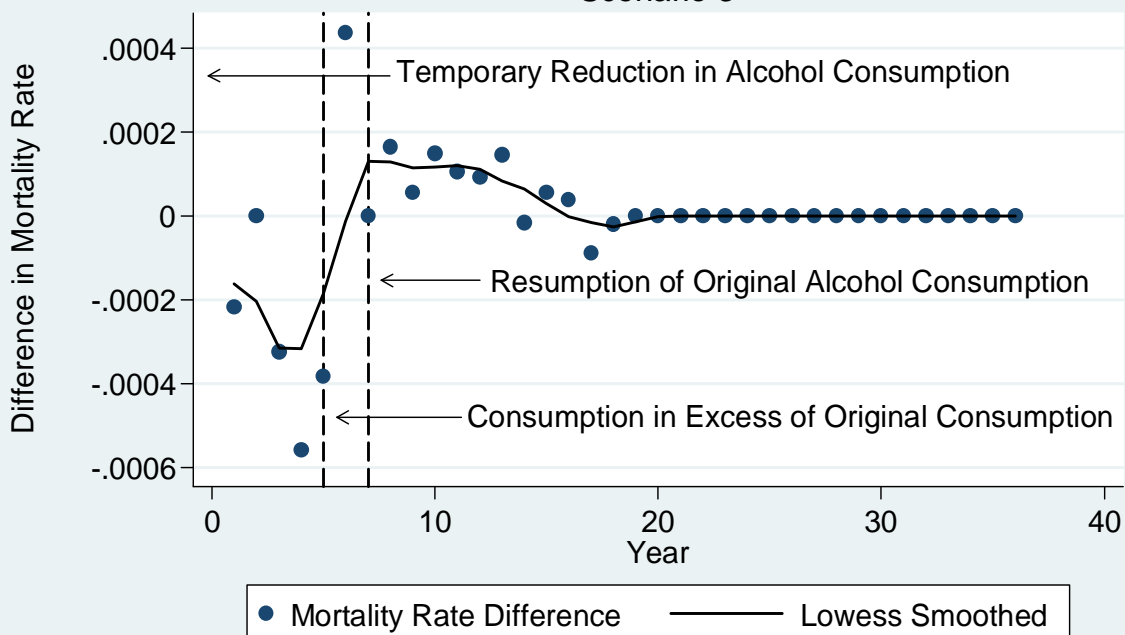
Appendix Figure A6: Temperance Campaign
Scenario 2



Note: t=1 is the first year and t=5 is the last year of the "campaign"

Appendix Figure A7: Temperance Campaign followed by Excess Drinking

Scenario 3



Note: t=1 is the first year and t=5 is the last year of the "campaign"; t=6, 7 are years of excess drinking

**APPENDIX TABLE A1:
CHANGES IN CRUDE DEATH RATES UNDER THE GORBACHEV ANTI-ALCOHOL CAMPAIGN
WITHOUT LOWER DATA QUALITY OBLASTS**

Alcohol Measure:	Total Alcohol Consumption		Official Alcohol Sales		Total Alcohol Consumption		
	Crude Death Rate	Crude Death Rate	Crude Death Rate	Crude Death Rate	Alcohol Poisoning Death Rate	Alcohol Poisoning Death Rate (Male)	Alcohol Poisoning Death Rate (Female)
Panel A: Mean Change across Campaign Years							
Campaign Intensity	6.539*** (1.104)	3.541*** (0.966)	4.264*** (0.991)	2.523*** (0.697)	69.977** (30.794)	91.244** (43.118)	48.711** (19.833)
Year Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oblast Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oblast-Specific Linear Trends	No	Yes	No	Yes	No	No	No
N	467	467	467	467	194	194	194
R ²	0.945	0.978	0.940	0.978	0.818	0.829	0.764
Panel B: Year-Specific Changes during the Campaign							
Campaign Intensity × 1985	8.737*** (1.303)	5.274*** (1.005)	5.517*** (0.980)	3.370*** (0.700)			
Campaign Intensity × 1986	6.166*** (0.994)	3.646*** (0.822)	3.951*** (0.818)	2.489*** (0.630)			
Campaign Intensity × 1988	6.314*** (0.978)	2.815*** (0.891)	3.810*** (0.894)	1.596** (0.753)			
Campaign Intensity × 1989	6.015*** (1.004)	1.738* (0.949)	3.936*** (0.937)	0.759 (0.817)			
Year Fixed Effects	Yes	Yes	Yes	Yes			
Oblast Fixed Effects	Yes	Yes	Yes	Yes			
Oblast-Specific Linear Trends	No	Yes	No	Yes			
N	467	467	467	467			
R ²	0.946	0.979	0.941	0.979			

Data on death rates and official alcohol sales were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Trembl and Alexeev (1993), Vassin and Costello (1997), Vallin et al. (2005) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research; estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details). Campaign intensity estimates were obtained by estimating equation (1) (and variants with interactions between campaign intensity and campaign year dummy variables). Crude death rates are per 1,000 population; alcohol poisoning death rates are per 100,000 population; campaign intensity variable were constructed using alcohol measures shown at the top of each column. All oblast-year samples are restricted to years prior to 1990 (for crude death rate regressions: 1970, 1978, 1980, 1985, 1986, 1988, and 1989; for alcohol poisoning death rate regressions: 1978, 1988, 1989) and exclude Tuva, Dagestan Republic, Ingushitiya Republic, Chechen Republic, Kabardino-Balkarskaya Republic, Karachaevo-Cherkesskaya Republic, North Osetiya-Alaniya Republic, Krasnodarskiy Krai, and Stavropolski Krai. Standard errors clustered at the oblast level shown in parentheses. *p<0.10, **p<0.05, and ***p<0.01.

**APPENDIX TABLE A2:
CHANGES IN CRUDE DEATH RATES UNDER THE GORBACHEV ANTI-ALCOHOL CAMPAIGN
CONTROLLING FOR ADDITIONAL OBLAST-YEAR COVARIATES**

Campaign Intensity	5.848*** (1.600)	3.200*** (0.947)	5.900*** (1.537)	3.399*** (1.126)	5.936*** (1.578)	3.443*** (1.126)	5.948*** (1.692)	3.374*** (1.134)
Year Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oblast Fixed Effects	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oblast-Specific Linear Trends	No	Yes	No	Yes	No	Yes	No	Yes
<u>Controls:</u>								
Crude Birth Rate	Yes	Yes	No	No	No	No	Yes	Yes
Doctors per Capita	No	No	Yes	Yes	No	No	Yes	Yes
Hospital Beds per Capita	No	No	No	No	Yes	Yes	Yes	Yes
N	318	318	312	312	311	311	311	311
R ²	0.952	0.991	0.953	0.992	0.953	0.992	0.953	0.992

Data on death rates and official alcohol sales were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Trembl and Alexeev (1993), Vassin and Costello (1997), Vallin et al. (2005) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research; estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details). Crude death rates are per 1,000 population; all campaign intensity variables are constructed using total alcohol consumption. Campaign intensity estimates were obtained by estimating equation (1). All oblast-year samples are restricted to years prior to 1990 (1970, 1980, 1985, 1986, 1988, 1989). Standard errors clustered at the oblast level shown in parentheses. *p<0.10, **p<0.05, and ***p<0.01.

**APPENDIX TABLE A3:
INSTRUMENTAL VARIABLES ESTIMATES OF CRUDE DEATH
RATE CHANGES UNDER THE ANTI-ALCOHOL CAMPAIGN**

<u>Panel A: Second Stage Estimates</u>		
Campaign Intensity	2.750* (1.568)	4.382*** (1.136)
Year Fixed Effects	Yes	Yes
Oblast Fixed Effects	Yes	Yes
Oblast-Specific Linear Trends	No	Yes
N	509	509
<hr style="border-top: 1px dashed black;"/>		
<u>Panel B: First Stage Estimates</u>		
Share Muslim 1979 × 1978	0.0008 (0.0010)	---
Share Muslim 1979 × 1980	0.0000 (0.0005)	-0.0007 (0.0012)
Share Muslim 1979 × 1985	-0.0006 (0.0005)	-0.0017 (0.0018)
Share Muslim 1979 × 1986	0.0002 (0.0005)	-0.0009 (0.0020)
Share Muslim 1979 × 1988	0.0010** (0.0005)	-0.0002 (0.0022)
Share Muslim 1979 × 1989	0.0026*** (0.0005)	0.0011 (0.0023)
F Statistic	10.08	15.13

Data on death rates and official alcohol sales were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992), Treml and Alexeev (1993), Vassin and Costello (1997), Vallin et al. (2005) as well as from Vladimir Shkolnikov and colleagues at the Max Planck Institute for Demographic Research; estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details); data on Muslim population share in the 1979 Soviet population census were obtained from Heleniak (2006). All estimates were obtained by estimating equations (1) (instrumenting for campaign intensity using interactions between 1979 population share Muslim and campaign year dummies as shown in Footnote 26). The dependent variable in all regressions is crude death rates per 1,000 population; all campaign intensity variables are constructed using total alcohol consumption. All oblast-year samples are restricted to years prior to 1990 (1970, 1978, 1980, 1985, 1986, 1988, and 1989). Standard errors clustered at the oblast level shown in parentheses. *p<0.10, **p<0.05, and ***p<0.01.

**APPENDIX TABLE A4:
COMPARISON OF TOTAL ALCOHOL CONSUMPTION ESTIMATES
(INCLUDING SAMOGON) WITH NEMTSOV (2000)**

Year:	1984 Total Alcohol Consumption		1990 Total Alcohol Consumption	
	Estimate	Nemtsov (2000)	Estimate	Nemtsov (2000)
<u>Region:</u>				
North and Northwest	16.0	15.6	12.5	12.3
Central	14.3	14.6	12.4	12.2
Northern Caucasus	13.0	12.7	11.0	10.7
Urals and Volga country	14.0	13.9	11.8	11.4
Western Siberia	14.8	14.8	13.4	12.8
Russian Far East	17.2	16.7	13.5	13.3

Data on official alcohol sales were obtained from annual statistical yearbooks compiled by Goskomstat and Rosstat through East View Information Services and the Hoover Institution's "Russian/Soviet/Commonwealth of Independent States Collection" print archives with supplementation from New World Demographics (1992); estimates of total alcohol consumption by extending the work of Nemtsov (2000) for estimating illegal alcohol production (see Appendices 1 and 2 for details).

**APPENDIX TABLE A5:
AN AGING FRAMINGHAM POPULATION**

Variable	Wave 1		Wave 7		Wave 17		Wave 23	
	Mean	St. Dev.	Mean	St. Dev.	Mean	St. Dev.	Mean	St. Dev.
Alcohol Consumption								
<i>none</i>	.	.	0.41	0.49	0.45	0.50	0.61	0.49
<i>light</i>	.	.	0.14	0.35	0.14	0.34	0.14	0.35
<i>moderate</i>	.	.	0.28	0.45	0.28	0.45	0.19	0.39
<i>heavy</i>	.	.	0.17	0.38	0.13	0.34	0.07	0.25
Education								
<i>8th grade or less</i>	0.29	0.45	0.28	0.45	0.24	0.42	0.20	0.40
<i>some high school</i>	0.14	0.35	0.14	0.35	0.14	0.34	0.13	0.33
<i>high school graduate</i>	0.29	0.46	0.30	0.46	0.32	0.47	0.35	0.48
<i>some college</i>	0.08	0.27	0.08	0.27	0.09	0.28	0.09	0.28
<i>college graduate</i>	0.08	0.27	0.08	0.27	0.09	0.28	0.08	0.27
<i>post-graduate</i>	0.12	0.33	0.13	0.33	0.14	0.35	0.16	0.37
<i>male</i>	0.45	0.50	0.44	0.50	0.38	0.49	0.34	0.47
<i>age</i>	44.52	8.57	56.14	8.46	73.59	7.46	82.50	5.71
N	5,209		4,851		3,113		1,602	

Data from the Framingham Heart Study (sample construction described in Appendix 3).

**APPENDIX TABLE A6:
MORTALITY HAZARD RATIOS—COX PROPORTIONAL HAZARDS MODEL**

Variable	Hazard Ratio	Robust Standard Error	95% Confidence Interval
Alcohol Consumption			
<i>none</i>	Reference Group		
<i>light</i>	0.92	(0.049)	[0.83 - 1.03]
<i>moderate</i>	0.96	(0.039)	[0.88 - 1.04]
<i>heavy</i>	1.11	(0.059)	[1.00 - 1.23]
Education			
<i>8th grade or less</i>	Reference Group		
<i>some high school</i>	1.00	(0.054)	[0.90 - 1.11]
<i>high school graduate</i>	0.97	(0.044)	[0.89 - 1.06]
<i>some college</i>	0.82	(0.054)	[0.72 - 0.94]
<i>college graduate</i>	0.88	(0.060)	[0.78 - 1.01]
<i>post-graduate</i>	0.84	(0.047)	[0.75 - 0.93]
<i>male</i>	1.52	(0.054)	[1.42 - 1.63]
<i>age</i>	1.08	(0.003)	[1.08 - 1.09]

Log Likelihood = -23796.28

Data from the Framingham Heart Study (sample construction described in Appendix 3). Hazard estimates obtained by estimating equation A1 in Appendix 3.

**APPENDIX TABLE A7:
TWO COUNTERFACTUAL PATHS**

	Path: $j = 3$	Path: $j = 4$
$t \leq 5$	<ul style="list-style-type: none"> • If $none_{it} = 1$, $light_{it} = 1$ or $moderate_{it} = 1$, set $\widehat{none}_{it}^3 = 1$ • If $heavy_{it} = 1$, set $\widehat{light}_{it}^3 = 1$ 	<ul style="list-style-type: none"> • If $none_{it} = 1$, $light_{it} = 1$ or $moderate_{it} = 1$, set $\widehat{none}_{it}^4 = 1$ • If $heavy_{it} = 1$, set $\widehat{light}_{it}^4 = 1$
$5 < t \leq 7$	<ul style="list-style-type: none"> • Set $\widehat{alc}_{it}^3 = alc_{it}$ 	<ul style="list-style-type: none"> • If $none_{it} = 1$, set $\widehat{light}_{it}^4 = 1$ • If $light_{it} = 1$, set $\widehat{moderate}_{it}^4 = 1$ • If $moderate_{it} = 1$, set $\widehat{heavy}_{it}^4 = 1$
$t > 7$	<ul style="list-style-type: none"> • Set $\widehat{alc}_{it}^3 = alc_{it}$ 	<ul style="list-style-type: none"> • Set $\widehat{alc}_{it}^4 = alc_{it}$