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Short report

Cross-national differences in the gender gap in subjective health in Europe: Does country-level gender equality matter?

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ABSTRACT

Multiple studies have found that women report being in worse health despite living longer. Gender gaps vary cross-nationally, but relatively little is known about the causes of comparative differences. Existing literature is inconclusive as to whether gender gaps in health are smaller in more gender equal societies. We analyze gender gaps in self-rated health (SRH) and limiting longstanding illness (LLI) with five waves of European Social Survey data for 191,104 respondents from 28 countries. We use means, odds ratios, logistic regressions, and multilevel random slopes logistic regressions. Gender gaps in subjective health vary visibly across Europe. In many countries (especially in Eastern and Southern Europe), women report distinctly worse health, while in others (such as Estonia, Finland, and Great Britain) there are small or no differences. Logistic regressions ran separately for each country revealed that individual-level socio-economic and demographic variables explain a majority of these gaps in some countries, but contribute little to their understanding in most countries. In yet other countries, men had worse health when these variables were controlled for. Cross-national variation in the gender gaps exists after accounting for individual-level factors. Against expectations, the remaining gaps are not systematically related to societal-level gender inequality in the multilevel analyses. Our findings stress persistent cross-national variability in gender gaps in health and call for further analysis.

Introduction

Women in industrialized societies generally report being in worse health than men, even though they live longer (Read & Gorman, 2010). These gender gaps vary cross-nationally, suggesting that gaps are affected by country-specific conditions (e.g., Bambra et al., 2009; Crimmins, Kim, & Solé-Auró, 2011; Van Oyen et al., 2010). Yet we know relatively little about these conditions.

This paper has three objectives. The first is to document gender gaps in subjective health in 28 European countries, measured by reports of self-rated health and of limited longstanding illnesses. Second, we analyze whether the gender gap and cross-national differences therein can be explained by gender differences in demographic and socioeconomic characteristics. The third objective is to analyze whether gender equality at the national level is related to gender gaps in subjective health. We use data from the European Social Surveys.

Subjective health measures are commonly used as summary indicators of health, which predict mortality independently of many objective health measures (Idler & Benyamini, 1997). The two main explanations to gender differences in subjective health are differences in health reporting and in morbidity (e.g., Case & Paxson, 2005; Macintyre, Ford, & Hunt, 1999). The former hypothesis holds that women report being in worse health than men even when faced with similar health conditions, because women are more health-aware and more often allowed to admit vulnerability and to seek help (Benyamini, Leventhal, & Leventhal, 2000; Courtenay, 2000; Hibbard & Pope, 1983; Idler, 2003). These claims have been both supported and doubted by empirical findings (Benyamini et al., 2000; Case & Paxson, 2005; Courtenay, 2000; Grol-Prokopczyk, Freese, & Hauser, 2011; Hibbard & Pope, 1983; Idler, 2003; Macintyre et al., 1999). Several studies report that a more important reason for gender gaps in self-rated health is women's higher morbidity (Case & Paxson, 2005; Idler, 2003; Read & Gorman, 2010). These gaps can be particularly large for chronic (Case & Paxson, 2005), as well as psychological and somatic conditions (Macintyre et al., 1999; McDonough & Walters, 2001).

Women may have worse health due to weaker labor market attachment, lower socioeconomic position, lesser participation in the public sphere (Lahelma, Arber, Kivelä, & Roos, 2002; Schnittker, 2007) as well as the double burden of paid work and household responsibilities (Backhans, Lundberg, & Månsdotter, 2007; Boye,

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2011; Månsdotter, Lindholm, Lundberg, Winkvist, & Öhman, 2006). Societies differ in the degree to which opportunities and valued resources are granted for women and men. Consequently, this variation may lead to national differences in gender gaps in health (e.g., Hunt & Annandale, 1999; Moss, 2002; Read & Gorman, 2010).

Living in a gender (un)equal society can affect women's and men's health, and the gender gap therein, independently of individual positions and characteristics. Predictions of these effects are partly contradictory. Societies can improve gender equality in health through access to health-promoting resources (Moss, 2002), by valuing female and male attributes more equally, and by holding less rigid gendered stereotypes of beliefs and behavioral patterns (Courtenay, 2000; Moss, 2002). These can promote women's health in particular. They can also benefit men's health, for example by endorsing more health conscious behaviors and life styles (Backhans et al., 2007; Månsdotter et al., 2006). On the other hand, gender equality can affect health negatively if women take up masculine unhealthy behaviors, even though this is not unequivocally supported by evidence (e.g., Pampel, 2001). High and unrealized expectations can harm women's health (Hopcroft & Bradley, 2007), and men's health may suffer if the loss of previous privileges is compensated with harmful masculine behavior (Backhans et al., 2007; Backhans, Burström, Ponce de Leon, & Marklund, 2012; Courtenay, 2000). Overall, theoretical accounts do not lead to straightforward predictions of whether gender equal societies have smaller gender gaps in health.

There are few European cross-national studies on differences in gender gaps in subjective health. Bambra et al. (2009) compared 13 countries and found that self-reported health was to women's disadvantage in Southern Europe and Scandinavia, to men's disadvantage in Finland and the UK, while no difference was found in Belgium, France, Germany and Ireland. Worth noticing is that women were in poorer health relative to men in the least (Southern Europe) as well as the most (Scandinavia) gender-egalitarian countries. Cross-national variation in gender gaps in health has also been reported for elderly (Jylhä, Guralnik, Ferrucci, Jokela, & Heikkinen, 1998) and youth (Torsheim et al., 2006). Related studies have reported cross-national differences in other health indicators (Crimmins et al., 2011; Van Oyen et al., 2010), and in mortality (Backhans et al., 2012).

Studies on the relationship between societal gender equality and health outcomes have used various approaches. Some have used aggregated data on countries (Backhans et al., 2012; Stanistreet, Bambra, & Scott-Samuel, 2005), regions (Kawachi, Kennedy, Gupta, & Prothrow-Stith, 1999) or municipalities (Backhans et al., 2007), whereas others have combined individual-level data with macro-level measures of gender equality in a multilevel setting (Chen, Subramanian, Acevedo-Garcia, & Kawachi, 2005; Hopcroft & Bradley, 2007; Jun, Subramanian, Gortmaker, & Kawachi, 2004; Seedat et al., 2009; Torsheim et al., 2006; Van de Velde, Bracke, & Levecque, 2010). Different measures and research designs do not permit strong conclusions. Many findings suggest that societal gender equality leads to smaller gender gaps in health, mainly by improving women's health. However, some findings point to worse health due to gender equality and potentially to larger gender health differences (Backhans et al., 2007; Hopcroft & Bradley, 2007; Månsdotter et al., 2006).

Summing up, the theoretical and empirical literatures are inconclusive regarding whether societal gender equality leads to smaller gender gaps in health. We contribute by providing the largest European cross-national study of gender gaps in self-rated health. We link these cross-national differences to national levels of gender equality within countries, while controlling for individual characteristics and levels of social development and income inequality.

Table 1
Summary statistics ($N = 191{,}104$).

	%/Mean	s.d.
Less than good self-rated health (SRH)	32.0%	
Limiting longstanding illness (LLI)	22.0%	
Female	53.3%	
Middle education (ref.: low)	44.5%	
High education	25.7%	
Partner low educ (ref.: no partner)	18.0%	
Partner mid educ	27.6%	
Partner high educ	16.1%	
Employed (ref.: not employed)	54.8%	
Retired	18.4%	
Has children	42.1%	
Tight with money	25.1%	
ISEI missing	8.1%	
ISEI	42.8	
Age	45.8	15.7
Year	2006.1	2.8
GII	14.4	5.8
Gini	29.2	4.2
HDI	83.3	5.3

Data analysis

We use data from 28 countries from all five rounds of the European Social Survey (ESS), collected biannually from 2002 to 2010 (see, Eikemo, 2010). The countries are Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Great Britain, Greece, Hungary, Ireland, Israel, Italy, Latvia, Luxembourg, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and Switzerland. These data were collected in the national languages by academic partners in each country, sampling individuals aged 15 and above. Different countries participated in different waves. The ESS has a target response rate of 70%, but in practice the response rates fell commonly between 50% and 70%, ranging from 30.5% (Germany 2010) to 81.4% (Bulgaria 2010) (www.europeansocialsurvey.org). We restrict our analyses to those aged 18–75 years. Our total sample consists of 191,104 individuals from 109 country-years (for country-specific *N*s, see Table 2). 1001 individuals were deleted due to missing data.

Our dependent variables are self-rated health (SRH) and whether one has a limiting longstanding illness (LLI). We recoded these into binary variables. Those with "fair", "bad" or "very bad" SRH were distinguished from those reporting "good" or "very good" health (cf. Eikemo, 2010); likewise, we separated those hampered "to some extent" or "a lot" in daily activities for health reasons from those who are not. SRH can be sensitive to specific cut-off points (e.g., Jürges, 2007; Jylhä et al., 1998), but our results were robust after rerunning our analysis contrasting "bad" and "very bad" health to better health (not shown). Gender is our main independent variable (male as the reference category). We adjust for a selection of socioeconomic and demographic variables (Table 1): age, age squared, own and partner's education (low (ISCED 0–2); middle (ISCED 3); high ISCED 4–6), occupational status (measured using the ISEI scale), whether occupation status was missing (mainly due to no occupation), whether one was employed or retired, has children, was tight with money, and calendar year (entered as dummies).

To analyze whether gender gaps in health are related to levels of gender equality in each society, we measure the latter using United Nations Development Programme's (UNDP) Gender Inequality Index (GII) (cf. UNDP, 2013), which runs from 0 (perfect gender equality) to 100. This index sums up inequalities in reproductive health, empowerment, and the labor market. It has become a common tool for assessing national levels of gender equality. Experiments with the Gender Gap Index (Hausmann, Tyson, & Zahidi,