



# Self-reported health and gender: The role of social norms<sup>☆</sup>



Eve Caroli<sup>a, \*</sup>, Lexane Weber-Baghdiguian<sup>b</sup>

<sup>a</sup> PSL, University Paris Dauphine, LEDa-LEGOS, Paris School of Economics and IZA, France

<sup>b</sup> PSL, University Paris Dauphine, LEDa-LEGOS, France

## ARTICLE INFO

### Article history:

Received 22 September 2015

Received in revised form

4 February 2016

Accepted 14 February 2016

Available online 17 February 2016

### Keywords:

EU countries (30)

Health

Gender

Social norms

Job quality

## ABSTRACT

The role of social norms in accounting for the different attitudes of men and women with respect to health is still an open issue. In this research, we investigate the role of social norms associated with specific gender environments in the workplace in accounting for differences in health-reporting behaviours across men and women. Using the 2010 European Working Conditions Survey, we build a database containing 30,124 observations. We first replicate the standard result that women report worse health than men, whatever the health outcome we consider. We then proxy social norms by the gender structure of the workplace environment and study how the latter affects self-reported health for men and women separately. Our findings indicate that individuals in workplaces where women are a majority tend to report worse health than individuals employed in male-dominated work environments, be they men or women. These results are robust to controlling for a large array of working condition indicators, which allows us to rule out that the poorer health status reported by individuals working in female-dominated environments could be due to worse job quality. This evidence suggests that social norms associated with specific gender environments play an important role in explaining differences in health-reporting behaviours across gender, at least in the workplace.

© 2016 Elsevier Ltd. All rights reserved.

## 1. Introduction

The literature on health and gender has long evidenced a striking paradox: women consistently report worse self-rated health than men while their probability of dying is lower than men's throughout their life – see [Lahelma et al. \(1999\)](#) and [Cambois et al. \(2011\)](#).

A first explanation of this paradox relies on “true” health differences: women would suffer more than men from chronic diseases generating serious limitations in their activity. [Case and Paxson \(2005\)](#) indeed show that gender differences in self-rated

health can be entirely explained by the distribution of chronic conditions. However, the authors also find that men with some specific health conditions are more likely to be hospitalised and die. The reason they consider most plausible to account for this specific pattern is that the symptoms that individuals experience convey little information about the severity of their disease.

Another – potentially complementary – explanation for the gender gap in self-reported health has to do with sex differences in health-reporting behaviour: for given health conditions, women would report worse health status than men do. Health-reporting biases have long been studied in the literature. They have been shown to be potentially large and to vary according to a number of dimensions, including education ([Bago d'Uva et al., 2011](#); [Schneider et al., 2012](#)), income ([Etilé and Milcent, 2006](#); [Johnston et al., 2009](#); [Schneider et al., 2012](#)), age ([Bago d'Uva et al., 2008](#); [Lindeboom and van Doorslaer, 2004](#)) and gender ([Bago d'Uva et al., 2008](#); [Lindeboom and van Doorslaer, 2004](#)). Another strand of the literature focuses specifically on the health-reporting behaviour of women as compared to men's and the debate is still open as to whether women tend to over-report minor health problems as compared to men and, if so, why – see the special issues of *Social Science & Medicine*, 36(1), 1993 and 48(1), 1999.

A new way to shed light on this issue is to consider whether

<sup>☆</sup> We are grateful to Andrea Bassanini, Clémentine Garrouste, Mathilde Godard, Mathilde Peron, Anne-Laure Samson, Loup Wolff, participants to the TEPP Public Policy Evaluation Winter School and DEFAP/LASER summer school in Applied Microeconometrics and LEDa-LEGOS and EuHEA seminars and two anonymous referees for useful comments and suggestions. All remaining errors are our own. The authors acknowledge financial support of Health Chair – a joint initiative by PSL, Université Paris-Dauphine, ENSAE, MGEN and ISTYA under the aegis of the Fondation du Risque (FDR). EWCS data were kindly provided by the European Foundation for the Improvement of Living and Working Conditions.

\* Corresponding author. University Paris Dauphine, LEDa-LEGOS, 75775 Paris Cedex 16, France. Tel.: +33 144054302.

E-mail address: [eve.caroli@dauphine.fr](mailto:eve.caroli@dauphine.fr) (E. Caroli).

differences in health-reporting behaviours across genders may be influenced by social norms. The role of social norms has been considered in the health literature mostly in relation with body weight. [Christakis and Fowler \(2007\)](#) provide evidence that weight gains tend to spread through a population via social networks. The extent to which this result can be interpreted as a causal effect of peers' weight on own weight or is, alternatively, due to endogenous peer-group formation has been much discussed since then – see [Cohen-Cole and Fletcher \(2008\)](#), [Fowler and Christakis \(2008\)](#), [Halliday and Kwak \(2009\)](#). Complementary evidence shows that individuals are sensitive to peers' weight: the probability for them to feel overweight or dissatisfied with their weight increases with their relative BMI – computed as the ratio of own BMI to average BMI in the reference group, the latter being defined with reference to age, gender and possibly geographic localisation (see [Blanchflower et al., 2009](#)). Similarly, life satisfaction appears to decrease with relative BMI. [Etilé \(2007\)](#) goes one step further and shows that social norms play a key role in the determination of ideal body weight, in particular for women. Social norms are captured by the average of ideal BMI in the reference group, where the ideal BMI is computed using the weight individuals report as the one they would like to “reach or keep”. The results show that the elasticity of women's ideal BMI to the norm is as high as 0.5. In contrast, men do not seem to be sensitive to social norms. Similarly, [Gil and Mora \(2011\)](#) show that women tend to underestimate their weight and that the gap between measured and self-reported weight is affected by social norms: it increases when the ideal weight decreases in the reference group.

Beyond body weight preferences, the literature has not much analysed the potential impact of social norms on other health outcomes. [Raspe et al. \(2008\)](#) mention that “social influences” may be one of the explanations for the convergence in prevalence rates of self-reported back pain in Western and Eastern Germany after reunification. The prevalence rate was 10 percentage points higher in Western than in Eastern Germany as of 1991, while the gap had virtually gone down to zero in 2003, because of a sharp increase in reported back pain in the Eastern part of the country over the period. One of the reasons mentioned by the authors to account for this increase is the fact that “back myths and misconceptions about back pain being pervasive in Western societies were immediately disseminated in East Germany”. Unfortunately, the authors cannot test this assumption with the data they have. [Powdthavee \(2009\)](#) considers the impact of social norms within the household on potential health-reporting biases. He shows that the specific health problems individuals suffer from have a negative impact on their self-assessed health, but that this impact is significantly lower for individuals living in households where the number of health problems per other family member is high. This result suggests that self-assessed health is potentially biased owing to the “confounding health norm effects”, although the bias turns out to be economically very small. One issue raised by Powdthavee has to do with the definition of the reference group. His paper innovates in considering the household as the reference group but he underlines that other people in close proximity, such as friends, colleagues or people in the same region could also be relevant.

In this paper, we investigate the importance of social norms in the working environment in accounting for differences in self-reported health across men and women. Using the European Working Conditions Survey (EWCS, 2010), we first replicate the standard result that women report worse health than men, whatever the health outcome we consider – except hearing problems and cardiovascular diseases. We then proxy social norms by the gender structure of the workplace environment and study how the latter affects self-reported health for men and women separately. Our findings indicate that individuals in workplaces where women

are a majority tend to report worse health than individuals employed in male-dominated work environments, be they men or women. These results are robust to controlling for a large array of working-condition indicators, which allows us to rule out that the poorer health status reported by individuals working in female-dominated environments could be due to worse job quality. We interpret this evidence as suggesting that social norms associated with specific gender environments play an important role in explaining differences in health-reporting behaviours across gender, at least in the workplace.

## 2. Health, gender and social norms

We refer to social norms as defined by [Akerlof and Kranton \(2000\)](#) in terms of “prescriptions”, i.e. “shared expectations about how the group members ought ideally to behave”. In their model, prescriptions affect identity so that social norms enter in the individual's utility function. A number of authors consider that individuals' utility depends on the dominant social norm within their group – see [Brock and Durlauf \(2001\)](#) and [Blanchflower et al. \(2009\)](#), for example. As a matter of fact, there is evidence that perceptions of social norms influence health behaviours in terms on alcohol consumption, tobacco use, dietary habits etc. – [Mahalik et al. \(2007\)](#). In such a framework we may expect individuals to be more inclined to report poor self-assessed health and/or more health symptoms when belonging to a group in which doing so is more legitimate because it is a commonly-held norm. As underlined by [Manski \(1993\)](#), proper identification of a social-norm effect requires that the group to which individuals are assigned be adequately defined. In what follows, the social group we consider is the group of work colleagues with similar job titles as the individual. We hypothesise that when discussing or even mentioning health problems is considered more legitimate in the reference professional group, individuals will tend to report such problems more easily when asked about their health.

Our assumption here is that health-reporting norms differ across genders in general, and in the workplace in particular. There is evidence in the literature that women tend to report higher morbidity rates than men, which is in contrast with their longevity advantage. The existence of such a gender-morbidity gap has been highly debated since the 1980s – see [Hunt and Annandale \(1999\)](#). [Marshall and Funch \(1986\)](#) study sex differences in the lag between first recognition of symptoms and definitive diagnosis and treatment for colorectal cancer. Report of pre-diagnostic symptoms and ratings of severity of symptoms did not differ significantly between men and women. Similarly, [Macintyre \(1993\)](#) studies a group of British volunteers who have been inoculated with a cold virus or an inert substance in hospital. The severity of their colds was evaluated both by the respondents themselves and by a clinical observer with double-blind ratings. The results suggest that women were not more likely than men to assess themselves as having a cold. Men were significantly more likely than women to over-rate their cold symptoms as compared to the observer's ratings. Another example is [Arber and Cooper \(1999\)](#) who consider men and women over 60 with similar levels of disability and find that men rather than women are more likely to assess their health as being poor, after accounting for structural factors.

In contrast, a large strand of literature does find greater reported morbidity among women. [Hibbard and Pope \(1983\)](#) use US data covering adults, most of whom are husband and wife pairs. The sample under study is restricted to respondents who rated their health as good or excellent. The authors find that women report more symptoms than men do. Similar results are found by [Verbrugge \(1989\)](#) on the *Health in Detroit* survey: women show higher morbidity on almost all health indicators with an especially

Download English Version:

<https://daneshyari.com/en/article/7330579>

Download Persian Version:

<https://daneshyari.com/article/7330579>

[Daneshyari.com](https://daneshyari.com)