

Socioeconomic Inequalities in Health of Older Europeans – Exploring the Contribution of Childhood Conditions

Anja K Leist¹, Mauricio Avendano², Johan P Mackenbach³

¹ University of Luxembourg, Luxembourg

² London School of Economics and Political Science

³ Erasmus Medical Center Rotterdam, Netherlands

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Shortened presentation



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Background

- Large inequalities in health of older adults depending on educational attainment are still poorly understood despite a wealth of research during the last decades (Mackenbach 2012; Bambra 2013)
- New perspectives suggest childhood conditions and childhood personal factors (health, cognitive abilities) are the “missing link” to explaining these inequalities (Heckman 2012; Wadsworth 1997)
- Childhood conditions which may influence both educational attainment and later-life health:
 - Cognitive ability (Batty et al 2006; Wrulich et al 2013; Wrulich et al in press), ‘below average school performance’ (Mehta et al 2009)
 - Childhood health (Haas 2006)
 - Childhood socioeconomic status (Poulton et al 2002)



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Research Questions

- Do childhood conditions contribute to explaining socioeconomic inequalities in health in middle and older age?
- Do childhood conditions contribute to explaining the association between educational attainment and six-year trajectories in health?
- Focus on parental socioeconomic status, childhood health, and below average school performance.

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Sample

- *Survey of Health, Ageing and Retirement in Europe (SHARE)*: population-representative longitudinal, cross-national survey on health, social, and economic situation of adults 50+ (these analyses: aged 50-74)
- SHARELIFE: one wave dedicated to assessing life histories, e.g., childhood conditions (wave 3, 2008/9)
- Information on health assessed in waves 1 (2004/5), 2 (2006/7), 4 (2010/11)
- 13 countries: Austria, Germany, France, Netherlands, Italy, Spain, Sweden, Denmark, Greece, Switzerland, Belgium, Poland, and Czech Republic

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Sample

- **Cross-Sectional Analyses:** 24,512 respondents to SHARE, aged 50-74) from 13 countries and having participated in wave 1 (2004/5) or 2 (2006/7), and in wave 3/SHARELIFE (2008/9). After excluding missing cases and respondents 75+: 8,252 men and 9,730 women
- **Longitudinal Analyses:** only respondents having participated in all waves: 1 (2004/5), 2 (2006/7), 3/SHARELIFE (2008/9), and 4 (2010/11). After excluding missing cases and respondents 75+: 7,112 respondents (3,903 women, 54.8 %)

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Variables and Data Analysis

- **Health:** excellent, very good, good, fair, poor
- **Education:** *International Standard Classification of Education*
- **Parental socioeconomic status at age 10:** Occupation of main breadwinner, availability of household items, number of books at household
- **Childhood health:** Self-rated health, infectious diseases, physical injuries, missed school 1+ month
- **Self-rated below-average school performance** compared to peers (*much better, better, same, worse, much worse*), in mathematics/language

Data Analysis

- Inverse probability weighting, country indicators
- Cross-sectional analyses with the Relative Index of Inequality (RII)
- Longitudinal analyses with *Generalized Estimating Equations (GEE)*

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Results

1. *Cross-sectional associations* between childhood conditions and education, between childhood conditions and health
 - All socioeconomic variables strongly associated with educational attainment, but only marginally with health
 - Childhood health associated with adult health, but not with educational attainment
 - School performance associated with both education and health
2. *Cross-sectional analyses with the Relative Index of Inequality:*
 - For men and women, large educational inequalities in health
 - Inequalities are not reduced by adjusting for childhood variables
 - Regional differences

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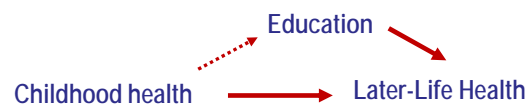
Results

3. *Longitudinal analyses:* Education has a strong association with six-year self-rated health trajectories. After including childhood variables, the association between education and health diminishes slightly. Childhood health seems to have the strongest association with later-life health.

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Discussion

- Educational attainment largely determines health in middle and older age
 - This association is only to a small extent explained by cognitive skills and socioeconomic status during childhood, but to some extent by childhood health.
- Reporting differences?
 - Higher educated remember health problems better despite (objectively) better health?



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Discussion

- What socioeconomic indicator to use?
 - Education and deprivation best according to Grundy & Holt (2001)
- Outcome self-rated health valid, but maybe inferior to functional limitations, chronic conditions, stroke ...
- In sum, childhood conditions can to a small part explain educational health inequalities
- Thinking about ways to foster children's potential in terms of health and cognitive ability is warranted.

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Thank you for your attention.

Contact: anja.leist@uni.lu



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