



Gender and health outcomes: The impact of healthcare systems and their financing on life expectancies of women and men[☆]

Sharon Asiskovitch*

75 Katzenelson St., Givataim 53270, Israel

ARTICLE INFO

Article history:

Available online 21 January 2010

Keywords:

Life expectancy
Gender
OECD member states
Public–private mix of healthcare financing
Panel-data analysis

ABSTRACT

The paper considers the impact of healthcare systems and how they are financed on the life expectancies (LEs) of women and men in 19 OECD countries during the period 1990–2005 using OECD Health Data 2009. There is a gap in life expectancy (LE) between men and women, with women living longer than men, and most studies point to socio-economic variables and lifestyle and health-related behaviors. The role of healthcare systems and access to medical services is still disputed. This article proposes a number of adjustments to previous studies. First, it uses several variables broken down according to gender. Second, it considers healthcare systems by measuring their national expenditure as well as their public and private sources of funding. Third, it includes factors indirectly affecting health as expenditures on other realms of social policy. Fourth, it examines the factors impacting LEs of women and men at birth and at 65. Using a hierarchical model of panel-data regressions, the study finds: (1) there is a marginal impact on LEs at birth for both genders and greater impact on LEs at 65 for both genders; (2) a public mode of funding has greater effect than private; (3) the findings that men benefit more from access to medical services might be the result of the variables controlled in the analysis.

© 2009 Elsevier Ltd. All rights reserved.

Introduction

Economists and sociologists of healthcare have been interested in identifying determinants of health, whether women and men are affected by different factors and to what extent, and whether healthcare systems and access to healthcare impact the health outcomes of individuals, both men and women. This article makes several adjustments to the quantitative methodology offered thus far in studies of these questions. In particular, it considers how to measure the impact of healthcare systems on health outcomes and highlights issues concerning independent variables representing lifestyle and health-related behavior, not broken down for women and men as in previous studies.

The efforts to contain public spending are at the center of healthcare reforms in most mature welfare states. One outcome of these reforms, along with the increased cost of medical treatment, is a change in the role of private funding, commonly identified with limited access to healthcare services. As life expectancies (LEs) in

developed countries have steadily increased during recent decades, a question naturally arises: to what extent do healthcare systems and their methods of financing impact health outcomes as measured by life expectancy (LE)? Furthermore, are different social groups affected differently by recent changes in the political-economy of healthcare systems, e.g. women vis-à-vis men, young people vis-à-vis senior citizens, and the poor vis-à-vis the wealthier strata. In this article, I focus on the division between men and women and, to some extent, generational gaps.

Longitudinal comparative data on LE indicate a central societal division between men and women (on average, women live longer than men). Gaps in LEs exist between countries as well, with some countries boasting longer LEs for both women and men. Certain factors have an impact on LE: biology and genetics, health-related behavior and lifestyle, social factors including economic wealth and levels of education, and utilization of healthcare services. In this paper, I focus on the roles of public and private modes of healthcare funding.

The study finds the following. Healthcare systems in developed countries seem to have a negligible effect on women and men's LE at birth, but this is not the case for the elderly: for older women and men, healthcare systems play a salient role in increasing LE. Controlling for other independent variables, access to healthcare services seems to benefit men more than women. When modes of healthcare funding are examined, one discovers that public funding is positively associated with LE at birth of both women and men,

[☆] The research presented in this article was conducted while the author was a Schusterman post-doctoral fellow and a visiting lecturer at the Department of Political Science and the Mosse/Weinstein Center for Jewish Studies at the University of Wisconsin-Madison during the academic year 2008–09.

* Corresponding author. 75 Katzenelson St., Givataim 53270, Israel. Tel.: +972 523 587 703.

E-mail address: s_asiskovitch@hotmail.com

while private funding tends to be negatively associated with LE at birth. Yet the coefficients are weak. Again, the situation is different for the elderly; while both modes of funding are associated with increased LE, the coefficients are much stronger for public funding. Moreover, the independent variables controlled in this study indicate that access to public funded healthcare services benefits men more than women.

The study adopts a macro-level data approach, considering the influence of modes of healthcare funding on LE as a health outcome (Nixon & Ulmann, 2006; Or, 2000). It uses hierarchical models of panel-data regressions that consider the impact of economic variables that are assumed in the literature either to indirectly impact LE (i.e. levels of societal wealth and welfare) or directly influence LE (i.e. extent of different modes of healthcare financing), as well as health-related behaviors and social factors.

The paper is organized as follows. The first section describes the literature on factors explaining health outcomes in terms of LE in developed economies. The second section includes the data source, the cases, the variables, and how they are measured. The third presents comparative descriptive data about modes of healthcare funding and LEs of women and men in the 19 countries studied. The fourth shows the results of the panel-data regressions. The last section discusses the results of the panel-data regressions and provides conclusions.

LEs as a social outcome and the gender LE gap: theoretical background

LE is a central indicator used to measure health outcomes and inequality in health. While LE as an indicator for healthcare reveals only one aspect of societal health outcomes and individuals' health status, it is a measurement which is available for most countries over time (Joumard, Andre, Nicq, & Chatal, 2008). For the most part, health outcomes measured as LE are linked to levels of economic development; individuals in high-income countries enjoy, on average, longer and healthier lives and lower levels of mortality (Cutler, Deaton, & Lleras-Muney, 2006; Hitiris & Posnett, 1992; Pritchett & Summers, 1996). That women on average live longer than men in developed countries is well known to students of sociology of health and healthcare. However, the explanations for variations in LEs between and within countries and between women and men are disputed (Nixon & Ulmann, 2006; Or, 2000; Self & Grabowski, 2003; Thornton, 2002). Much of the dispute concerns whether healthcare systems and access to healthcare are more important in explaining health outcomes than are health-related behaviors like smoking and consumption of alcohol, or social factors like education and income distribution.

Recently, Joumard et al. (2008) reviewed the explanatory factors highlighted in the literature on LE variations between and within societies. They count three groups of factors that impact health outcomes as measured by LE. The first, *healthcare resources*, refers to levels of national or public healthcare spending or physical resources. While Joumard et al. focus on the role of healthcare systems in explaining LE variations between OECD countries, they argue that merely focusing on the "institutional" features of a healthcare system in a particular state creates methodological and theoretical pitfalls and does not explain between-country variations. The second group is *lifestyle factors* – health-related behaviors such as smoking and consumption of alcohol, and dietary habits such as consumption of fat, sugar, fruits, and vegetables. The third group, *socio-economic factors*, includes income per capita, income inequality, levels of education, poverty, unemployment, ethnic composition, the physical environment, and air pollution.

Berger and Messer (2002) examine the impact of public financing of healthcare expenditures on the overall mortality rate

using fixed-effects panel-data regressions and OECD Health Data (they do not specify the dataset's year). Using the share of total healthcare expenditures that are publicly financed, they find that total national investments in healthcare are negatively and significantly correlated with mortality, but higher shares of public funding are positively and significantly associated with higher mortality. In their view, then, greater commodification of healthcare services is associated with improved health outcomes as it leads to more efficient provision of healthcare. In the following, I will argue for a different point of view.

Joumard et al. (2008) and Mohan and Mirmirani (2007) focus on the impact of healthcare systems on LE variations between countries across time using OECD Health Data for 2004 and 2002, respectively, and fixed-effects panel-data regressions. Nixon and Ulmann (2006) discuss the impact of healthcare expenditure and healthcare systems utilization in the EU member states using OECD Health Data for 2000 and fixed-effects panel-data regressions. Shaw, Horrace, and Vogel (2005) use OECD Health Data for 2000 and OLS regressions to find the impact of pharmaceuticals consumption on LE. These studies all find that healthcare systems positively influence LE. Cremieux, Ouellette, and Pilon (1999), using fixed-effects panel-data regression, find that higher spending on healthcare is positively associated with improved health outcomes across Canada's provinces. And Or (2000: 63) states, "The way health expenditure is financed also appears to affect health outcomes; a larger share of public financing of healthcare is associated with lower rates of premature mortality for both sexes".

To date, all studies ignore differences between women and men in the independent variables (while they account for sex in their dependent variables). As the OECD Health 2009 database shows, while in most countries the gaps in tobacco consumption between the sexes, for example, have narrowed, they have not disappeared (see Fig. 1). In other words, there are meaningful gaps between the sexes in health-related behaviors, lifestyle, and socio-economic variables. This means that important differences in health-related behavior and life circumstances were ignored in previous studies.

The impact of healthcare systems on health outcomes as LE can be explained by both materialist and neo-materialist approaches to health outcomes and inequality (Bartley, 2004; Cutler et al., 2006). The materialist approach argues that incomes, education, and positions in the labor market of individuals and families affect health outcomes. Individuals with higher incomes have access to better medical services. Higher incomes are correlated with higher education. Higher education is correlated with a more health-related lifestyle and better dietary habits and most importantly, with better life circumstances. Individuals with a higher education (and higher income) work in jobs that are not physically difficult, dirty, or dangerous. Moreover, according to Grossman (1999) in his "Human Capital of the Demand for Health Model", education is investment in better health as the better-educated have knowledge that enables them to better control other health-related behaviors and lifestyle factors and demand medical care.

The neo-materialist approach argues that inequality in health outcomes, as measured by LE, is affected by the scope of state welfare and public-sponsored health services. The argument says that public funding supports the access of economically weak groups to adequate education, housing, and medical care. This allows them life circumstances similar to those of the wealthy; they can enjoy the same opportunities and health-related behavior, thereby improving their health outcomes.

A neo-materialist perspective puts the emphasis not on increasing wealth as a determining factor shaping LE but on the more equal distribution of material resources that indirectly or directly improve health. Greater social solidarity will mean that the wealthy are willing to politically and financially extend healthcare

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات