

Marital status, work, subjective health & well-being:

**A cross national comparative study of gender specific
working hours and self-assessed health**

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Overview

The extant literature on health has found that there is a wide variation in the factors that affect individual health (Svedberg et al., 2006; Von dem Knesbeck et al., 2007).

Numerous empirical studies link marriage to better health (Bookwala, 2011; Dieperink et al., 2012; St. John 2009; Holt et al., 2008).

Married individuals live longer than unmarried individuals, this effect cannot be entirely explained by the selection of healthy individuals into marriage (Lillard & Panis, 1996).

However, there is some indication that men derive more benefits from being married than women (Rogers 1995; Bernhard ,1972; Grove & Tudor ,1973).

The unequal division of labour (both paid and unpaid) has been hypothesised to be one of the main factors driving these gender-specific inequalities in health (Bernhard 1972; Grove & Tudor, 1973; Horwitz & White, 1991).

Limitations of previous studies

Limitation 1 - A heavy focus on psychological health and well-being.

Limitation 2 - Previous research may have provided an overly simplistic picture of the ways through which health benefits may be mediated through marriage, failing to consider factors such as:

- Welfare/family policies
- Access to economic resources
e.g. women's incomes explain their housework behavior (Gupta, 2005)
- Financial security/Marriage premium
e.g. married people command higher wages in the labour market (Waite, 1995)
- Exchange of social support (House et al, 1988)
- Beneficial influence of spouses health behaviour (Eng et al.,2005; Lee et al., 2005)

Limitation 3 - Previous studies have failed to model explicitly the number of hours worked by men and women.

Research aim

We seek to extend current literature through an examination of the effect of marriage on the subjective health and well-being (general health and stress) of men and women.

- *By testing other health outcomes-self reported health and stress.*
 - The use of a single item measure of self-reported health has been validated as a measure of general health in previous studies (Bowling 2005; Desalvo et al., 2006, Cummins et al. 2005; Stafford et al., 2003). This measure has been shown to be related to physical health problems, functional capacity and mortality (Manderbacka et al., 1999; Martikainen et al. 2003).
- *By examining cross-national differences*
 - Allows us to examine the effect of differing welfare policies on individual working life
- *By explicitly modelling time allocation: paid and unpaid work.*
 - **Paid work:** tasks completed for economic gain. These include paid market work, paid work at home, and second jobs.
 - **Unpaid work:** activities for which one is not paid but are productive. These include: cooking, washing, gardening, shopping, childcare, and other domestic activities.

Studies?

- **Study 1:** examines the association between paid and unpaid work and self-reported health, comparing married and cohabiting partners across different welfare regimes.
- **Study 2:** examines the association between paid and unpaid work and stress, comparing married and cohabiting partners across different welfare regimes.

Hypotheses

Four hypotheses are formulated to investigate whether there are gender differences by marital status when time allocation is explicitly tested:

- In comparison to cohabiting unions, marriage is expected to be related to better health outcomes for both men and women.
- We expect hours spent doing paid and unpaid work to be more equally distributed amongst men and women in countries with policies that facilitate greater gender equality.
- Welfare policies that facilitate greater gender equality will be associated with similar health outcomes among men and women.
- Observed health differences are associated to the type/position women hold in paid labour market.

Data

- Data for the analysis was taken from the Multinational Time-Use Survey (MTUS)/wave 5.3.
- The countries considered are France (1998), UK (2000), Germany (2001), Italy (2002), Netherlands(2000), Spain(2000) and USA (2003).
- The data is constructed from national randomly sampled time-diaries with a common series of background variables and total time spent in 41 activities, defined as the primary or main activities (Gershuny, 2009).
- The diarist reports their activities throughout the 24 hours of the day/10 minute intervals.

A strength of using the diary based estimates of time-use is that it is more reliable and accurate than estimates derived from direct questions.

Analyses

Model testing will be conducted using two main analytical techniques:

- Multivariate linear regression
- Blinder-Oaxaca decomposition method

The goal in introducing the multivariate linear regression is to:

- Analyse the datasets separately by gender (i.e. for females and males)

This will allow us to examine the effects of all the independent variables together on the subjective health and well-being outcomes.

- Conduct a second set of analyses with pooled data (i.e. for both males and females simultaneously)

This helps us assess the effect of sex on subjective health and well-being after controlling for the possible confounding variables.

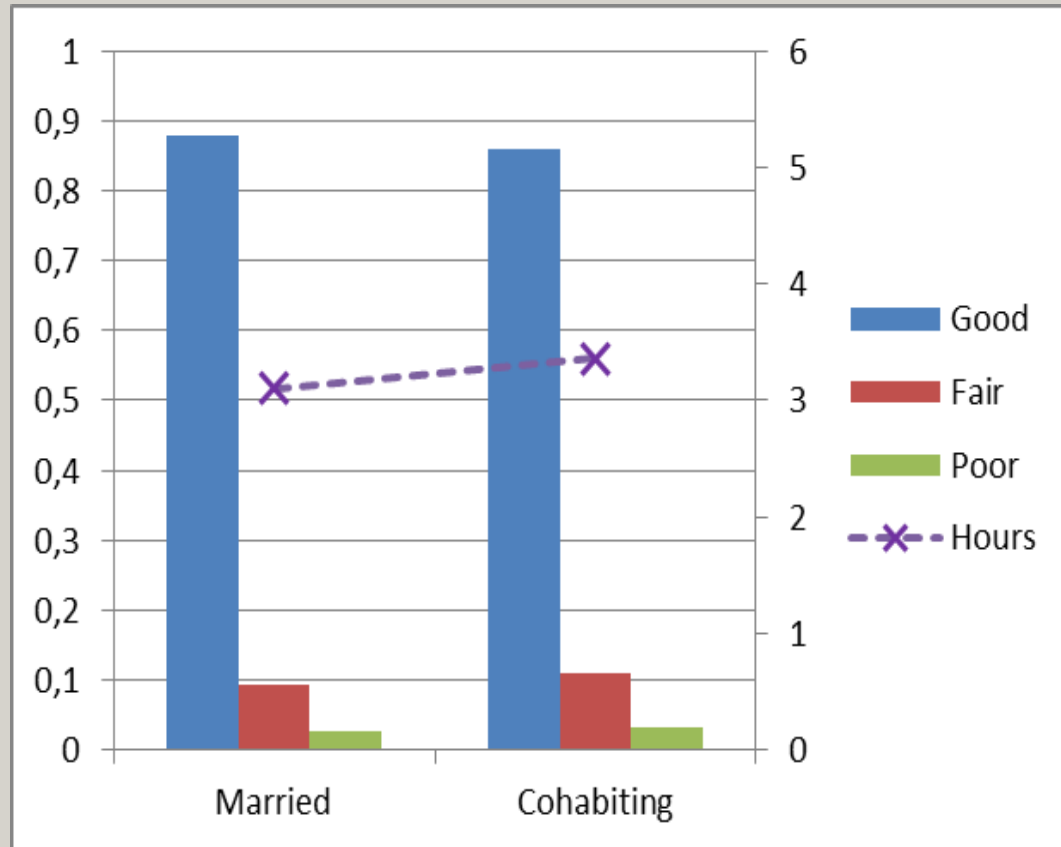
- Some interaction terms between sex and some of the confounding variables will be included and tested in the pooled model.

Analyses

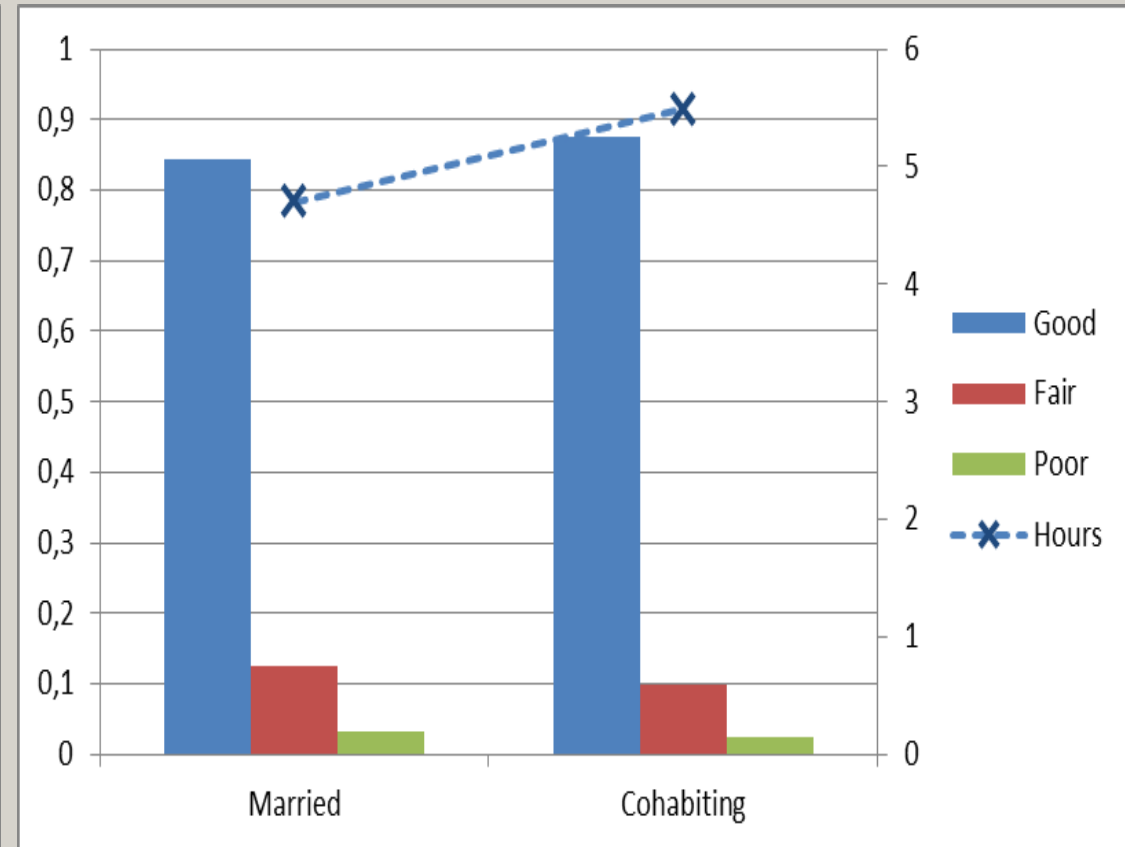
Blinder-Oaxaca decomposition method allows us to partition mean differences in a counterfactual manner. Therefore allowing us to partition any inequality found in health by sex:

- **Component 1**, the “explained” part of the model. This would essentially provide us with average health of men and women separately, and the percentage difference between these two groups.
- **Component 2**, the “residual” part of the model. Provides us with information **(a)** that cannot be explained by group differences on the determinants of health. **(b)** counterfactual information i.e. for example if women had the same characteristics of men, what would their health be.

Average total unpaid work & self-assessed health (United States)

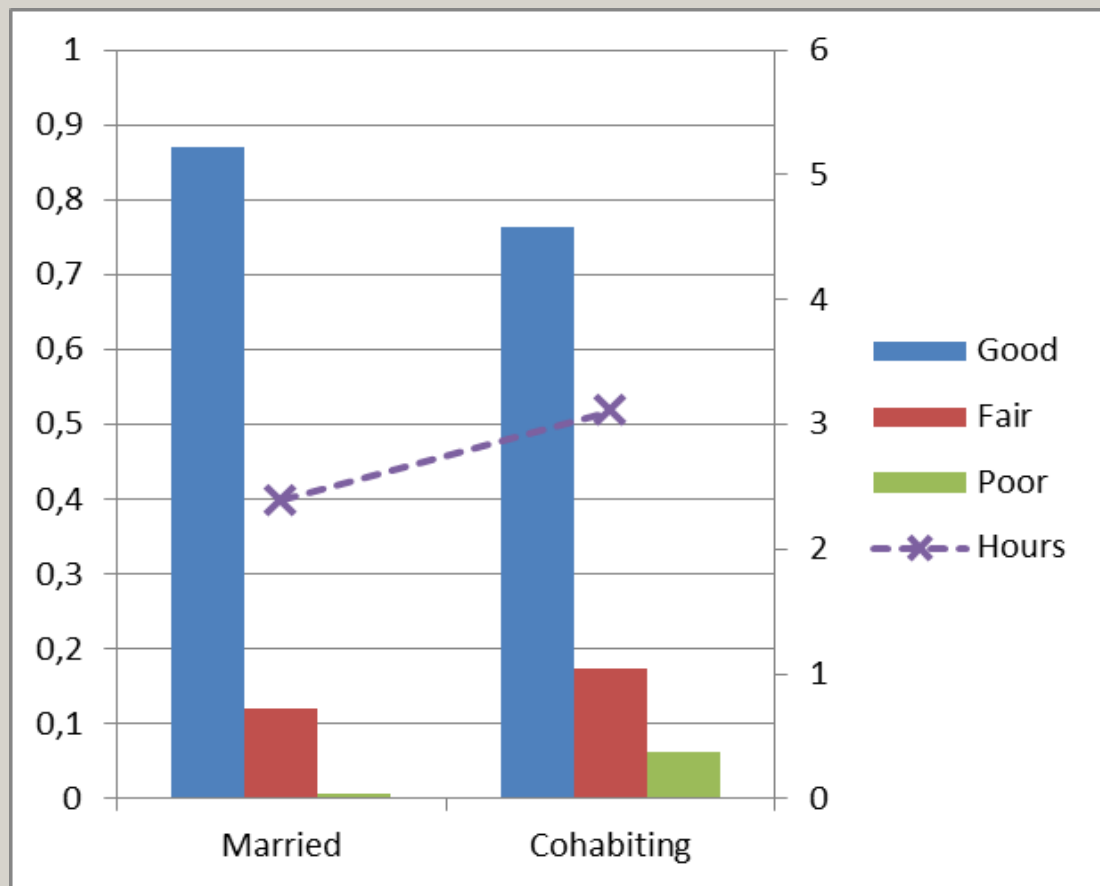


Men

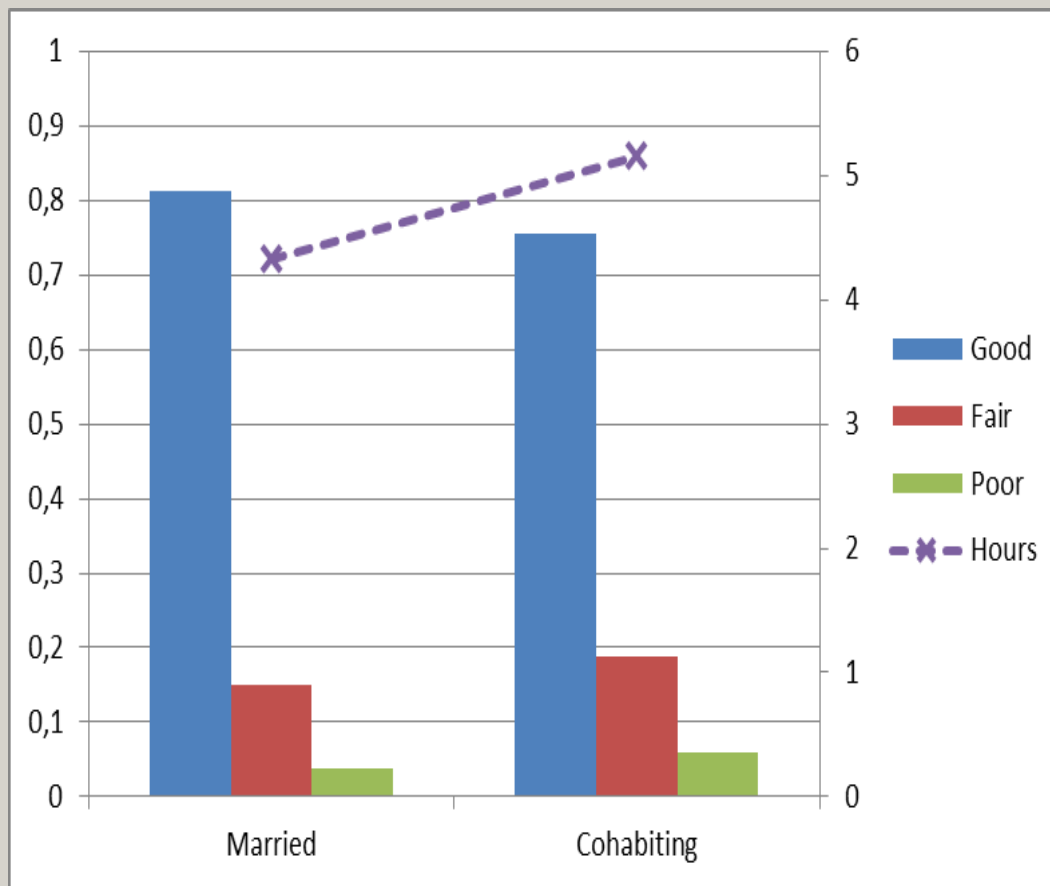


Women

Average total unpaid work & self-assessed health (United Kingdom)

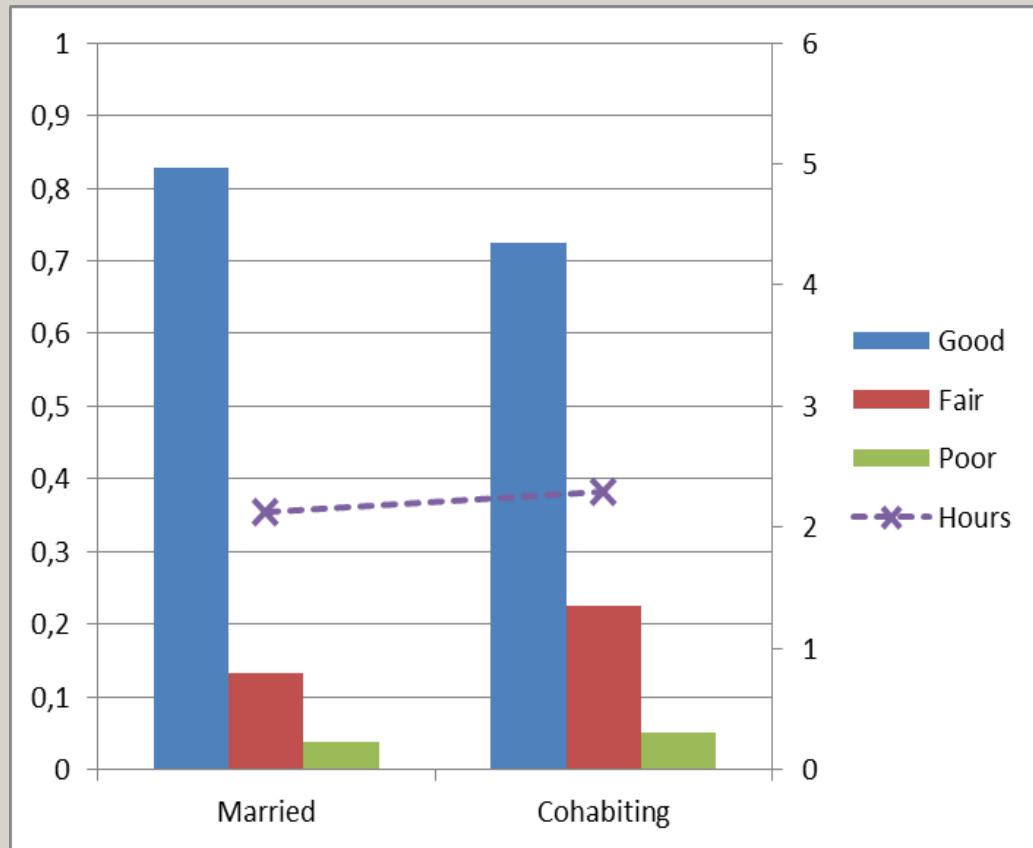


Men

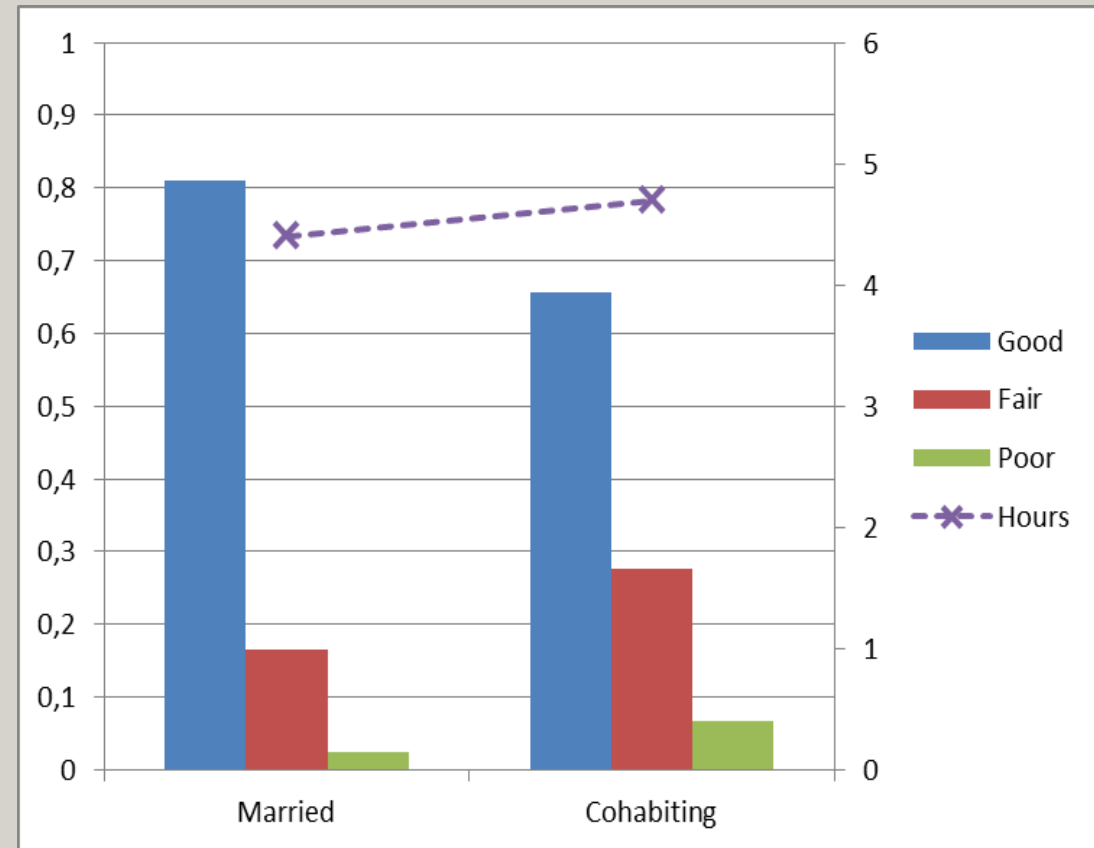


Women

Average total unpaid work & self assessed health (France)

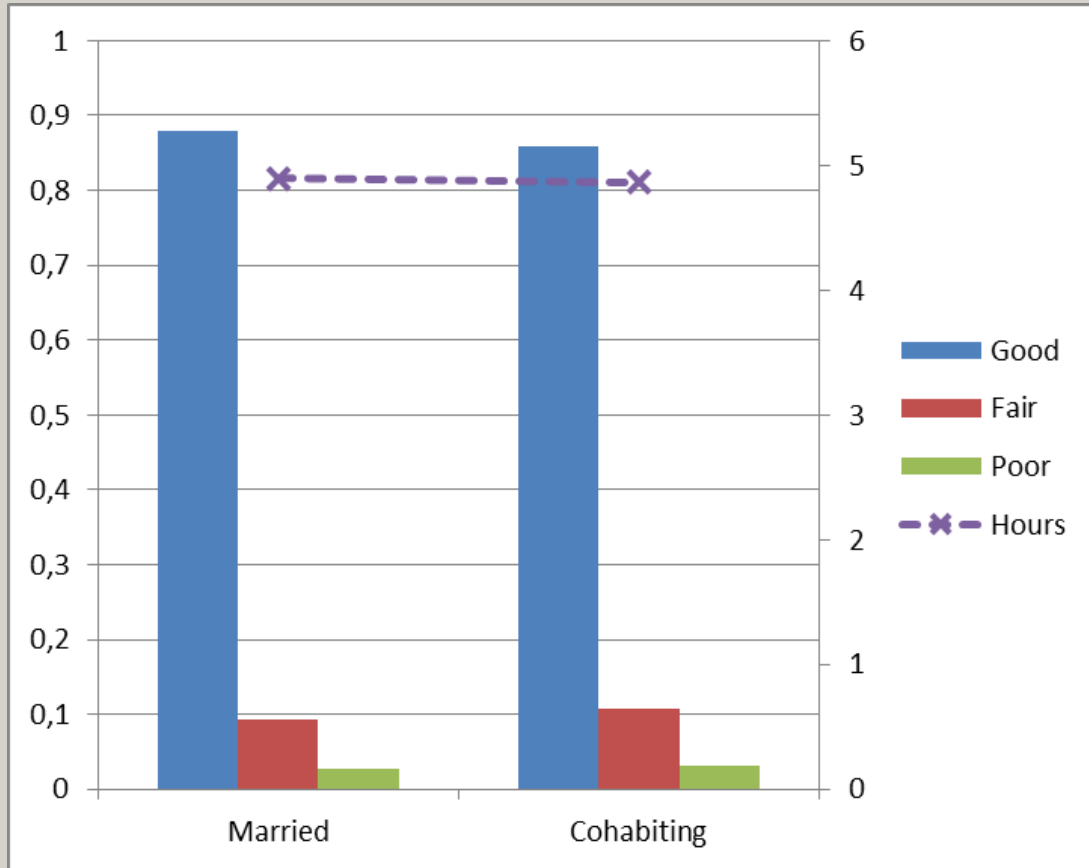


Men

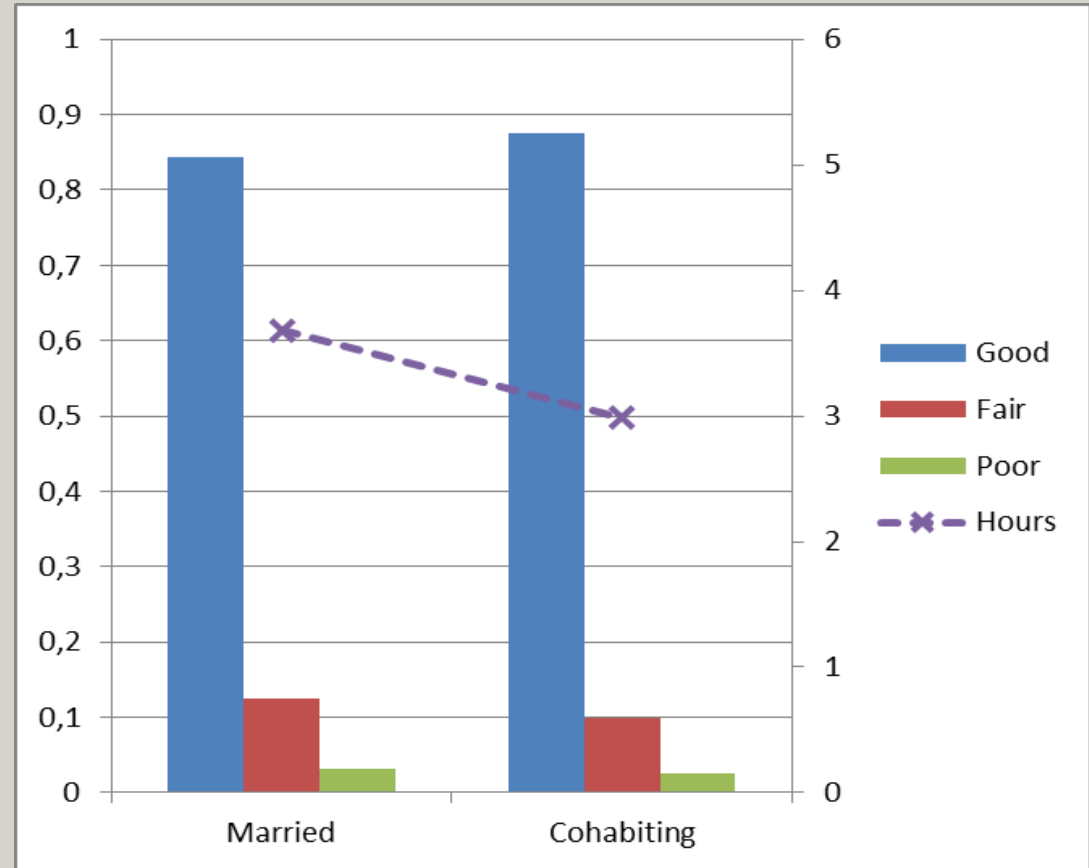


Women

Average total paid work & self-assessed health (United States)

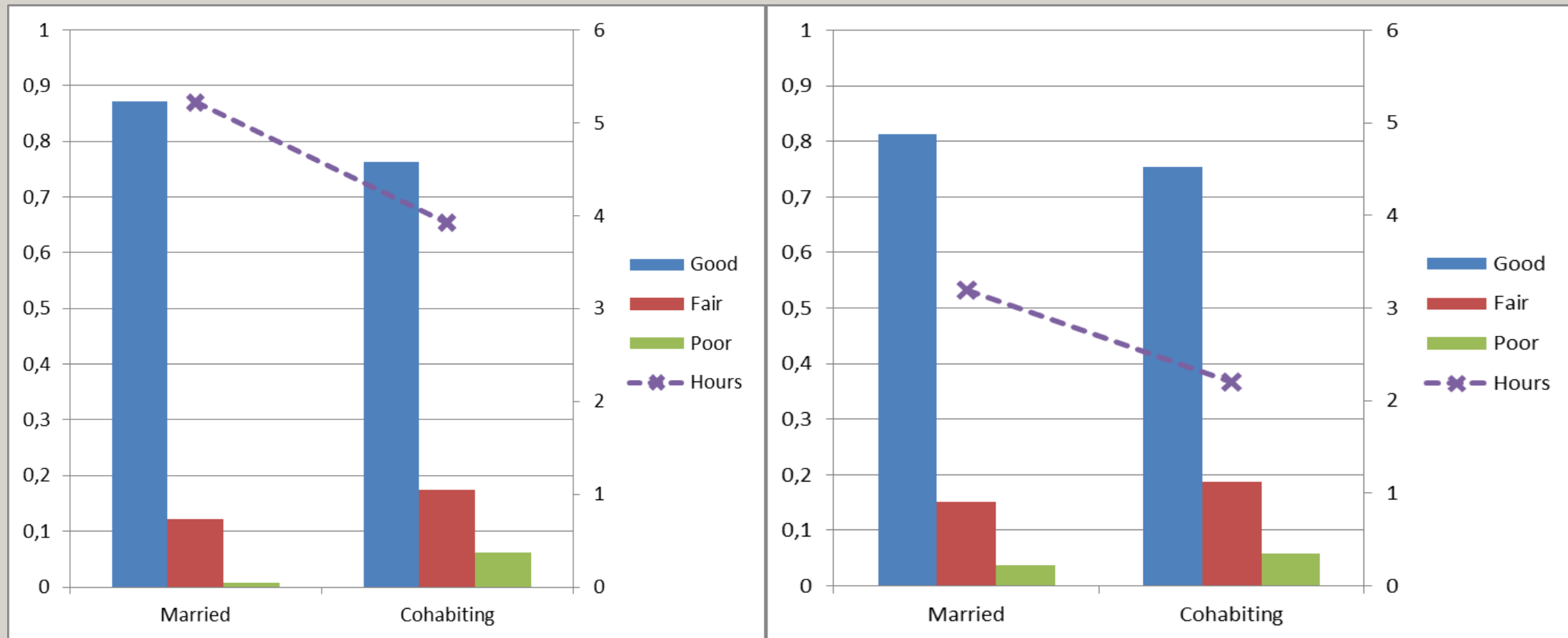


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Women

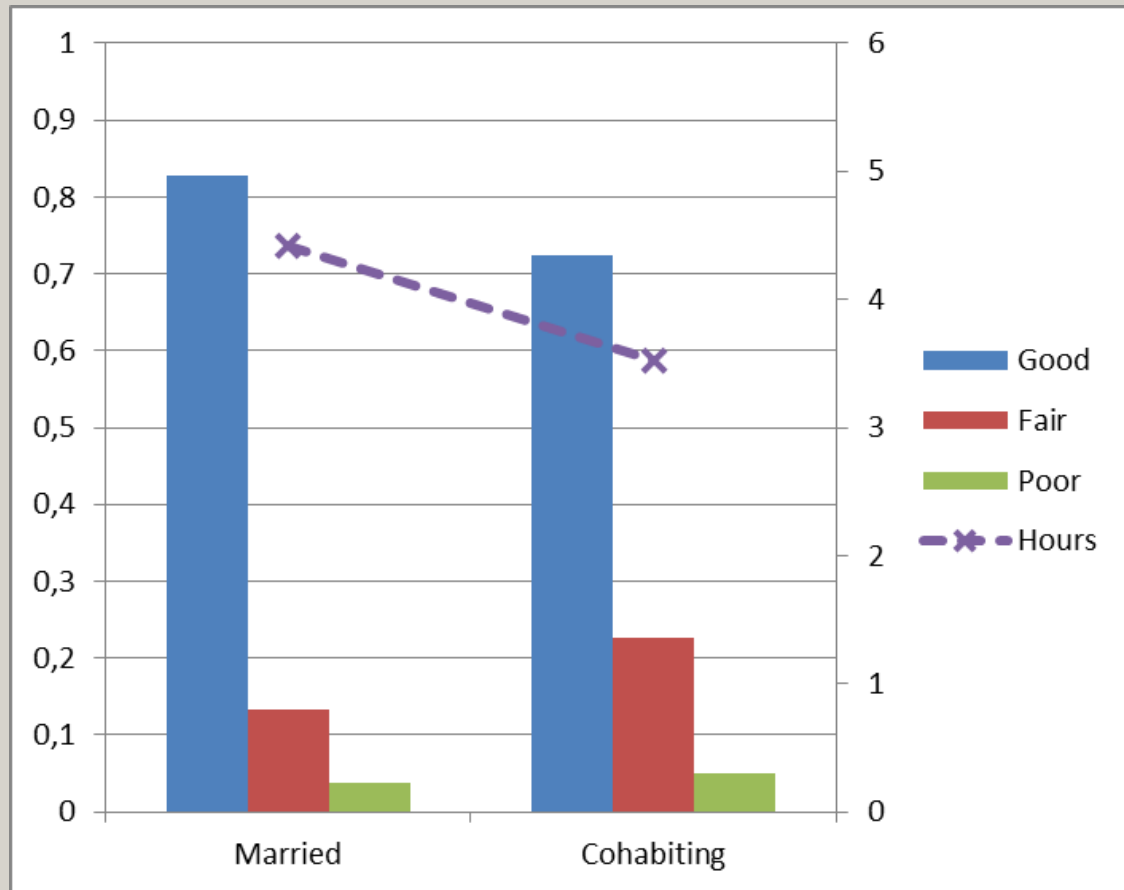
Average total paid work & self-assessed health (United Kingdom)



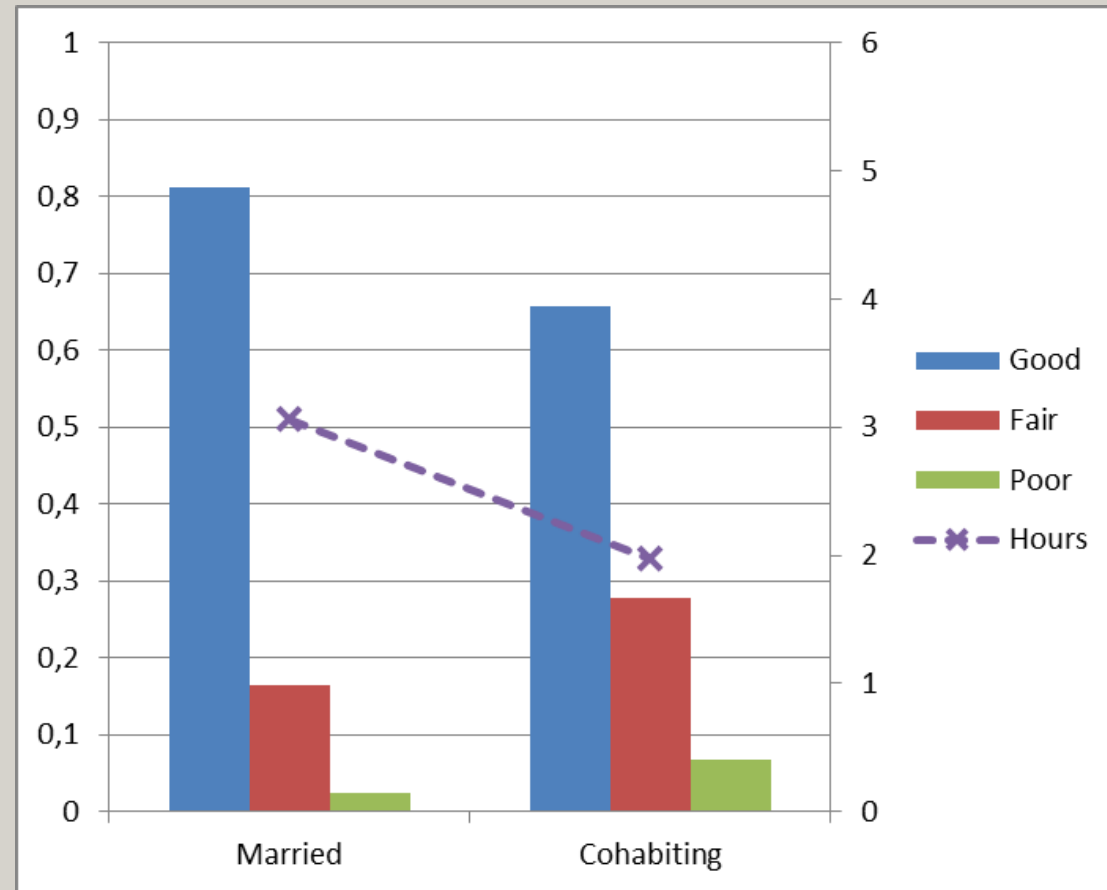
Men

Women

Average total paid work & self-assessed health (France)

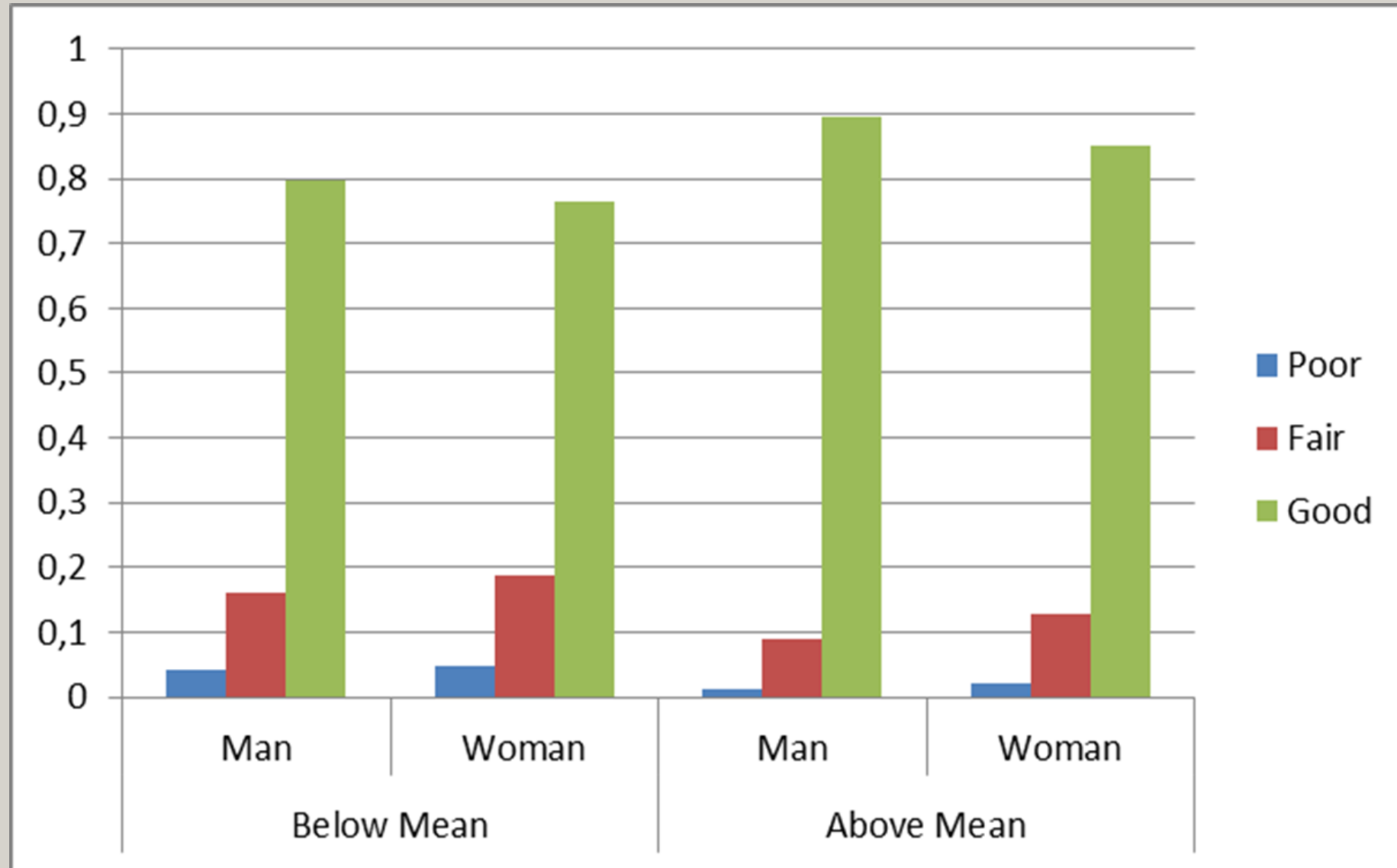


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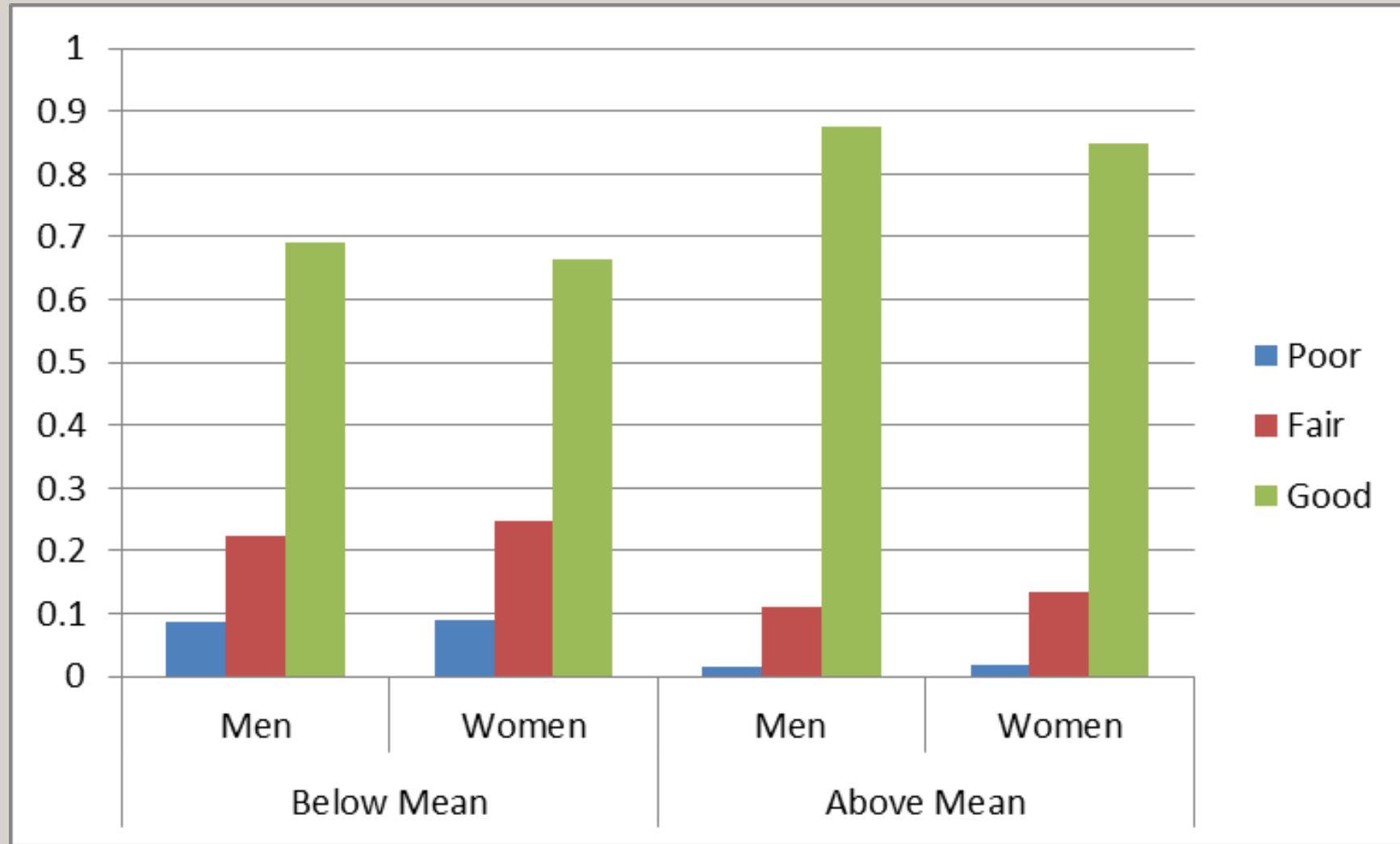


Women

Health Status by Work Hours: Married Partners



Health Status by Work Hours: Cohabiting partners



Discussion/Conclusion

- We observe that married people do more paid work whereas cohabiting partners engage in more unpaid work. Pattern is similar across all countries
- Distinct gender pattern in unpaid work- women in cohabiting partnerships engage in far greater number of hours of unpaid work, when compared to women who are married
- In UK and USA married people have roughly the same health and total working hours as cohabiting people. In France cohabiting people work shorter hours in total and have worse health than married people.
- Both married and cohabiting men who work above the mean total working hours (6.7 hours per day), report better health than men who work below the mean. A similar pattern exists among women.
- Unfortunately based on current analyses unable to say much about the differing welfare policies

THANK YOU FOR YOUR TIME