

MULTIPLE ROLES AND HEALTH AMONG BRITISH AND FINNISH WOMEN: THE INFLUENCE OF SOCIOECONOMIC CIRCUMSTANCES*

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Abstract

Objectives. Two contrasting hypotheses have been presented to predict women's health variations. The multiple burden hypothesis predicts that combining a paid job, being married, and having children is likely to be detrimental to women's health. The multiple attachment hypothesis predicts that multiple roles provide attachment to the community, which is likely to be beneficial to women's health. These hypotheses are examined in Britain and Finland, which have different patterns of women's employment participation. Lone mothers form a critical case, since they have fewer attachments and greater burdens, and therefore are expected to have poorer health. The socioeconomic position of lone mothers differs in Britain and Finland, but in both societies they are likely to have fewer attachments. We assess the extent to which health variations between women with different family and parental role combinations are because of differences in their socioeconomic status and material circumstances.

* This paper has already been published in *Social Science and Medicine*, special issue, vol. 54, no. 5, March 2002, p. 727-740.

Data and methods. Comparable surveys from Britain and Finland from 1994 were used. Perceived general health and limiting long-standing illness were analysed for working age women (20-49 years) by family type and employment status, as well as other socioeconomic variables.

Results. In both countries, women living in two parent families and having children had better health than women living in other family types or on their own. Lone mothers form a disadvantaged group and showed overall worse health in both countries. Adjusting for employment status, education and household income weakened the association between family type and poor health.

Conclusion. The findings are broadly in accordance with the multiple attachment hypothesis. Despite the more generous welfare state and high full-time employment among Finnish women, single lone mothers report poorer health than other women in Finland as well as in Britain. However, in Britain the disadvantaged social position of lone mothers accounts for a greater proportion of their poor health than in Finland.

Keywords: Women, Health, Work, Family, Britain, Finland.

Résumé

Objectifs. Deux hypothèses de sens opposé sont avancées pour expliquer les variations de la santé des femmes. Selon l'hypothèse de la multiplicité des tâches, avoir à la fois un mari, des enfants et un emploi rémunéré peut être néfaste pour la santé de la femme. Selon l'hypothèse de la multiplicité des appartenances, avoir plusieurs rôles procure à la femme une intégration dans la collectivité qui peut être bénéfique pour sa santé. Les auteurs testent ces deux hypothèses sur les cas de la Grande-Bretagne et de la Finlande, deux pays qui diffèrent l'un de l'autre en ce qui concerne la participation des femmes à l'activité économique. Les mères isolées constituent un cas critique, car elles ont moins d'appartenances et plus de charges que les autres, et par conséquent, leur santé doit être moins bonne. Les mères isolées n'ont pas la même situation socio-économique en Grande-Bretagne qu'en Finlande, mais dans les deux sociétés elles ont tendance à avoir un éventail d'appartenances plus restreint. Les auteurs examinent dans quelle mesure les différences de santé entre femmes qui vivent des combinaisons diverses de rôles familiaux et parentaux sont dues au fait qu'elles sont dans des situations socio-économiques et matérielles différentes.

Données et méthodes. Les auteurs exploitent des données d'enquêtes comparables réalisées en 1994 en Grande-Bretagne et en Finlande. L'analyse porte sur la perception de l'état de santé général et les maladies invalidantes de longue durée chez

les femmes d'âge actif (20-49 ans), en fonction de la forme d'organisation familiale, du degré d'activité et d'autres variables socio-économiques.

Résultats. Dans les deux pays, les femmes qui vivent avec leurs enfants dans une famille à deux parents sont en meilleure santé que celles qui vivent seules ou dans d'autres types de familles. Les mères isolées constituent un groupe défavorisé et leur santé est généralement moins bonne. Quand on contrôle l'activité économique, le niveau d'instruction et le revenu du ménage, l'association entre le type d'organisation familiale et l'état de santé se relâche.

Conclusion. En gros, les résultats concordent avec l'hypothèse de la multiplicité des appartenances. En Finlande, malgré un État-providence plus généreux et un taux d'activité féminine à temps plein plus élevé, les mères célibataires isolées se déclarent en moins bonne santé que les autres femmes, tout comme en Grande-Bretagne. Mais en Grande-Bretagne, la mauvaise santé des mères isolées tient beaucoup plus qu'en Finlande à leur situation sociale défavorisée.

Mots-clés : *Femme, Santé, Travail, Famille, Grande-Bretagne, Finlande.*

1. Introduction

This paper focuses on health variations among working age women in two different welfare states, that is Britain and Finland in the mid-1990s. The production of health variations among women is a complex process, emerging from women's social structural and material position as well as their family status and parental roles (Arber, 1991). The two countries under study differ in the nature of welfare policies to support child care among working mothers and to support lone mothers, as well as in the level of paid employment of women (Forssén, 1998). They therefore provide appropriate cases for comparing to what extent the patterning of women's health by employment and family status varies in Britain and Finland, and to what extent this variation is because of their differential socioeconomic and material circumstances (Arber and Lahelma, 1993a).

Among men health variations have traditionally been studied using a social class framework, whereas among women a role framework has been common. For example, studies have examined whether family and parental roles, as well as the 'additional' role of paid employment are associated with women's health (Nathanson, 1980; Gove, 1984).

However, to deepen the understanding of the production of health variations among women we need to go beyond both the social class framework and the role framework, and examine women's employment participation, socioeconomic status and material circumstances simultaneously with their family and parental roles. An increasing stream of research has shown the importance of combining women's structural and material position in society, and their family roles in the analysis of health variations (Bartley *et al.*, 1992; Popay *et al.*, 1993; Macran *et al.*, 1994; Macran *et al.*, 1996; Martikainen, 1995; Arber and Cooper, 2000).

Previous studies suggest that marriage is supportive of good health (Verbrugge, 1979; Macintyre, 1992; Martikainen, 1995). On the one hand, this is likely to be due to social supports and material advantages of marriage. On the other hand, poorer health of unmarried women may relate to selection in the 'marriage market' since women with poor health may be less likely to marry. Being a lone mother seems to be a particularly disadvantageous position for women, including for their health, as found by a number of recent studies (Burström *et al.*, 1999; Kivelä and Lahelma, 2000; Whitehead *et al.*, 2000). Lone motherhood implies responsibilities and strains of child rearing which cannot be shared and which therefore may have adverse effects on women's health. However, employment status as well as the material and socioeconomic position of lone mothers vary between different societies, and this is likely to contribute to variations in the health status of women with different family and parental statuses.

Non-employed women, including housewives and unemployed, may have difficulties finding a job if their health is poor. Khlal, Sermet and Le Pape (2000) have shown that in France health advantages are found for married women who have a paid job. They discuss the 'healthy married' and 'healthy mother' effect, in addition to the 'healthy worker' effect which has been known for a long time. However, the combinations of different family and work roles may be shaped by women's socioeconomic status as the authors show for French women.

A study examining mental and somatic symptoms found that Finnish women living with a spouse and children were least likely to report these symptoms, which remained unchanged when age and number of children were adjusted for (Kivelä and Lahelma, 2000). Recent studies reported in this volume from the Netherlands (Fokkema),

Britain (Matthews and Power) and Canada (McDonough *et al.*; Walters and McDonough) also support the conclusion that combining multiple roles of being an employee, a spouse and a mother are associated with good rather than poor health. There is by now increasing evidence suggesting the health advantages related to multiple roles among women, but less is known to what extent this is caused by differential socioeconomic and material circumstances associated with role occupancy.

2. Women's employment and family status in Britain and Finland

Whether combining being an employee, a spouse and a mother is good or bad for women's health and well-being has become an increasingly important policy issue in many countries, because of the increased labour force participation of women with dependent children (Rubery *et al.*, 1997). Different employment arrangements, such as part-time and full-time employment, may contribute to women's health in varying ways according to a women's family status, and socioeconomic circumstances. It is important to consider how different family status arrangements, such as being married with or without dependent children, being a lone mother or living without a partner, may have a differential bearing on women's health and well-being.

The two countries compared in this paper, Britain and Finland, show similarities and dissimilarities as to women's position in the labour market, the nature of social welfare policies, as well as family structure. With regard to employment participation, Finland is an extreme case since women are equally likely to be in full-time employment as men, and employment participation shows no gender differences throughout the age range (Figure 1). The proportion of part-time employed women is only seven percent of all women aged 20-49, whereas in Britain this proportion is 27 percent (Table 1). The employment pattern across the age structure is very different for British women compared to their Finnish counterparts. Particularly high proportions of British women are employed part-time at ages 30-54 (Figure 1). Although British women have increasingly taken paid jobs outside the home, their employment participation is still lower on average than in Finland. The difference between the two countries in full-

Table 1
Distribution of variables and age-adjusted prevalence
of 'less than good' perceived health and limiting long-standing illness
among British and Finnish women aged 20-49

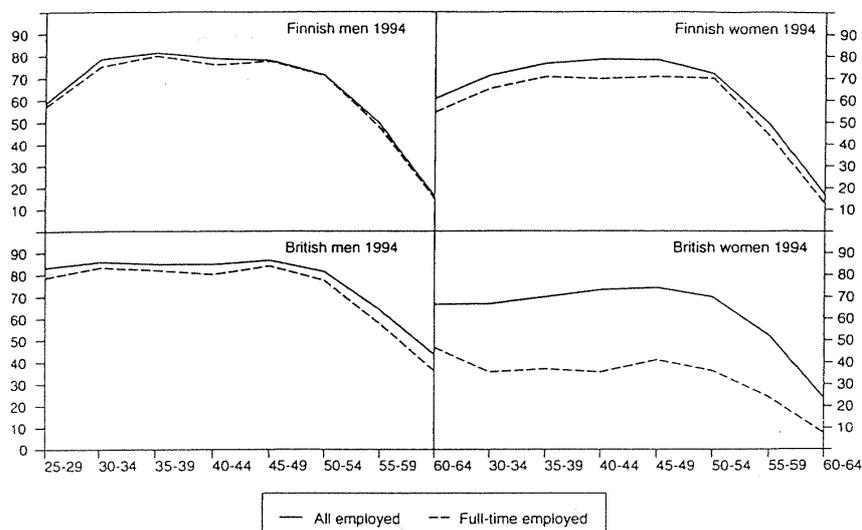
Variables	Britain			Finland		
	Col. %	Perceived health (%)	Limiting long-standing illness (%)	Col. %	Perceived health (%)	Limiting long-standing illness (%)
<i>Total</i>	5,163	31	14	2,595	22	23
<i>Age</i>		*	*		*	*
20-29	31	29	10	26	12	18
30-39	37	31	14	37	20	22
40-49	32	36	19	37	32	27
	(5,163)			(2,595)		
<i>Family type</i>		*	*			
Couple with children	56	29	13	59	22	22
Couple, with no childr.	18	31	14	19	22	21
Lone mother, divorced	6	45	25	3	22	26
Lone mother, single	9	43	20	6	24	23
Single (no children)	11	36	18	13	27	26
	(5,146)			(2,489)		
<i>Employment status</i>		*	*		*	*
Full-time employed	42	28	10	61	21	20
Part-time employed	27	27	10	7	22	23
Unemployed	5	37	19	13	28	31
Housewife	21	40	18	9	23	26
Retired or disabled	2	95	91	1	84	86
Other	3	51	28	9	15	16
	(5,080)			(2,586)		
<i>Education</i>		*	*		*	*
Higher	31	25	12	18	13	17
Secondary	45	33	14	60	22	22
Basic	24	40	18	22	30	27
	(4,771)			(2,595)		
<i>Household income</i>		*	*			
1. Highest quintile	20	22	9	20	16	19
2.	20	27	11	20	21	23
3.	20	33	14	20	26	25
4.	20	36	18	20	27	24
5. Lowest quintile	20	40	18	20	24	25
	(4,480)			(2,595)		

<i>Number of children</i>			*		*	
No children	44	33	17	39	25	26
One	23	34	14	24	25	23
Two	22	31	11	25	22	22
Three or more	10	36	11	12	15	18
	(5,159)			(2,595)		
<i>Age of children</i>			*		*	
No children	44	33	17	39	25	26
Pre-school only	13	32	11	17	22	23
School-aged only	31	32	14	30	22	22
Children in both age groups	12	39	13	14	14	20
	(5,159)			(2,595)		

* $p < 0.05$.

Sources: British General Household Survey 1994 and Finnish Survey on Living Conditions 1994.

Figure 1
Employment participation by gender and age in Britain and Finland (%)



Sources: British General Household Survey 1994 and Finnish Survey on Living Conditions 1994.

time employment participation is even more clear, since among Finnish women aged 20-49 years 61 percent are employed full-time compared to 42 percent among their British counterparts.

There is additionally a major difference between Britain and Finland in the proportion of women who are full-time housewives. In Britain this proportion is still significant, amounting to over a fifth of women aged 20-49, whereas in Finland the proportion is less than a tenth (Table 1). In Finland, the housewife role is usually only a temporary one during two-three years when mothers have very young children. Although this holds true increasingly for Britain among more educated women, less educated married women with children still tend to spend longer periods of their life in the housewife role compared to their better educated counterparts (Glover and Arber, 1995; Hakim, 1996; Rake, 2000).

The marital status and family type distributions among British and Finnish women are broadly similar. More than half of women aged 20-49 live in couples with one or more dependent children (Table 1), and fifth of women in both countries live with a partner without dependent children. In Britain 15 percent of women aged 20-49 are lone mothers, but in Finland this proportion is 9 percent. A small proportion of women are not partnered and live single without children, 11 percent in Britain and 13 percent in Finland.

Women's family and parental status, such as being married or a lone mother, and the number and age of their dependent children influences women's employment opportunities in Britain (Rubery *et al.*, 1997). British lone mothers are less likely to be employed, particularly in full-time employment, than married or cohabiting women and are more likely to be housewives (Table 2).

In Finland differences in employment status between lone mothers and married women are relatively small (Table 2). The proportion of married women with children below 7 years who are employed is 65 percent compared to 52 percent for corresponding lone mothers. In Britain, having small children strongly reduces women's likelihood of being employed, particularly full-time employed, which is the case to a much lesser extent in Finland. In Britain only 9 percent of lone mothers are full-time employed, whereas this proportion for Finnish women is 48 percent. Two thirds of British lone mothers with small children are housewives, whereas the corresponding proportion for Finnish lone mothers is 16 percent. While in Britain 9 percent of lone mothers

Table 2
Employment status of (a) British and (b) Finnish women
aged 20-49 by parental status and marital status (%)

	Married/Cohabiting			Lone mothers		
	Youngest child below 6	Youngest child 6-16	All	Youngest child below 6	Youngest child 6-16	All
(a) Britain						
Employed	54	77	66	25	51	40
<i>Full-time employed</i>	20	32	26	9	26	19
<i>Part-time employed</i>	34	45	40	16	25	21
Housewives	43	19	30	66	38	50
Other non-empl. ^a	3	4	4	9	11	10
<i>Total</i>	100	100	100	100	100	100
<i>N</i>	(1,020)	(1,201)	(2,221)	(256)	(327)	(583)
(b) Finland						
Employed	65	84	74	52	79	68
<i>Full-time employed</i>	57	75	66	48	72	62
<i>Part-time employed</i>	8	9	8	4	7	6
Housewives	26	2	15	16	3	9
Other non-empl.	9	14	11	32	18	23
<i>Total</i>	100	100	100	100	100	100
<i>N</i>	(679)	(605)	(1,284)	(73)	(113)	(186)

a. Non-employed include unemployed and retired/disabled.

Sources: British General Household Survey 1994 and Finnish Survey on Living Conditions 1994.

with small children state that they are non-employed for other reasons than being a housewife (i.e. unemployed, disabled or early retired), this proportion in Finland is 32 percent. It is likely that eligibility for sickness and unemployment benefits contributes to this difference between the two countries. In Finland lone mothers with small children are much more likely to state that they are non-employed for other reasons than being a housewife than other women.

Currently, there are stronger incentives for women to combine paid work and motherhood in Finland than in Britain. These include publicly organised day care, lengthy periods of maternity leave, leave to

care for sick children, paternity leave and various subsidies for families and children. In a comparison of family policies in OECD countries Finland had a wide range of forms of support to families, whereas Britain was below the average level (Forssén, 1999). Consequently, Finnish lone mothers are nearly as likely to be employed as married or cohabiting women. The presence of dependent children among married women or being a lone mother with small children makes little difference to Finnish women's full-time employment participation (Table 2). In contemporary Finnish society combining family and paid employment represents a norm for women, the most common way of life and is regarded as 'normal'. In Britain the younger generation of highly educated women who are married/cohabiting with children have high levels of employment (Rake, 2000). However, being a lone mother reduces markedly British women's employment participation in general, and having small children in particular further reduces their likelihood of being in paid employment.

3. Hypotheses and aims

Britain and Finland show contrasting features in relation to women's participation in paid employment, and it is therefore appropriate to examine the patterning of women's health with regard to their different employment status and family role arrangements. From previous work on women's employment patterns and social roles as determinants of health, two competing hypotheses can be drawn which predict health variations according to different combinations of employment, socioeconomic position, material circumstances, marital status and motherhood.

First, the *multiple burden hypothesis* suggests that having a paid job, particularly a full-time job, and dependent children is likely to lead to health damaging role-strain among women (Gove, 1984). This hypothesis is based on the model of role conflict which results from competing demands and obligations related to multiple roles. As characterised by William Goode (1960) such a conflict can be understood as a 'felt difficulty in fulfilling the role obligations'. Role conflicts enhance role overload and result in subsequent elevated strain and stress levels contributing to poor health. Role overload is thus hypothesised to produce health variations between women belonging to different

combinations of employment and family status groups. Lone mothers form a particular risk group, since they have multiple simultaneous obligations as a breadwinner and as a mother. Non-employed lone mothers in countries with limited levels of welfare benefits run the additional risk of severe material deprivation and poverty. Employed lone mothers run the risk of role conflicts and overload, since they do not have a partner to help support their role as a parent. Thus the multiple burdens due to role overload are modified opportunities to share the burdens, as well as available material resources to help overcome the overload.

Second, the *multiple attachment hypothesis*, suggests that multiple roles imply multiple attachment to the community which is likely to promote women's health (e.g. Nathanson, 1975; Arber, 1991; 1997; Bartley *et al.*, 1999). Undertaking a paid job outside the home and having children, as well as a partner, act as sources of social support and result in higher self-esteem. Additionally, paid employment provides income and financial independence for women, and these taken together are likely to advance women's health (e.g. Kawachi *et al.*, 1999). Non-employed lone mothers run the risk of financial problems, and they lack the attachment to the community provided by a job. Lone mothers will also lack the additional source of attachment through their partners. Grandparents are important sources of additional support for mothers in caring for children, but single lone mothers are likely to lack this source of support from the paternal grandparents of their children. We expect that multiple attachment to the community through a paid job, children and a partner provides women with emotional as well as instrumental social supports which are likely to advance women's health and buffer against adverse health effects.

This study aims, first, to examine whether, and to what extent, the multiple burden hypothesis and the multiple attachment hypothesis explain health variations among British and Finnish women of child-bearing age in the mid-1990s. For this purpose we focus on the analysis of health variations by family type with special reference to women's employment status. We compare the patterning of health among women in these two contrasting countries. A particular interest is devoted to the health and well-being of lone mothers, i.e. women who have dependent children, but live without a partner. Lone mothers form a critical case both in terms of the multiple burden and the multiple attachment hypothesis since those in full-time employment

are likely to be under stronger role strain particularly in Finland and those who are not employed may be less attached to sources of social support particularly in Britain. Additionally, without a partner they have less support to share the burdens of childcare and everyday life than married/cohabiting women. Thus, we can assess whether marriage in these two contrasting countries is a source of support advancing women's health rather than a source of strain damaging married women's health.

The second aim of the study is to assess, whether health variations between women with different role combinations are because of differences in their socioeconomic status and related material circumstances. In particular, we examine to what extent the poorer health of lone mothers can be explained by their disadvantaged position in terms of employment status, education and income. Our expectation is that this will be the case to a greater extent in Britain than in Finland.

4. Data and methods

4.1. Data

We examine the relevance of the multiple burden and the multiple attachment hypothesis for variations in women's health by using comparable data sets from Britain and Finland, both from 1994. The British data derive from the General Household Survey (GHS), collected by the governmental Office for National Statistics (ONS) (Bennett *et al.*, 1996). This survey is nationally representative and comprised personal interviews with all adults aged 16 or over in private households. The number of respondents was 18,237 and the response rate was 81 percent.

The Finnish data derive from the governmental Survey on Living Conditions (SLC), collected by Statistics Finland (Ahola *et al.*, 1995). This survey is nationally representative and involved personal interviews with people aged 15 or over. The number of respondents was 8,650 and the response rate was 74 percent for women.

Our analyses are restricted to women aged 20-49, since we are interested in the ways in which women's attachment to paid employment and the family are associated with their health, 5,163 in the GHS and 2,595 in the SLC.

4.2. Health indicators

Two common health indicators are used in this study, that is self perceived general health (PH) and limiting long-standing illness (LLI). These indicators can be regarded as suitable for an examination of differences in health among women. Both health indicators have been used in previous comparisons of health inequalities between European countries (Lahelma and Arber, 1994; Rahkonen *et al.*, 1995; Cavelaars *et al.*, 1998). Perceived health, particularly, has been recommended for comparative purposes by a recent WHO report (De Bruin *et al.*, 1996). Two parallel health indicators are used which provide some degree of cross-validation to the extent that the two indicators produce comparable results and reduce uncertainty of conclusions derived from the use of only a single health indicator.

Perceived health broadly indicates health related well-being (Manderbacka, 1998a). This indicator has been found to be a strong predictor of subsequent mortality (Idler and Benyamini, 1997; Ferraro and Farmer, 1999). In Finland the respondents were asked whether they assessed their health as 'excellent', 'good', 'average', 'poor' or 'very poor'. In Britain the response alternatives were 'good', 'fairly good' and 'not good'. These perceived health indicators were dichotomised in comparable way to indicate good/excellent versus 'less than good' perceived health. This was done in Finland by combining the categories 'average', 'poor' and 'very poor', and in Britain combining the categories 'fairly good' and 'not good'.

Limiting long-standing illness (LLI) is a widely used health indicator in many countries (e.g. Arber, 1991; Lahelma *et al.*, 1993). It captures a variety of conditions from serious to milder ones, which relate closely to medically confirmed diseases (Blaxter, 1989; Manderbacka, 1999). The questions in the Finnish and British surveys were identical and read: 'Do you have any long-standing illness, disability or infirmity?'. A positive response was followed by a further question asking whether the illness limited the respondent's activities 'in any way' in Britain, whereas in Finland the follow up question asked whether the illness limits 'daily life (gainful employment, housework, schooling, studying)?'. If the answer to the follow up question was positive, the respondent was classified as having a 'limiting long-standing illness'.

The slight differences in the wording of the limiting long-standing illness question and the variation in the categorisation of response al-

ternatives for perceived health in the two countries may affect the absolute levels of health, but is unlikely to affect the patterning of health by marital status, employment status and socioeconomic variables (see Manderbacka, 1998b) which is the main aim of this study.

4.3. Sociodemographic indicators

The main focus of this study is on two variables shaping women's health, that is their employment status and family type.

Employment status was categorised into full-time employed women who worked 30 hours or more per week, and part-time employed who worked 29 hours per week or less. Further employment status categories included 'unemployed', 'housewife', 'retired or disabled' and 'other'. The retired/disabled were omitted from the multivariate analyses. The percentage distributions for employment status and other variables included in this study are presented in Table 1.

Family type was categorised into 'couple with children', i.e. women living with a partner (married or cohabiting) and dependent children, i.e. children below 18 years in Finland and below 17 years in Britain; 'divorced lone parents', i.e. previously married women living with dependent children; 'single lone parents', i.e. never married women living with dependent children; 'couple with no children', i.e. women living with a spouse or partner, but without dependent children; and 'single', i.e. women living without a partner. The 'single' category includes never married, divorced and separated women who do not live with a partner or with dependent children. Pre-school age children were further distinguished, i.e. in Britain as children below 6 years and in Finland as below 7 years. However, this distinction was only used in Tables 1 and 2, and not in further analyses due to the small number of cases in the Finnish data.

Other background variables included *age, education, and net household disposable income per consumption unit*. *Education* was harmonised according to our previous comparative analyses (see Rahkonen *et al.*, 1995) and categorised into three educational levels, higher, secondary and basic education. In Britain *household income* was aggregated from each adult in the household giving information during the interview about the respondent's own income from all sources. In Finland income was obtained from the tax registry by using record linkage at the individual level. Income was adjusted for household composition to yield 'net

household disposable income per consumption unit'. This was done by adjusting income by household composition using the following formula: first adult = 1.0, second adult = 0.7, child below 18 years = 0.5 (Uusitalo, 1997).

4.4. Statistical analyses

Age adjusted prevalence percentages for the two health measures are presented in Table 1, and were calculated using direct age standardisation with five-year age groups. All women aged 20-49 in each country were used as the standard population. The age adjusted prevalence percentages have to be interpreted with caution, since small numbers of cases in some cells, particularly for categories of family type, may make the results unreliable.

In Tables 3 and 4 multivariate logistic regression analyses are presented. Nested models were fitted using the SPSS statistical package. The results of the modelling are presented as odds ratios (OR), with the reference category receiving the value of 1.00. Since our aim was to compare differences in health according to women's family status and employment status, Model 1 presents age adjusted odds ratios by family type and Model 2 adjusts for women's employment status. In Model 3 we additionally adjust for educational attainment and household income. The statistical significance of variables in the models were tested by the chi square approximation test. For the odds ratios 95 percent confidence intervals were calculated. Three variable interactions between employment status, family status and country were tested using pooled data from the two countries. However, the interactions were not statistically significant and are not presented here. Accordingly, the British and the Finnish data sets were analysed separately.

5. Prevalence of ill-health

Age adjusted prevalence of 'less than good' perceived health and limiting long-standing illness by the social background variables showed broadly similar distributions in Britain and Finland. As expected, women in younger age-groups and with higher household income and education had better health than other women (Table 1).

Employment status was associated with health (Table 1). Employed women reported the best health in both countries, with similar level of health among the full-time and part-time employed. The groups with the worst health were housewives and unemployed women in Britain, and unemployed women in Finland. Finnish housewives had a comparable level of perceived health to employed women, but this was not the case in Britain. The disabled/retired reported very bad health in both countries, which is expected since premature pension in Finland and disability benefits in Britain are usually granted on the basis of chronic illness and reduced functional disability.

Living with a spouse and dependent children was associated in both countries with good health according to both health indicators (Table 1). Lone mothers, whether divorced or single, had the poorest health. In Finland, there were no statistically significant differences in health by family type, but a suggestion that lone mothers and non-partnered women without children had poorer health.

The number and age of children showed relatively weak associations with women's health, suggesting that women without children or with only one child tended to have poorer health than women with two or more children. In general the differences for perceived health and limiting long-standing illness by family type were greater in Britain than in Finland, in particular British lone mothers showed clearly poorer health than women living in other family types.

6. Family type, employment status and health

To examine the patterning of women's perceived health and limiting long-standing illness by family type, and the bearing of women's employment status and other socioeconomic and material circumstances on this patterning, multivariate logistic regression analysis was used for the two countries and the two health indicators.

6.1. Perceived health

Britain

British women living with a partner and dependent children consistently reported better health. When *perceived health* was analysed ad-

justing for age in five year age groups (Table 3a, Model 1) lone mothers had poorer health than married women living with dependent children (the reference category OR = 1.00). Never married lone mothers were somewhat more likely to report poor health than divorced/separated lone mothers (OR = 2.12 and 1.94 respectively) although this difference was not statistically significant. In contrast to lone mothers, non-partnered women and married women without dependent children, showed little difference from married women with children.

Adjusting for employment status and education as well as household income (Model 3, Table 3a) the health of women living with a partner without children (OR = 1.47) and not partnered women (OR = 1.27) was poorer than that of married women with children. After adjusting for these structural variables, the health of British lone mothers remained substantially worse (OR = 1.65-1.79) than that of married mothers, suggesting that lone mothers' poor health is not solely due to their low education and income, and lack of paid employment.

Employment status was associated with perceived health among British women. Part-time employed women (OR = 0.82) perceived their health as good slightly more often than full-time employed women (OR = 1.00) after adjusting for other socioeconomic variables in Model 3, Table 3a. In Model 2 housewives (OR = 1.51) were more likely to report poor health than other women. However, British housewives' poor health depended partly on their socioeconomic status, since after adjusting for education and household income the health difference between housewives (OR = 1.21) and full-time employed women (OR = 1.00) was only borderline statistically significant. The odds ratio for unemployed women as well declined after adjustment, and it was little different from that of full-time employed women. This suggests that the health disadvantage of being a housewife and unemployed is related to low household income and lack of educational qualifications.

Education and household income showed expected patterns with perceived health being better for women in higher socioeconomic positions. However, women in the lower 60 percent of the household income distribution reported equally poor health, which was statistically significantly lower than the reference category of those with the highest income.

Table 3
Odds ratios and 95% confidence intervals (CI) for 'less than good'
perceived health, (a) British women, and (b) Finnish women, aged 20-49

	Model 1		Model 2		Model 3	
	Age + Family type		Model 1 + Em- ployment status		Model 2 + Edu- cation + Income	
(a) Britain (N = 4,818)						
<i>Family type</i>	*** ^a	CI	***	CI	***	CI
Couple with children	1.00		1.00		1.00	
Couple with no childr.	1.13	0.93 – 1.36	1.23	1.01 – 1.51	1.47	1.18 – 1.82
Lone mother divorced	1.94	1.54 – 2.45	1.79	1.42 – 2.27	1.65	1.29 – 2.12
Lone mother, single	2.12	1.62 – 2.77	1.92	1.47 – 2.53	1.79	1.35 – 2.37
Single (no children)	1.08	0.84 – 1.38	1.17	0.90 – 1.52	1.27	0.97 – 1.66
<i>Employment status^c</i>			***		**	
Full-time employed			1.00		1.00	
Part-time employed			0.96	0.80 – 1.15	0.82	0.68 – 0.99
Unemployed			1.33	0.96 – 1.83	1.07	0.76 – 1.50
Housewife			1.51	1.25 – 1.83	1.21	0.97 – 1.50
<i>Education</i>					**	
Higher					1.00	
Secondary					1.32	1.11 – 1.57
Basic					1.37	1.11 – 1.68
<i>Income</i>					***	
1. Highest					1.00	
2.					1.28	1.01 – 1.62
3.					1.68	1.31 – 2.15
4.					1.72	1.32 – 2.24
5. Lowest					1.75	1.32 – 2.33
	*** ^b		***		***	
(b) Finland (N = 2,334)						
<i>Family type</i>		CI		CI		CI
Couple with children	1.00		1.00		1.00	
Couple with no childr.	0.96	0.72 – 1.28	0.95	0.71 – 1.28	1.00	0.73 – 1.36
Lone mother divorced	1.36	0.92 – 2.02	1.34	0.90 – 1.98	1.24	0.83 – 1.84
Lone mother, single	1.76	0.98 – 3.17	1.68	0.93 – 3.04	1.52	0.84 – 2.75
Single (no children)	1.10	0.78 – 1.54	1.10	0.78 – 1.55	1.14	0.80 – 1.62
<i>Employment status</i>						
Full-time employed			1.00		1.00	
Part-time employed			1.11	0.76 – 1.63	1.01	0.69 – 1.45

Unemployed			1.43	1.07 – 1.91	1.23	0.91 – 1.66
Housewife			1.04	0.72 – 1.52	0.92	0.63 – 1.36
<i>Education</i>					***	
Higher					1.00	
Secondary					1.72	1.24 – 2.37
Basic					2.55	1.79 – 3.64
<i>Income</i>						
1. Highest					1.00	
2.					1.16	0.83 – 1.61
3.					1.42	1.01 – 1.99
4.					1.36	0.95 – 1.94
5. Lowest	***		***		1.24	0.85 – 1.81

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

a. Statistical significance of variables in tables 3 and 4.

b. Statistical significance of nested models in tables 3 and 4.

c. Retired/disabled/other omitted from analyses in tables 3 and 4.

Finland

In Finland, the health variations by family type, employment status and socioeconomic status were somewhat smaller than those in Britain. The adjustment for employment status, education and income further narrowed the health differences by family type, but did not alter the basic pattern found when adjusting for age only.

As in Britain, Finnish married women living with dependent children were least likely to have poor perceived health compared to women living in other family types, but unlike in Britain married women without dependent children also reported good health (Table 3b). The largest difference from the reference category of married women with dependent children was found for never married lone mothers adjusting for age only in Model 1, Table 3b (OR = 1.76) but this just failed to reach statistical significance.

Employment status showed a weak association with perceived health among Finnish women. Only unemployed women (OR = 1.43) in Model 2, Table 3a differed statistically significantly from the reference category, and adjusting for income and education removed this difference. Household income was less closely associated with perceived health for Finnish than British women, but low educational at-

tainment was much more strongly associated with poor health among Finnish women.

Table 4
Odds ratios and 95% confidence intervals (CI)
for limiting long-standing illness,
(a) British women, and (b) Finnish women, aged 20-49

	Model 1 Age + Family type		Model 2 Model 1 + Em- ployment status		Model 3 Model 2 + Edu- cation + Income	
(a) Britain (N = 4,818)						
<i>Family type</i>	**	CI	**	CI	**	CI
Couple with children	1.00		1.00		1.00	
Couple with no childr.	1.26	0.97 – 1.63	1.46	1.11 – 1.94	1.64	1.22 – 2.21
Lone mother divorced	1.79	1.32 – 2.43	1.58	1.16 – 2.16	1.48	1.06 – 2.06
Lone mother, single	1.55	1.05 – 2.29	1.34	0.90 – 1.99	1.28	0.86 – 1.93
Single (no children)	1.09	0.76 – 1.56	1.25	0.86 – 1.83	1.29	0.88 – 1.89
<i>Employment status</i>			***		***	
Full-time employed			1.00		1.00	
Part-time employed			1.02	0.78 – 1.33	0.93	0.71 – 1.23
Unemployed			1.77	1.15 – 2.71	1.54	0.98 – 2.41
Housewife			1.90	1.46 – 2.47	1.68	1.25 – 2.26
<i>Education</i>						
Higher					1.00	
Secondary					1.07	0.84 – 1.36
Basic					1.01	0.76 – 1.34
<i>Income</i>					***	
1. Highest					1.00	
2.					1.23	0.88 – 1.72
3.					1.52	1.07 – 2.15
4.					1.49	1.03 – 2.17
5. Lowest					1.56	1.05 – 2.31
	***		***		***	
(b) Finland (N = 2,334)						
<i>Family type</i>	*	CI	*	CI		CI
Couple with children	1.00		1.00		1.00	
Couple with no childr.	0.83	0.62 – 1.12	0.84	0.62 – 1.14	0.86	0.63 – 1.17
Lone mother divorced	1.30	0.87 – 1.93	1.27	0.85 – 1.89	1.22	0.82 – 1.83
Lone mother, single	1.93	1.11 – 3.36	1.81	1.04 – 3.18	1.74	0.99 – 3.06
Single (no children)	1.18	0.85 – 1.63	1.22	0.88 – 1.70	1.22	0.88 – 1.71

<i>Employment status</i>			***		**	
Full-time employed			1.00		1.00	
Part-time employed			1.28	0.88 – 1.85	1.25	0.86 – 1.82
Unemployed			1.83	1.39 – 2.42	1.77	1.32 – 2.37
Housewife			1.26	0.88 – 1.80	1.23	0.85 – 1.77
<i>Education</i>					*	
Higher					1.00	
Secondary					1.20	0.89 – 1.61
Basic					1.52	1.09 – 2.14
<i>Income</i>						
1. Highest					1.00	
2.					1.15	0.83 – 1.58
3.					1.28	0.91 – 1.79
4.					1.06	0.75 – 1.52
5. Lowest	**		***		1.01	0.70 – 1.48

6.2. Limiting long-standing illness

Britain

The associations between family type and other variables for British women were not as strong for limiting long-standing illness as for perceived health but generally showed similar patterns. Adjusting for age only in Model 1, Table 4a, lone mothers (OR = 1.55-1.79) more often reported limiting long-standing illness than single women (OR = 1.09) and married women living with dependent children (OR = 1.00). Adjusting for employment status in Model 2 narrowed slightly the health gap between the reference category and lone mothers. Adjusting for education and income in Model 3 further caused small changes in the patterning of limiting long-standing illness by family type. The order of the family type categories changed. The reference category of married women with children still reported least limiting long-standing illness, but single lone mothers were no longer statistically significantly different from the reference category. This suggests that limiting long-standing illness among single lone mothers in Britain is primarily associated with their disadvantaged social structural and material position, i.e. low income, lack of educational qualifications and less likelihood of being in paid employment.

Divorced lone mothers (OR = 1.48) and unexpectedly also married women without dependent children (OR = 1.64) more often reported limiting long-standing illnesses than single lone parents after adjusting for employment status, education and household income in Model 3, Table 4a.

Employment status was also associated with limiting long-standing illness among British women and this association was broadly similar to that found for perceived health (see Table 3a). However, the differences between employment status groups were clearer for limiting long-standing illness than for perceived health, with the highest levels of limiting long-standing illness among housewives and unemployed women. Unexpectedly educational attainment showed no association with limiting long-standing illness among British women. For income the association was as expected and was similar to that found for perceived health.

Finland

Finnish single lone mothers were most likely to report limiting long-standing illness (OR = 1.93) compared with married women with children adjusting for age only in Model 1, Table 4b. Adjusting additionally for employment status, education and household income had little impact on the age adjusted pattern. Single lone mothers (OR = 1.74) showed a borderline statistically significant difference from married women with children even after adjusting for structural variables in Model 3, suggesting that Finnish lone mother's poor health was largely unrelated to their employment status, income level and educational attainment. This was different from Britain where after adjustment there was a smaller health difference between lone mothers and married women with children. In Finland married women without children had the best health.

Employment status was associated with limiting long-standing illness, and this association remained after adjusting for education and income for Finnish women. The reference category of full-time employed women (OR = 1.00) were least likely to report limiting long-standing illness, whilst unemployed women (OR = 1.83-1.77) were more likely to report illness than other women (Models 2 and 3, Table 4b). Unlike in Britain, the health of Finnish housewives (OR = 1.26-

1.23) was equal to that of part-time employed women and neither differed statistically significantly from that of full-time employed women.

7. Discussion

We have examined the associations between family type and ill-health among British and Finnish women aged 20-49, while also examining women's employment status and other socioeconomic and material characteristics. This comparative study was based on cross-sectional surveys.

A key concern was to examine to what extent differences between countries in family structure and employment participation, as well as related social policies, also differentiate women's health. In Britain being a lone mother and particularly having pre-school children reduces markedly women's employment participation, whereas in Finland this holds true only to a very limited extent.

We found that in Britain, as well as in Finland, women living with partners and dependent children report the best health compared to women in other family types or single women. Among British women perceived health was worst and limiting long-standing illness was most prevalent for lone mothers, irrespective of whether they were divorced or never married. Finnish single lone mothers had the worst health according to both health indicators, reporting somewhat poorer health than divorced lone mothers.

In terms of employment status, women having a paid job had the best health in both countries. In Britain there was a tendency for part-time employed women to have better health than their full-time employed counterparts, whereas there was a tendency for the reverse in Finland. In Finland, housewives' health was close to that of employed women, whereas in Britain housewives reported the worst health on both measures. This may suggest some health selection into the role of housewife in Britain, but not in Finland.

In both countries adjusting for employment status, education and household income weakened the association between lone motherhood and illhealth, but to a somewhat greater extent in Britain than in Finland. Additionally, in Britain the adjustment accentuated the ill-health among married women without dependent children. These findings suggest that in Britain lone mothers live in relatively poor

socioeconomic and material circumstances, whereas married women without dependent children live in relatively good conditions. However, in Finland the adjustment for socioeconomic and material variables had little effect on the health of married women without dependent children, who generally reported the best health. Thus, in Britain more than in Finland the illhealth of lone mothers is because of their disadvantageous socioeconomic and material circumstances. The smaller effect of these circumstances in Finland is likely to be because of women's higher levels of full-time employment. Nevertheless, in both countries there is a residual effect of lone mothers having poorer health. This is likely to be due to lone mothers suffering both from multiple burdens as well as less attachment to the community than other women. Additional residual effects may be partly due to unmeasured socioeconomic circumstances since we lacked comparable occupational social class variable in this study.

Our results are broadly in accordance with the multiple attachment hypothesis, since employed women, and women living with a partner and dependent children had the best health throughout the analysis in Britain and in Finland (apart from the good health of married Finnish women without dependent children). Further indirect support for the multiple attachment hypothesis can be drawn from the poor health of lone mothers in both countries after adjusting for employment status, education and household income. This adjustment reduced the health disadvantage of lone mothers particularly in Britain.

It has previously been argued in favour of the multiple burden hypothesis that women with multiple roles including being a wife, mother and an employee run the risk of role conflict and role overload, which may contribute to elevated stress and strain levels and subsequent poor health (Gove, 1984). However, this was not supported by our findings. On the contrary, multiple roles were associated with good health rather than with poor health. This suggests that, although being a mother and an employee does mean multiple obligations and potential multiple strains, multiple attachment to the community is likely to buffer against health damaging burdens among women.

Lone mothers since the late 1970s have been found to suffer from health disadvantage in Sweden and Britain (Whitehead *et al.*, 2000; Burström *et al.*, 1999). Thus, not only are the socioeconomic and material circumstances among lone mothers poor but also their health is poorer than that of women in other family types, particularly those

living with a partner and dependent children. This seems to hold broadly true in a similar way in different European welfare states.

Despite the differences between Britain and Finland in the welfare state, provision of publicly supported childcare and employment status of lone mothers, in both countries lone mothers report poor health but this is mainly restricted to never married rather than divorced mothers in Finland. In Britain, a greater part of the health disadvantage of lone mothers is explained by their disadvantaged structural characteristics than in Finland. These findings suggest that lone mothers are in particular need of special measures to promote their health. This can be achieved by improving lone mothers' poor living conditions and socio-economic circumstances. A basic condition for women with dependent children in general is managing their everyday life, which includes access to comprehensive and subsidised child care services. This is true for lone mothers in particular. Furthermore, lone mothers are in need of better educational and employment opportunities, as well as income support, in order to maximise their prospects for good health. Providing women with better employment opportunities is a key measure to reduce health variations, but this needs to be supplemented by day care provision which allows mothers in less advantageous positions and living without a partner to take a paid job.

The Finnish welfare state, which includes large public service sectors, has been very much dependent on women's high employment participation. There is a general normative atmosphere supporting women, irrespective of their parental and family status, to undertake full-time paid jobs. Women's employment, including lone mothers, has been supported by social policies and by providing public childcare. This has contributed to women's economic independence irrespective of their marital or parental status.

Finally, it is important to monitor future trends in the associations between women's health, employment status and family type, since women-friendly policies and welfarestate structures are under increased pressure from international competition and economic downturns. Adverse economic developments and a reversal of women-friendly policies are likely to hit hardest the social position and living conditions, as well as health and well-being, of the most vulnerable groups in society, such as lone mothers.

Acknowledgements

This study was supported by a grant from the Academy of Finland, Research Council for Health (#37800).

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