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Gender gap in self-rated health in South Korea compared with the United States



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Abstract Addressing the gender gap issue is a key to the reduction of the health gap between and within nations. This study aimed to describe gender differences in SRH of populations in South Korea and the United States (U.S.). Data on 33,240 eligible participants from the KNHNES and 39,646 participants from the NHNES was included in the study. Multiple logistic regression analysis was performed to identify gender differences in SRH. SRH was rated as poor in 18.8% and 16.3% of the participants in South Korea and in the U.S. The results of this study indicated that South Korean women had a higher risk of poor SRH, differed from women in the U.S. The 20–39 age group had a higher risk for poor SRH in both South Korea and the U.S. It suggested that South Korea's traditional gender roles negatively affect women. Thus, the welfare of South Korean should be improved to reduce these between-country health gaps by applying health-related laws to differentiation of beneficiaries' gender and age group.

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Diferencias de género en la salud autopercebida en Corea del Sur en comparación con Estados Unidos

Resumen Se abordan las diferencias de género como clave para la reducción de la brecha de salud. Este estudio se plantea describir las diferencias de género en salud autoinformada en Corea del Sur y Estados Unidos. Un total de 33.240 participantes de los KNHNES y 39.646 de la NHNES se incluyeron en el estudio. Se realizó un análisis de regresión logística múltiple para identificar las diferencias de género en salud autoinformada. Ésta fue calificada como pobre por

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el 18,8% y 16,3% de los participantes en Corea del Sur y en los Estados Unidos, respectivamente. Los resultados indicaron que las mujeres de Corea del Sur tienen mayor riesgo de mala salud autoinformada, difiriendo de las mujeres estadounidenses. El grupo de edad 20-39 años tuvo un mayor riesgo de mala salud autoinformada, tanto en Corea del Sur como en Estados Unidos. Se sugiere que los roles de género tradicionales de Corea del Sur afectan negativamente a las mujeres. Por lo tanto, el bienestar de Corea del Sur debe ser mejorado para reducir estas brechas de salud entre países mediante la aplicación de leyes que tengan en cuenta el género y el grupo de edad de los beneficiarios.

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The World Health Organization report on social determinants of health concludes that reducing the health gap between and within nations is only possible if gender inequities are addressed (Commission on Social Determinants of Health, 2008; Molarius et al., 2012). Inequity is defined as systematic biases in the conditions of daily living that are produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of, and access to, power, wealth, and other necessary social resources (Commission on Social Determinants of Health, 2008; Molarius et al., 2012). Following this definition, gender inequities can be defined as unfair systematic differences between men and women in the conditions of daily living, which are shaped by these social structures and processes. To reduce the health gap it is therefore important to elucidate possible reasons for gender differences in health.

The World Economic Forum (WEF) reports annually on global gender gaps and also ranks nations. South Korea's gender gap improved in 2013, but its overall rank was below average (117th out of 142 nations) (World Economic Forum, 2014). The United States (U.S.) was ranked 20th, overall. WEF uses four sub-indexes (economic participation and opportunity, educational attainment, health and survival, and political empowerment) to calculate the gender gap index (World Economic Forum, 2014). The performance of all sub-indexes is below average in South Korea. Among the sub-indexes, the health and survival index is ranked highest (74th) in this country. However, in the U.S. the health and survival index is the lowest-ranked (62nd) of the sub-indexes (World Economic Forum, 2014).

Self-rated health (SRH) is a widely used indicator of health and is a good predictor of morbidity and mortality (Halford et al., 2012; Mair, 2013; Molarius et al., 2012). It has been widely used as a measure of general health status in large, population-based social and epidemiologic health studies, and is thought to reflect both mental and physical health domains. SRH is generally stable until 50 years of age (McCullough & Laurenceau, 2004), and then declines (McFadden et al., 2008). Low SRH is associated with declining health and higher mortality (Franco et al., 2012; Tamayo-Fonseca et al., 2013; Wolinsky et al., 2008). In most countries women have poorer health than men, and have lower SRH (Crimmins, Kim, & Solé-Auró, 2011;

Melchior, Berkman, Niedhammer, Chea, & Goldberg, 2003; Molarius et al., 2007). Large socioeconomic differences have been observed in SRH. In general, individuals with low socioeconomic status (SES) have poorer SRH, compared with individuals with high SES (Kneesebeck, Lüschen, Cockerham, & Siegrist, 2003; Laaksonen, Rahkonen, Martikainen, & Lahelma, 2005; Stringhini et al., 2012).

Cross-national comparison studies have focused primarily on gender differences in life expectancy and mortality. Fewer studies have compared various health domains (e.g., SRH) between Eastern and Western countries (Oksuzyan et al., 2010). South Korea and the U.S. have diverse cultures and health systems (South Korea: universal healthcare versus the U.S.: employer based health care). Due to population growth and aging, the demand for healthcare has been increasing. Inequality of health is against this flow, and therefore, governments or health policy makers' interests are toward to reduce inequality of health. This study aimed to describe and compare gender differences in SRH with respect to age, marital status, and SES in populations of two countries where shows very different aspect of equality.

Method

Source of data

- KNHANES, 2007–2012. Data from the fourth and fifth Korea National Health and Nutrition Examination Surveys (KNHANES IV and V, 2007–12) were used for this study. KNHANES IV and V are cross-sectional surveys that have been conducted annually since 1998 by the Korea Centers for Disease Control and Prevention (KCDC, Seoul, Korea) to assess the health and nutritional status of the South Korean population. A stratified multistage cluster-sampling design is used to obtain a nationally representative sample. Each survey is composed of three parts: Health Interview Survey, Health Examination Survey, and Nutrition Survey. We used data from the Health Interview Survey component, which asked questions pertaining to socio-demographic characteristics, health status, medical history, and healthcare utilization. A total of 50,838 individuals (4,594 in 2007, 9,744 in 2008, 10,533 in 2009, 8,958 in 2010, 8,491 in 2011, and 8,518 in 2012)

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