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Subjective socioeconomic status and health in cross-national comparison

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ABSTRACT

Research has established a robust association between subjective socioeconomic status (SES) and health outcomes, which holds over and above the associations between objective markers of SES and health. Furthermore, comparative research on health inequalities has shown considerable variation in the relationship between different objective markers of SES and health across countries. Drawing on data from 29 countries, we present the first cross-national study on the subjective SES–health relationship. For two health outcomes, namely self-rated health (SRH) and psychological wellbeing, we are able to confirm that subjective SES is related to health in all countries under study, even when income, education, and occupational prestige are accounted for. Furthermore, we document considerable variation in the strength of the subjective SES–health association across countries. This variation however is largely independent of country differences in income inequality and country affluence. The health benefits of a high subjective SES appear to be slightly larger in more affluent countries, but only for SRH, not for psychological wellbeing.

1. Introduction

The relationship between objective and subjective socioeconomic status (SES) is a classic topic within sociology (Evans and Kelley, 2004; Lindemann and Saar, 2014; Marx, 1976) that has recently resurfaced in public health research (Adler, 2013; Nobles et al., 2013; Singh-Manoux et al., 2005; Wolff et al., 2010). While sociological research on the issue long focused on class conflict and the potential for social revolution, public health research has discovered a robust association between subjective SES and a diverse range of health outcomes, usually over and above the influence of objective measures of social status. The general finding appears to be that those with a higher self-perception rating of their socioeconomic status enjoy better health (Adler, 2013).

Contrary to objective, long-established measures of socioeconomic status like education, income, and occupational prestige, subjective socioeconomic status is a self-appraisal about one's location in a socioeconomic status order (Ross and Mirowsky, 2002). Terms that are sometimes used synonymously are perceived social position (Garbarski, 2010) and subjective social status (Adler et al., 2000; Demakakos et al., 2008). The great recent interest in subjective SES among public health researchers has two reasons. Firstly, the subjective SES–health link has great potential to reveal the effects of social hierarchy on health. One strand of research, inspired by the works of Wilkinson (1992), suggests that subjective socioeconomic status reflects the relative rather than absolute position in the hierarchy of a society, and that the perception of inequality and subordination in the hierarchy of a society has damaging effects on health outcomes. Secondly, a more methodological reason for the relevance of the subjective SES–health relationship, is the interest in the general performance of subjective SES as a general marker of SES compared to other indicators like income or education. Some public health researchers, for instance Singh-Manoux et al. (2005), suggest that subjective socioeconomic status could be a 'cognitive average' of objective SES markers, yielding a more precise measurement of overall SES.

With our study, we aim to shed light onto previously understudied aspects of the relationship between subjective SES and health, namely examining how this relationship operates in cross-national comparison. While existing comparative research on health inequalities has so far focused on objective SES indicators,

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such as education (Mackenbach et al., 2008), income (Huijts et al., 2010), or class (Eikemo et al., 2008b), our study will extend that line of research by focusing on an innovative SES measure, namely subjective SES. Different indicators of SES cannot be used interchangeably (Torssander and Erikson, 2010), as they all tap at different, loosely related aspects of SES and vary in the strength of their association to health. Given the variation in levels of subjective SES across countries (Lindemann and Saar, 2014), we expect that comparing subjective SES–health gradients across societies is a valuable contribution to the literature. In fact, a recent review article on subjective SES and health explicitly demanded more cross-nationally comparative research on the subjective SES–health relationship (Euteneuer, 2014). Drawing on comparable data from 29 societies from all continents of the world, we explore the variability in the relationship between subjective SES and health. By doing so, we contribute to the recent 'comparative turn' in research on health inequalities (Beckfield et al., 2013; Eikemo et al., 2008a; Olafsdottir et al., 2013).

1.1. The subjective SES–health relationship

Public health research was able to amass substantial evidence for the existence of an association between subjective socioeconomic status and health. Health outcomes linked to subjective socioeconomic position included self-rated health (SRH; Demakakos et al., 2008; Singh-Manoux et al., 2005), depression (Demakakos et al., 2008; Sakurai et al., 2010; Singh-Manoux et al., 2003), nurse-rated health (Nobles et al., 2013), cortisol (Adler et al., 2000; Wright and Steptoe, 2005), and mortality rates (Kopp et al., 2004). While some studies showed that the association between subjective socioeconomic status and health was explained when accounting for objective markers of SES, at least for some outcomes (Singh-Manoux et al., 2003), the majority of studies suggest that subjective SES is associated with health even after controlling for objective SES.

These findings do not only pertain to US or UK samples (Operario et al., 2004; Seeman et al., 2014; Singh-Manoux et al., 2003, 2005), a number of studies also drew on samples from other regions, such as Finland (Karvonen and Rahkonen, 2011), Hungary (Kopp et al., 2004), Indonesia (Nobles et al., 2013), Japan (Sakurai et al., 2010), Taiwan (Collins and Goldman, 2008), or Canada (Dunn et al., 2006). While many of the studies focused on select populations, such as pregnant women (Reitzel et al., 2007), adolescents (Quon and McGrath, 2014), older adults (Garbarski, 2010), or civil service workers (Singh-Manoux et al., 2003, 2005), relatively few used representative samples of the general population (Nobles et al., 2013; Sakurai et al., 2010; Wolff et al., 2010). Understanding the interplay of objective and subjective SES, however, requires samples that are free from selection bias, including all SES groups of a population, as associations found in restricted samples might misrepresent those apparent in the general population.

An important function of cross-national research is to confirm the presence of relationships found in single-context studies in a variety of contexts. Based on the mass of research findings, we pose the following hypotheses:

H1a. Subjective SES is positively related to health in all countries under study.

H1b. Subjective SES is positively related to health in all countries under study after accounting for objective measures of SES (household income, education, and occupational prestige).

1.2. Country affluence, income inequality, and the subjective SES–health relationship

Two major contextual factors that are frequently discussed in the literature on social determinants of health are the economic resources of a country, most commonly expressed as GDP per capita, and income inequality, usually expressed as the Gini coefficient. While most of the current literature focuses on the direct effects of country affluence and income inequality on health, we will extend this literature by making a case that both these factors can have moderating effects on the subjective SES–health relationship.

The effects of country affluence on population health have been variously and prominently demonstrated (Deaton, 2013). Populations flourish in terms of health when economic resources are available in great quantity. Societies with greater resources available in the infrastructure can benefit all their members, reducing the importance of individual perceptions for health and wellbeing. In line with the notion of 'A rising tide lifts all boats,' greater wealth in a country might decrease the strength of the subjective SES–health relationship. Semyonov et al. (2013) also suggest that the availability of resources in a country could reduce the relationship between SES and health, as individual command over resources becomes less important. The same could be true for the subjective SES–health relationship, as status competition might be less crucial as long as basic needs are met.

H2. The subjective SES–health association is weaker in countries with greater affluence.

Some researchers, however, have pointed out that the relationship between country affluence becomes unimportant for population health as soon as a certain threshold of wealth has been surpassed (Wilkinson, 1997; Wilkinson and Pickett, 2010). After that level has been reached, it is presumably income inequality that becomes the important driver of population health (Wilkinson and Pickett, 2010). The debate about the relationship between income inequality and health has been discussed at length in the literature (Ellwardt et al., 2014; Kondo et al., 2009; Pickett and Wilkinson, 2015), however, here we would like to focus on any moderating effects of income inequality on the subjective SES–health association.

A few previous studies have suggested that income inequality might exacerbate health inequalities (Beckfield et al., 2013; Semyonov et al., 2013; Wilkinson and Pickett, 2008). Beckfield et al. (2013) suggest a 'fundamental cause' (Phelan et al., 2010) explanation for this hypothesized relationship. High-SES individuals in less egalitarian societies might have even more resources that they can translate more easily into better health, leaving the disadvantaged even further behind in terms of health. Also, given that income can serve as a buffer for the stress individuals face in their lives, low-income individuals in less egalitarian societies should be more stressed and, thus, less healthy, exacerbating the health gradient in less egalitarian countries. Semyonov et al. (2013) point to the neo-materialist pathway (Lynch et al., 2000) that is suggested to connect income inequality and average population health. According to this pathway, societies with a high degree of income inequality are also characterized by a country's systematic underinvestment across a wide range of human, physical, and social infrastructures. The less well-off are likely to suffer most from these underinvestments, as they lack the personal resources to make up for these public underinvestments, thus, it is reasonable to expect that health inequalities in countries with greater income inequality should be greater as well. Wilkinson and Pickett (2008) suggest that status competition should be stronger in places characterized by greater income inequality,