The influence of gender equality policies on gender inequalities in health in Europe

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ABSTRACT

Few studies have addressed the effect of gender policies on women's health and gender inequalities in health. This study aims to analyse the relationship between the orientation of public gender equality policies and gender inequalities in health in European countries, and whether this relationship is mediated by gender equality at country level or by other individual social determinants of health.

A multilevel cross-sectional study was performed using individual-level data extracted from the European Social Survey 2010. The study sample consisted of 23,782 men and 28,655 women from 26 European countries. The dependent variable was self-perceived health. Individual independent variables were gender, age, immigrant status, educational level, partner status and employment status. The main contextual independent variable was a modification of Korpi's typology of family policy models (Dual-earner, Traditional-Central, Traditional-Southern, Market-oriented and Contradictory). Other contextual variables were the Gender Empowerment Measure (GEM), to measure country-level gender equality, and the Gross Domestic Product (GDP). For each country and country typology the prevalence of fair/poor health by gender was calculated and prevalence ratios (PR, women compared to men) and 95% confidence intervals (CI) were computed. Multilevel robust Poisson regression models were fitted.

Women had poorer self-perceived health than men in countries with traditional family policies (PR = 1.13, 95%CI: 1.07–1.21 in Traditional-Central and PR = 1.27, 95%CI: 1.19–1.35 in Traditional-Southern) and in Contradictory countries (PR = 1.08, 95%CI: 1.05–1.11). In multilevel models, only gender inequalities in Traditional-Southern countries were significantly higher than those in Dual-earner countries.

Gender inequalities in self-perceived health were higher, women reporting worse self-perceived health than men, in countries with family policies that were less oriented to gender equality (especially in the Traditional-Southern country-group). This was partially explained by gender inequalities in the individual social determinants of health but not by GEM or GDP.

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1. Introduction

Gender inequalities are differences between men and women that systematically empower one group (men) to the detriment of the other (women). In terms of health, it is well known that in industrialized countries women live longer than men, but they often do it in worse health (Annandale and Hunt, 2000; Espelt et al., 2010). Gender inequalities in health arise because of inequalities in

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power, status and financial resources (Arber and Khlat, 2002) as well as of the sexual division of work (Malmusi et al., 2012).

Gender inequalities in health are for the most part socially produced, and as such they can be ameliorated through changes in the gender order (Annandale and Hunt, 2000). Gender equality policies refer to those policies promoting equality between men and women, including family policies (which seek to increase family wellbeing and promote reconciliation between paid work and family), but also others such as policies promoting equal opportunities in the labour market or equal political representation (Borrell et al., 2014). These policies impact gender inequalities in health through their effect on social determinants of health, such as the distribution of power, income, paid and unpaid work, and more proximal pathways such as discrimination, violence, financial hardship or time pressure. Consequently, gender equality policies at the country level are assumed to affect gender inequalities. However, few studies have investigated the effect of the orientation of gender policies on women's health or on gender inequalities in health (Borrell et al., 2014).

A gender policy regime is said to entail a logic based on the rules and norms about gender relations that influences the construction of policies (Sainsbury, 1999). The majority of gender policy typologies proposed so far have been based upon criticisms to Esping-Andersen's (Esping-Andersen, 1990) "gender blind" classification of welfare states (Sainsbury, 1999). Korpi et al. (2013) have classified countries in terms of dimensions of their family policies that affect the situation of women with respect to paid and unpaid work. These family policy models are therefore based on the extent of sexual division of work they are promoting and constitute a summary or proxy measure for the configuration of gender equality policies in a given country or group of countries. Some policy models are supportive of the traditional family model, with men as breadwinners and women as caregivers, resulting in more public support to the care-giving role of families, and a bigger or smaller role for the market in providing care. Other policy models are more supportive of the dual-earner model, which relies to a great extent on the provision of public services for care, in turn, making women more independent from their family. This model is mainly represented by the Nordic countries, which are usually better-off in terms of gender equity than the others. A recent review has partially supported the thesis that in the Nordic countries the socioeconomic position of women is better and gender inequalities in health are smaller, although the need for further studies was highlighted (Borrell et al., 2014).

In recent decades, there has also been an interest in measuring gender equality at country level and several indices summarizing the complexity of different gender equality indicators have been developed. Examples of these are the Gender Inequality Index -http://hdr.undp.org/en/statistics/gii/-, the Gender-related Development Index and the Gender Empowerment Measure -http://hdr.undp.org/en/-, the Gender Equality Index -http://eige.europa.eu/content/gender-equality-index- or the Gender Gap Index -http://www.weforum.org/issues/global-gender-gap-. Most of these indices include health-related indicators, so correlating them with inequalities in health could be redundant. An index that does not contain any health indicator is the Gender Empowerment Measure (GEM) (UNDP, 2009), which is a measure of women's agency based on their participation and decision-making power in the political and economic spheres and power over economic resources.

Recently, some studies have looked at the effect of gender equality at the country level on gender inequalities in health (Dahlin and Härkönen, 2013; Van de Velde et al., 2013; Van Tuyckom et al., 2013; Wells et al., 2012) and one has considered the effect of the orientation of gender policies on gender gaps in mortality (Backhans et al., 2012). As in the study by Backhans et al.,

we take into account both a policy typology and a gender equality indicator, although in the present study we focus on self-perceived health, which is an indicator generally showing women to be disadvantaged compared to men. Moreover, the present study not only considers a wider range of European countries, including some of Eastern Europe, but also the potential influence of individual-level social determinants of health (both as mediators and effect modifiers). Thus, the aim of this study is to generate evidence on the relationship between the orientation of public gender equality policies and gender inequalities in health in European countries, and to determine whether this relationship is mediated by gender equality at country level or by other individual social determinants of health. Our hypothesis is that countries with more equitable gender policies will achieve more equality in health, because of the higher gender equality at both the country level and the level of individual social determinants of health such as educational level, employment status or income.

2. Methods

2.1. Design, study population and information sources

A multilevel cross-sectional study was performed, using individual-level data on health, gender and other social determinants of health, and country-level data on family policy models and GEM as the indicator of gender equality. Individual data was obtained from the 5th round of the European Social Survey (2010). This is an academically driven cross-national survey that uses representative samples of all persons aged 15 and over residing in private households in European countries (http://www.europeansocialsurvey.org). In this study we used data from 26 countries (Belgium, Bulgaria, Switzerland, Cyprus, Czech Republic, Germany, Denmark, Estonia, Spain, Finland, France, United Kingdom, Greece, Croatia, Hungary, Ireland, Lithuania, Netherlands, Norway, Poland, Portugal, Russian Federation, Sweden, Slovenia, Slovakia and Ukraine). Individual data was available for an additional country (Israel), but which did not enter the study as none of the classifications of family policy regimes included it. Response rates in the countries ranged from 30.5% in Germany to 81.4% in Bulgaria. Finally, the study sample consisted of 23,782 men and 28,655 women.

2.2. Variables

Our dependent variable was self-perceived health measured through the question: "How is your health in general? Would you say it is very good, good, fair, bad, or, very bad?". The answer was dichotomised into good (very good, good) and poor (fair, bad, very bad) (Manor et al., 2000).

Our main independent variable was gender measured as man or woman. Other individual social determinants of health used were: A) age, used both as a continuous variable for standardisation and adjustment and as a categorical variable for stratification (15–19, 20–34, 35–49, 50–64, 65+). B) Being an immigrant from a country other than an advanced economy using the definition of the International Monetary Fund (2013). Although this variable may not be an important determinant of gender inequalities in health it was important for us to consider the intersections between different axes of inequality. C) Educational level, measured by the International Standard Classification of Education (ISCED), which we merged into 'up to lower secondary education' (ISCED 0, 1 or 2), 'upper secondary and post-secondary non-tertiary education' (ISCED 3, 4 or 5) and 'tertiary education' (ISCED 6, 7 or 8). D) Partner status, classified as: never married; separated, divorced or widowed; cohabiting but not married; or married. E) Employment