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Cumulative disadvantage, employment–marriage, and health inequalities among American and British mothers

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ABSTRACT

This paper illuminates processes of cumulative disadvantage and the generation of health inequalities among mothers. It asks whether adverse circumstances early in the life course cumulate as health-harming biographical patterns across the prime working and family caregiving years. It also explores whether broader institutional contexts may moderate the cumulative effects of micro-level processes. An analysis of data from the British National Child Development Study and the US National Longitudinal Survey of Youth reveals several expected social inequalities in health. In addition, the study uncovers new evidence of cumulative disadvantage: Adversities in early life selected women into long-term employment and marriage biographies that then intensified existing health disparities in mid-life. The analysis also shows that this accumulation of disadvantage was more prominent in the US than in Britain.

Although access to higher education and the labour market have improved the health of women overall, social inequalities in health among women remain disappointingly large (Schutte, Chastang, Parent-Thirion, Vermeylen, & Niedhammer, 2013; Shaw, McGeever, Vasquez, Agahi, & Fors, 2014). In the face of this observation, researchers are turning their attention to the social processes that create and sustain health inequalities. Informed by life course sociology, work in this tradition moves beyond cross-sectional snapshots of material and social circumstances, towards identifying the pathways through which such conditions leave their traces in bodies over time. Cumulative advantage/disadvantage (CAD) is a prominent framework for understanding these processes (O'Rand, 2009). A central tenet is that the social gap in health grows over the course of a woman's life, through mechanisms that concentrate the impact of early advantages or disadvantages as an individual ages (Hamil-Luker & O'Rand, 2007; Kuh et al., 2009).

Despite the promise of this framework, the pathways through which social inequalities in women's health develop over the life course remain something of a black box. Most existing CAD research focuses on a restricted selection of cross-sectional mediators – typically, adult socioeconomic position and health behaviours – thought to link early adversity to adult health. While this emphasis is well-justified, studies have yet to incorporate a number of central findings from research on women's health and the life course. One is the consistent conclusion that non-employment and the absence of an intimate relationship are detrimental to women's health (Klumb & Lampert, 2004; Waite & Maggie, 2000). Another is the consensus among life course researchers that adult circumstances over the long term are more significant for health than conditions at a single point in time (Dupre, Beck, & Meadows, 2009; Moen, Dempster-McClain, & Williams,

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1992). Related to this is the contention that biographies in one area of life are not separate from those in other domains (Elder, Johnson, & Crosnoe, 2003; MacMillan, 2005). These insights shift the research focus from the health effects of single aspects of the life course (e.g., employment *or* marital histories) to their combined influences over time. Finally, life course researchers acknowledge that individuals construct their biographies within a set of opportunities and constraints defined, in part, by institutional contexts—central among them, is the welfare state (Kohli, 2007; Mayer, 2005). From this perspective, nations' broad approaches to social welfare are seen to influence at least two aspects of individual life courses germane to women's health: the protection (or otherwise) of a minimum level of economic well-being for individuals and families in need, and the shaping of mothers' employment histories and their reliance on marriage (Esping-Andersen, 1990; Orloff, 1993). CAD health research that links macro-level contexts to micro-level processes is, however, virtually non-existent.

Our study builds on existing CAD research on social inequalities in women's health in three key ways. First, we adopt a *broader* view than previous studies, by considering how paid work and marriage collectively mediate early-life social conditions and adult health. Although employment and marital status are known determinants of women's health on their own, whether and how they function together in the cumulation of health (dis)advantage has yet to be investigated. Second, we take a *longer* view than much existing research—using multi-dimensional optimal matching analysis (Pollock, 2007) to model patterns in employment and marriage across a significant period of adulthood. Our innovative approach to working with detailed life histories allows us to assess whether health risks accrue across the life course, in part, because adversity in the early years selects women into employment–marriage biographies that are more likely to harm, rather than enhance, health in adulthood. Third, we take a *contextual* view of CAD processes by comparing results for Britain and the US. Although these two nations share a broad orientation to the mix of public and private provision, they differ somewhat in their approaches to minimizing socioeconomic inequality and providing support for family responsibilities. This variation may yield distinct individual-level processes of cumulative disadvantage among women. Our study focuses on mothers because they are a group most likely to be affected by differences in welfare state generosity. Moreover, maternity is pivotal in the life courses of women. Among other things, childbirth marks a moment at which socioeconomic position becomes particularly consequential for women's employment trajectories (Baum, 2002; Macran, Joshi, & Dex, 1996; Warren, 2000); and primary responsibility for raising children heightens the significance of marriage for women's health (Bartley, Sacker, Firth, & Fitzpatrick, 1999; Koropeckyj-Cox, Pienta, & Brown, 2007; Williams, Sassler, Frech, Addo, & Cooksey, 2011).

We begin by outlining three bodies of scholarship that are integral to our inquiry, yet are seldom linked in empirical research: cumulative disadvantage; employment/marriage and womens health; and the institutional contexts that shape the life course. We then describe the methods used to conduct our investigation, including our unique strategy for modelling mothers' adult biographies. Following this, we document longitudinal patterns in British and American mothers' paid work and marriage biographies, and examine how these biographies contribute to processes of cumulative health disadvantage. The paper concludes with a discussion of the implications of our results for theory and research about the social processes that generate health inequalities among mothers and the institutional contexts that structure them.

1. Background

1.1. Cumulative advantage/disadvantage (CAD)

CAD research focuses on identifying the mechanisms whereby inequality grows over the life course (Willson, Shuey, & Elder, 2007). It encompasses the view that benefits associated with a person's structural position during his/her youth increase over time, widening differences between individuals or groups as they age (O'Rand, 2006). Path dependency – the idea that advantages at a given point are dependent on previous advantages – is a key aspect of this process (DiPrete & Eirich, 2006). Focusing on *dis*advantage (as does most empirical work), a large body of research has documented the pivotal role of education in the inter-generational transmission of adversity. Parents with little formal education tend to have fewer of the financial, cultural, and social resources needed to ensure the educational success of their children (Lareau, 2003; Walsemann, Geronimus, & Gee, 2008). These children's low educational attainment may, in turn, limit their employment opportunities in adulthood (England, Garcia-Beaulieu, & Ross, 2004; Falci, Mortimer, & Noel, 2010) and their ability to form the enduring marital partnerships (Martin, 2006; McLanahan, 2009) that foster health (Dupre, 2008; Mirowsky & Ross, 2005). Epidemiologists call these path-dependent processes 'chains of risk' to capture the notion that a negative experience at one point in time increases the risks that others will follow (Lynch & Davey Smith, 2005).

There is ample evidence, across a variety of jurisdictions, that social and economic disadvantages during childhood affect adult health. Low parental education, income, and occupational class; parental divorce; and living in a sole-parent household are positively associated with early mortality (Galobardes, Lynch, & Davey Smith, 2004; Kuh et al., 2009; Remes & Martikainen, 2012), poor physical health (Guralnik, Butterworth, Wadsworth, & Kuh, 2006; Hamil-Luker & O'Rand, 2007), and poor psychological health during adulthood (Elovainio et al., 2012; Gilman, Kawachi, Fitzmaurice, & Buka, 2003; Luo & Waite, 2005). Studies that explore the pathways between childhood adversity and adult health find that the process is partially mediated by socioeconomic position and lifestyle during adulthood (Galobardes et al., 2004; Haas, 2008; Kuh, Power, Blane, & Bartley, 1997; Murray et al., 2011; O'Rand & Hamil-Luker, 2005). This body of work, however, has largely neglected other potentially important pathways, including those associated with the dominant