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A comparative study of the patterning of women's health by family status and employment status in Finland and Sweden

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Abstract

The main aim of this study is to compare the patterning of health by family status and employment status among women in Finland and Sweden and to explore whether the patterning of health by family status is influenced by employment status and income. An additional aim was to identify which combinations of family status and employment status are especially disadvantageous for women's health . The data derived from comparable interview surveys carried out in 1994/1995. The analyses were restricted to ages 25–49; 2282 women in Finland and 2685 in Sweden. Firstly, age-adjusted prevalence percentages were presented by family status and employment status. Secondly, the patterning of health by family status and employment status, and the influence of adjusting for income, were studied by logistic regression analysis. The main results showed that women living in couples with children had the best health in both countries. Additional analyses showed that in Finland particularly poor health can be found among women who are simultaneously non-partnered and non-employed, whereas in Sweden poor health can be found among all non-employed groups of women. Income did not explain the poor health among the non-partnered and non-employed. This study confirmed that health is patterned by family status and employment status both among Finnish and Swedish women. It was found that non-employed women without a partner are likely to have poor health. In order to reduce inequalities in health among women, more efforts should be put on promoting health among these groups.

Keywords: Women; Family; Health; Employment; Finland; Sweden

Introduction

Women in many European countries are increasingly involved in paid work, and as a result families have more and more been transformed into dual-earner households (Rubery, Smith, & Fagan, 1999). Women's roles in society have changed and most women occupy multiple roles, as a partner, a mother, and an employee outside the home. In the Nordic countries, such a transformation occurred earlier than in many other western European countries. Especially in Finland and Sweden, society has for decades supported women to combine family and paid work. The female labour market participation rate in the Nordic countries has exceeded that of other industrial nations by 15–20% units throughout the period after 1945. Women's

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participation rate has in other countries during the last few decades increased but slightly decreased in Finland and Sweden. Despite that development, the Nordic countries maintained their unique position in the 1990s in terms of women's labour force participation (Marklund & Nordlund, 1999).

A number of previous studies have examined the association of marital status with women's health. Marriage seems to be supportive of good health for women (Verbrugge, 1979; Ross, Mirowsky, & Goldsteen, 1990; Arber, 1991; Macintyre, 1992; Martikainen, 1995; Waldron, Hughes, & Brooks, 1996; Lahelma, Arber, Kivelä, & Roos, 2002a). Suggested explanations for the association of marriage and health include that marriage provides material advantages and social support, but also that marriage is selective so that healthy women are more likely to marry and remain married than women with ill health (see Ross et al., 1990; Khlat, Sermet, & Le Pape, 2000). Ross et al. (1990) concluded in a review of family status and health that protective effects of marriage probably account for most of the association between marital status and health. Joung, van de Mheen, Stronks, van Poppel, and Mackenbach (1998) found among Dutch women that health-related selection seemed to explain the health differences between married and divorced women.

Parenthood has not been as much associated with health as marriage (Ross et al., 1990). Hibbard and Pope (1993) found no association between parenthood and health among women. Waldron and Weiss (1998) found some evidence of advantage of having children.

In a number of studies, employment participation has been associated with lower morbidity (Arber & Lahelma, 1993; Arber, 1997; Elstad, 1996; Waldron & Weiss, 1998; Annandale & Hunt, 2000; Lahelma et al., 2002b). According to the social causation hypothesis, employment influences health by contributing to social status and power as well as economic independence, social support and self-esteem compared to those who are non-employed (Ross & Mirowsky, 1995). According to the selection hypothesis, often referred to as the "healthy worker effect", unhealthy people are disproportionately non-employed (Ross & Mirowsky, 1995).

Several studies in Western countries have shown that women who combine family life with paid work, and have multiple roles and attachments to the community, have better health than women with fewer roles (see Annandale & Hunt, 2000; Khlat et al., 2000; Lahelma et al., 2002a). Some studies have also found an interaction effect of multiple roles among women. According to Waldron and Weiss (1998), the protective effect of marriage could only be observed among non-employed US women, but according to Waldron, Hughes, and Brooks (1996), selection to marriage explained the association between marital status and health among the non-employed but not among the employed.

In the Nordic countries, there is a long tradition of analysing inequalities in health especially by structural factors, such as employment status and occupational class or educational level (see Lahelma et al., 2002b). A common conclusion from these studies is that those with lower status and the non-employed are less healthy. Fewer studies have looked at health inequalities by family roles in the Nordic countries. A common conclusion from these studies is that women living in couples and with children have better health (Lahelma et al., 2002a) and lower mortality (Martikainen, 1995) than women in other types of family arrangements. Lone mothers are often found to be an especially vulnerable group (Martikainen, 1995; Burström, Diderichsen, Shouls, & Whitehead, 1999; Lahelma et al., 2002a; Whitehead, Burström, & Diderichsen, 2000). From a health promotion perspective, it is important to be able to identify subgroups of women who are especially vulnerable regarding their health.

Countries with a long tradition of combining family life with paid work are ideal for studying the patterning of women's health by family and paid work. By comparing countries with largely similar welfare state arrangements but with some historical and structural differences, we wish to contribute to a deeper picture of women's health inequalities. This will add our understanding of the universal and unique patterning of women's health, and thus allow conclusions to be drawn on how culture and policies shape socioeconomic and household structures and roles (Moss, 2002). Previous comparative studies of women's multiple roles, motherhood and health have been carried out between Finland and Britain (Lahelma et al., 2002a), and between Sweden and Britain (Whitehead et al., 2000). These studies suggest that despite a more generous welfare state and high women's employment participation as well as favourable social policies, the health of lone mothers is poor in the Nordic countries as well as in Britain. Nevertheless, in Britain, the disadvantaged social and economic position of lone mothers is likely to account for a greater proportion of their poor health than in Finland and Sweden.

Finland and Sweden are usually referred to as Scandinavian type of welfare states, and are in many respects similar and differ less from each other than from Britain usually characterised as a liberal type of welfare state (Esping–Andersen, 1990). However, even these two welfare states, Finland and Sweden, differ from each other. The employment rate in 1994 was lower among women in Finland (56%) compared to women in Sweden (71%), and the unemployment rate was higher among women in Finland (16%) compared to women in Sweden (8%). Part-time employment among employed women was much less common among women in Finland (11%) compared to women in Sweden (40%) in 1994. (Rubery et al., 1999).