

Are couples really a homogeneous cluster in terms of health in Europe?

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Living with a partner protects or even enhances the health status of both partners, although its impact differs between men and women in terms of the intensity and level of these positive effects. Beyond comparative studies between different partnership statuses, the knowledge about internal differences within each status is still limited. Perhaps it is therefore that, while the non-married or those not living with a partner have often been the subject of analysis, couples have been less studied with the exception of differences between cohabitation and marriage. To fill this gap we study different countries in the European context where we question whether it is plausible to assume that having a partner –a situation that pertains to the majority of the adult and an important part of the older population– has a homogeneous effect on their health.

The bulk of the studies that analysed the relationship between partner or marital status and health have demonstrated that adult individuals with a partner have a better health profile than their counterparts who do not. In brief, the healthier profile of people in union has been explained by a range of factors which promote a healthier lifestyle: social and partners' control which discourage individuals to follow risky behaviours; creation and maintenance of social nets to which individuals count on in case of economic and/or personal setbacks; and economies of scale in the context of the household which optimize resources (Rendall et al. 2011). In addition, a selection mechanism in the marriage market has also been proposed, whereby those with a good health profile have a higher probability of finding a partner and maintaining a relationship (Koball et al, 2010).

However, the majority of these studies considered living with a partner as a homogeneous situation for all couple members after controlling for individual's characteristics but without taking into account specific couple characteristics. Only the fact of living in a marriage or in cohabitation has been explored, whereby findings were not conclusive. For instance, when differences were found country of residence appeared to play a key role because it is related to the level of social acceptance of cohabitation: the higher the level of acceptance, the lower the health difference between marriage and cohabitation (Soons and Kalmijn, 2009).

Nowadays Western countries are experiencing a process of diversification of couples' profiles in terms of age, education, working status or nationality, among other characteristics. This questions whether this diversification also leads to health differences between couples according to their profile. Indeed, the

abovementioned characteristics are also considered to be social determinants of health at the individual level. Particularly those related to the socioeconomic status of individuals like educational attainment, occupation or employment status are the most studied sources of health inequities in past and current populations, whereby socioeconomic status tends to be significant and positively associated with health status (Marmot and Wilkinson, 1999).

Method and data

In this study we will therefore explore whether socioeconomic and demographic characteristics of each partner –characteristics known to be health determinants at the individual level– are translated to health differences among individuals with a partner. The idea of including information from partners is to see whether partner homogeneity or heterogeneity in socio-demographic characteristics affects their own health and that of their partner. Only individuals who live with a partner are analysed, irrespective of their marital status. We selected Spain, Germany, the United Kingdom and Poland because these countries represent meaningful examples of different types of welfare states (familistic traditional, traditional, liberal and post-soviet transition) (Ferrera, 1996; Esping-Andersen, 1999). Nordic countries are discarded due to restrictions in the data source¹. The cross-sectional data of the 2012 EU-SILC survey will be used in the analysis of middle-aged adults (aged 30-59). Only natives of each country are analysed in order to avoid possible bias due to differences in the socio-demographic profile of immigrants. This survey collects information from all household members, which allows information from both partners to be analysed. Logistic regression models (pooled model and country-specific models) will be used in order to identify which of the individual- and partner-level socio-demographic factors are associated with differences in health status.

Preliminary results

For illustrative purposes we only display results from three of the selected countries (Spain, France and the United Kingdom). Descriptive analysis of middle-aged adults living with a partner where the oldest member of the couple is aged between 30 and 59 years old (4359, 3562, 2664 and 5346 couples in Spain, France, the United Kingdom and Poland respectively) showed evidence of socioeconomic health differences. For instance, when the educational level of both partners are combined we observe differences in the prevalence of good health among each couple member in the three countries, with the highest values when both partners have upper secondary education or higher and the lowest when both declare to have attained lower secondary or primary level (Table 1). The highest difference is found in the United Kingdom (33.6 percentage points

¹ Only information from one member of the household is compiled in Nordic countries and the Netherlands

between the two extremes) whereas this difference is similar in Spain, France and Poland, though with different values in the highest and lowest values. Observing the categories in between these two extremes we see a range of values for good health which conform to the educational attainment of one or both partners, though when partners differ in their education the percentage of both in good health is higher when men declare to have the highest educational level.

Looking at the health status of both couple members according to their working status, Table 2 shows values for both members in good health ranging from the highest when both partners work (employed or self-employment) to the lowest when both partners declare to be not work (unemployed or inactive). Once again we see higher values for the prevalence of both partners in good health in the case of Spain and the United Kingdom whereas France and Poland display the lowest ones. We also observe that values in between the two extremes seem to be ordered according to the combinations of working statuses and who declares to be working, being the percentage of both partners in good health when men work

Conclusions

Preliminary results from the descriptive analysis of adult population living with a partner in three different European contexts showed that even though having a partner is associated with a better health status than other partner status categories, there is a wide diversity of socioeconomic profiles among couples that produce health differences within this group. Known health determinants at the individual level like education and working status also seem to be related to health differences between couples of different socioeconomic statuses. Although the displayed preliminary results are merely descriptive and the number of categories for educational and working status have been reduced due to restriction in the length of the extended abstract, the United Kingdom (liberal) shows the highest difference between the most advantaged and disadvantaged situation in terms of health status of both partners, whereas France and Spain (traditional and familistic traditional) present similar relative differences though with differences in the values. The Polish case show a similar pattern than the other three countries though with lower percentages of good health.

However, these preliminary results need to be confirmed by multivariate analysis including key control variables like age, which is related to both health and socio-demographic profiles, especially in countries where social changes are relatively recent (increase of women in education and labour market, etc.) like probably in the case the ex-soviet countries or Spain in a lowest extend.

Table 1. Health status by educational level of both partners. Individuals aged from 30 to 59, 2012

		Both good health	Man good health- Woman not good health	Man not good health- Woman good health	Both not good health	Total
Spain	Both partners primary or lower secondary	62.8%	11.5%	14.0%	11.6%	100%
	Ego lower secondary or primary-Partner higher education	75.0%	9.3%	11.1%	4.5%	100%
	Ego higher education-Partner lower secondary or primary	71.1%	14.5%	7.2%	7.2%	100%
	Both partners upper secondary or higher	84.8%	6.2%	7.0%	2.1%	100%
	Total	74.9%	9.3%	9.8%	5.9%	100%
France	Both partners primary or lower secondary	40.9%	16.5%	17.1%	25.6%	100%
	Ego lower secondary or primary-Partner higher education	57.2%	16.7%	12.9%	13.2%	100%
	Ego higher education-Partner lower secondary or primary	44.4%	23.3%	14.9%	17.4%	100%
	Both partners upper secondary or higher	66.6%	12.5%	13.4%	7.5%	100%
	Total	62.3%	14.2%	13.6%	9.8%	100%
Poland	Both partners primary or lower secondary	31.2%	20.8%	12.7%	35.3%	100%
	Ego primary or lower-Partner higher education	41.1%	12.1%	15.6%	31.2%	100%
	Ego higher education-Partner primary or lower	38.8%	13.8%	11.9%	35.4%	100%
	Both partners Upper secondary or higher	55.9%	12.6%	13.7%	17.9%	100%
	Total	53.4%	12.9%	13.7%	20.0%	100%
the United Kingdom	Both partners primary or lower secondary	45.3%	15.1%	18.9%	20.8%	100%
	Ego lower secondary or primary-Partner higher education	58.6%	13.8%	16.0%	11.6%	100%
	Ego higher education-Partner lower secondary or primary	49.1%	19.4%	13.9%	17.6%	100%
	Both partners upper secondary or higher	78.9%	9.3%	7.7%	4.2%	100%
	Total	74.7%	10.3%	9.0%	6.0%	100%

Source: EU-SILC 2012. Note: Not good health means “fair” or “poor/very poor”.

Table 2. Health status by working status of both partners. Individuals aged from 30 to 59, 2012

		Both good health	Man good health- Woman not good health	Man not good health- Woman good health	Both not good health	Total
Spain	Both working	83.1%	7.0%	6.8%	3.0%	100%
	Man working-Woman not working	74.8%	12.3%	7.2%	5.6%	100%
	Woman working-Man not working	61.9%	5.8%	22.8%	9.5%	100%
	Both not working	50.8%	13.0%	19.2%	17.0%	100%
	Total	74.6%	9.3%	9.9%	6.1%	100%
France	Both working	66.9%	12.6%	12.4%	8.1%	100%
	Man working-Woman not working	53.8%	20.6%	14.1%	11.5%	100%
	Woman working-Man not working	45.8%	15.0%	23.3%	15.8%	100%
	Both not working	37.9%	15.2%	18.9%	28.0%	100%
	Total	62.3%	14.2%	13.6%	9.9%	100%
Poland	Both working	61.7%	11.5%	12.7%	14.1%	100%
	Man working-Woman not working	51.5%	19.1%	8.7%	20.7%	100%
	Woman working-Man not working	32.0%	7.1%	31.2%	29.8%	100%
	Both not working	19.8%	10.5%	15.7%	54.0%	100%
	Total	53.4%	12.9%	13.7%	20.0%	100%
the United Kingdom	Both working	82.1%	7.5%	6.9%	3.6%	100%
	Man working-Woman not working	64.3%	22.1%	6.1%	7.4%	100%
	Woman working-Man not working	37.2%	7.3%	34.3%	21.2%	100%
	Both not working	31.4%	21.4%	20.1%	27.0%	100%
	Total	74.3%	10.5%	8.8%	6.4%	100%

Source: EU-SILC 2012. Note: Not good health means “fair” or “poor/very poor”.

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