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Intergenerational financial transfers and health in a national sample from France

Claire Scodellaro [a,c,*], Myriam Khlat [c], Florence Jusot [b,c]

[a] Université de Lorraine, Laboratoire Lorrain de Sciences Sociales, France
[b] PSL, Université Paris-Dauphine, LEDA-LEGOS, France
[c] Institut National d'Etudes Démographiques, Paris, France

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ABSTRACT

Financial transfers from parents to their adult children are a growing trend in contemporary societies, and this study investigates the relation of those transfers to their beneficiaries' health in France. In the 2005 nationally representative Gender and Generation Survey, nearly 6% of the subjects aged 25–49 years reported having received financial transfers during the last 12 months. Subjects who had achieved intergenerational upward mobility as well as those who had remained in the upper class were more likely to receive transfers, suggesting that parents rewarded those of their children who achieved most social success. After adjusting for a wide range of socio-demographic factors, subjects who had been given large transfers were much more likely to report very good health than subjects who had not been given anything. Findings were interpreted within the framework of sociological research on intergenerational transfers and that of lifecourse epidemiology.

Introduction

Everywhere in the world, those with greater levels of economic resources have better health (Adams, Hurd, McFadden, Merrill, & Ribeiro, 2003; Ecob & Davey Smith, 1999; Kiuilia & Mieszkowki, 2007; Mackenbach et al., 2005; Martikainen, Mäkela, Koskinen, & Valkonen, 2001). Although people's earnings are greatly influenced by educational qualifications and occupational status, which are fundamental determinants of health, the association between financial resources and health was found to hold even after adjusting for structural variables (Fritzell, 2004). Various mediating mechanisms have been suggested. Further to the satisfaction of the basic needs related to sanitation, nutrition and housing, the ability to consume goods and services serves psychosocial and symbolic purposes, as it is related to opportunities for social participation, self-fulfillment and control over one's life circumstances (Marmot, 2002; Marmot & Wilkinson, 2001).

Most studies have focused on income, which is the key measure of material resources. There are however other contributors to household means which are worthy of consideration. Family exerts a strong influence on health, as it provides different kinds of resources that may protect the health of its members (Carr & Springer, 2010). Particularly, the transfer of resources between generations is an important component of familial solidarity, and maintains the interdependence between parents and children long after leaving parental home (Arber & Attias-Donfut, 1999). In pre-industrial Western Europe, adult children used to provide financial support to their parents, although to a lesser extent than conventionally thought (Low, 1998). This kind of support has lessened considerably with the introduction of social protection schemes in Europe, as the public pension incomes and healthcare coverage have enabled the older generations to support the younger generations. This has led to a change of direction of the flow, with a shifting from help to aging parents to help to children and grandchildren (Björnberg & Latta, 2007; Lennartsson, 2011). The consequences of this reversal on family dynamics has given rise to different interpretations: the "crowding in" hypothesis assumes that the new welfare arrangements for the elderly actually strengthened family bonds (Reil-Held, 2006), while the "crowding out" hypothesis, which has been challenged (van Oorschot & Arts, 2005), assumed on the contrary that it undermined and displaced family solidarity.

In France, it has been estimated that private financial transfers from parents to children are ten times larger than private transfers from children to parents (Masson, 2004). Public transfers are therefore partly redistributed through private pathways to reduce inequalities in living standards across generations (Attias-Donfut & Wolff, 1999). This is particularly the case between the "pivot generation" (which supports both parents and offspring) and the young generations that experience less favorable social trajectories

* Corresponding author. Université de Lorraine, Laboratoire Lorrain de Sciences Sociales, France.
E-mail addresses: claire.scodellaro@univ-lorraine.fr, claire.scodellaro@ined.fr (C. Scodellaro).

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due to the evolutions of the labor market (Chauvel, 1998). Financial transfers may take different forms: pocket money, one-off donations associated with family events or regular monthly complements. At the beginning of year 2004, half of the parents in France whose children had left the parental home had provided financial help or support for housing and although parental support was particularly active at the start of adulthood (in particular for students) it remained important throughout the life cycle (Cordier, Houdré, & Ruiz, 2007). Since parents' resources determine their ability to financially support their offspring, intergenerational transfers are likely to reinforce inequalities by social origin within generations (Attias-Donfut & Lapierre, 2004; Blöss, 2005; Herpin & Déchaux, 2004; Masson, 2004; Wolff & Attias-Donfut, 2007), and from there contribute to health inequalities.

The influence of social origin on health has been extensively investigated and theorized within the framework of life course epidemiology (Ben-Shlomo & Kuh, 2002; Blane, Netuveli, & Stone, 2007; Kuh, Ben-Shlomo, Lynch, Hallqvist, & Power, 2003). The conceptual models (critical period model and pathway model) are centered on early life, i.e. childhood, adolescence and beginning of adulthood, but they do not explicitly consider that the parental influence may be carried on after the children's transition to adult life. Furthermore, the finding that social origin influences health at adulthood, independently of adult socioeconomic position, is generally interpreted as reflecting the "long arm of childhood" (Hayward & Gorman, 2004). And yet, financial transfers from parents to their adult children bring them supplementary resources and raise their standards of living. From this point of view, parental social status seems to remain an active component of grown up children's socioeconomic conditions.

While health inequalities by social origin are well documented, the health impact of intergenerational transfers has not yet been investigated. On similar issues, some studies have highlighted the favorable influence of transitory income supplements on health (Lindhal, 2005) and found a mortality disadvantage for income instability at middle-income levels (McDonough, Duncan, Williams, & House, 1997). There is also limited evidence that income supplementation can lead to improvements in health outcomes (Kehrer & Wolin, 1979), which raises the question of financial policy interventions.

The purpose of this paper is to investigate the relation of financial transfers from parents to their adult children's health in France. Based on the data of the 2005 wave of the European Gender and Generation survey (GGS), we have explored financial transfers received from the parents, and their association with self-rated health, adjusting for respondent's social trajectory. Findings were interpreted within the framework of sociological research on intergenerational transfers and that of lifecourse epidemiology.

Data and method

The first wave of the Generation and Gender Survey, called ERFI survey (Régnier-Loilier & Guisse), was held in France in 2005 and funded by INED (Institut National d'Etudes Démographiques), INSEE (Institut National de Statistiques et d'Etudes Economiques), CNAF (Caisse Nationale d'Allocations Familiales), ANR (Agence nationale de la recherche), DREES (Direction de la Recherche des Études de l'Évaluation Statistique, Ministère de la santé et des solidarités), COR (Conseil d'orientation des retraites), DARES (Direction de l'animation de la recherche, des études et des statistiques, Ministère du travail), and CNAV (Caisse nationale d'assurance vieillesse). The current study, partly funded by the Ministère de l'Enseignement Supérieur et de la Recherche, is based on the exploitation of secondary data from this survey. Familial and intergenerational relationships are the main themes of the survey, which also includes questions about health and well-being, parental social positions and transfers between households. This national survey was elaborated by drawing dwellings, and 64% of the dwellings in the sampling frame fully completed the questionnaire. The resulting sample was weighted in order to ensure representativity at the national level for the basic socio-demographic variables, i.e. age, sex, occupational category, nationality and household size (Régnier-Loilier & Guisse, 2009). The final sample consisted of ten thousands and sixty nine persons aged between 18 and 79 years.

Sample selection

The selected sample for our research includes the persons aged from 25 to 49, who are no longer students and have spent the most of their childhood with their biological parents. The 25-year old threshold was chosen in order to select respondents who had completed their education and entered the labor market. The 49-year old threshold was set as very few people declare having received transfers from their ascendants at a later age. After eliminating missing answers for income and transfer amount (126 individuals), the sample included 4216 individuals.

Variables

Health status was analyzed through self-rated health, a subjective health indicator that reflects quality of life and is a good predictor of mortality (Idler & Benyamini, 1997). Respondents were asked: "In general, would you say your health is… 1. Very good. 2. Good. 3. Medium 4. Bad 5. Very bad"?

We used occupationally-based social classes for both own current occupation (or last occupation for the unemployed or retired) and father's occupation when aged 15 years.

The categorization into "lower class" and "upper class" was based on a multiple correspondence analysis (not shown) of the sample of persons aged 25 and over (excluding students). In this analysis, active variables were household income, number of consumption units (according to OECD equivalence scale), educational level and activity status (employed or not), and supplementary variables were detailed occupations and social classes (more than 40 categories). The "lower" class includes employees, manual workers, farmers (owners), people who never worked and, only for fathers, unknown occupation (57% of the respondents and 65% of their fathers). Farmers, who have a relatively low educational level and income were indeed closer in the plane formed by the first two axes of the correspondence analysis to employees and manual workers than to intermediate occupations, highly qualified occupations, shopkeepers and company directors. The "upper" class includes intermediate occupations, highly qualified occupations, shopkeepers and company directors.

Studies usually treat separately social position in adulthood (own social class) and social origin (parental social class) by introducing each variable in turn in the analysis. Having found significant interactive effects of father's occupation and respondent's occupation on both intergenerational transfers and respondent's self-rated health, we have included the social trajectory as the independent variable in the regression. Mother's highest diploma was considered as follows: secondary education, baccalaureat, at least 2 years of higher education, and unknown diploma.

Financial flow and donations were measured over a period of 12 months prior to the interview using the question: "During the last 12 months, did you or your spouse exceptionally, occasionally or regularly receive money, values or goods given by someone who