HEALTH AND SUBJECTIVE WELL-BEING – A TWO WAY RELATIONSHIP? Evidence from three Central European countries

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Abstract

Literature and meta-analyses of the scientific texts (see for example Ngamaba, Panagioti and Armitage, 2017) provide evidence on the complex relationship between health and subjective well-being. Diner and his colleagues (2017) argue that there is still work to be done especially on the circumstances when subjective well-being (SWB) influences health status. According to them special attention should be paid to the interacting effects of other variables that can mediate the relationship between health and subjective well-being.

The European Value Survey provides data allowing for answers to some important issues related to opinions and attitudes towards self-perceived health and well-being of the adult European population. The issue of well-being is investigated at the subjective level and refers to personal evaluation of life satisfaction and happiness in life.

The main aim of this paper is two-folded: a) to assess the strength of the association between health status and subjective well-being across three countries in Central Europe (Czech Republic, Slovakia and Austria) and in a time perspective by use of individual data; and b) to test whether and how third variables (mediators) are responsible for the association between health and subjective well-being.

The analysis will be run on data from the European Values Study conducted in 1991, 1999, 2008 and 2017. Our analysis will also include a time dimension as the trends in both self-perceived health and subjective well-being will be presented.

Introduction

Very low levels of fertility and the ageing of societies have been regarded as one of the most important population challenges of the 21st century. The increasing life expectancy corroborated with a sharp drop in fertility has significantly changed the demographic structure of populations in many contemporary post-modern societies. Consequently, health and well-being issues have been taking a more significant position within both academic and policy-making debate. The process of aging is shaped by a number of phenomena which are closely linked. Among them, we can mention the change in the economic setting of our societies, the reducing support offered by the social welfare state system accompanied by a gradually shift towards neoliberalism, as well as continuous adjustments in personal values, attitudes and norms accommodated by post-modern societies.

The choice of the countries we run our analysis on is based on two arguments: on one hand, they share a common historical and cultural heritage; on the other hand, we can talk about path dependence. In terms of path dependence, Bailey (1992) argues that cross-national differences and similarities in values are to a great extent the products of each country's unique trajectory of social development, its historical heritage, and cultural experiences and traditions.

The historical, social and economic developments that have taken place in the Central and Eastern European space cannot be regarded as a process that has occurred in isolation, as the histories of these countries are closely linked to each other. They have been part of larger political structures in their past (either the Austria-Hungary empire or the block of communist countries), and today, they are members of the European Union. Additionally, the Czech and Slovak republics have a common history in modern times as one national state and only 30 years ago the two separated and became independent states.

Given the significant variation in health across population (across cohorts) and the grown significance in maintaining independence (both physically and mentally) and perpetuating active aging, it is crucial to grasp how perceived health condition and subjective and social well-being, are inter-related, and to determine the differences in well-being in an age-comparative perspective.

There is a large body of literature focused on the relation between well-being and health which shows significant correlation at the individual level (e.g. ….). A significant number informs about the possible reciprocal relationship between health status and subjective well-being. As

for the mediators, many papers discuss the influence of third variables on this relation. Among the most discussed we find the socioeconomic status components that can mediate the relationship between health status and subjective well-being.

Education and employment, together with income, have traditionally been regarded as indicators of socio-economic status at the individual level. The relationship between socio-economic status and health status of individuals and groups has been proven many times. In the mid-1980s, scientists came to the conclusion that the impact of socio-economic status on health was wider than previously thought. In general, people with less resources are worse off in terms of health status (e.g. Adler, Rehkopf 2008, Marmot, Ryff, Bumpass, Shipley, Marks 1997, Marmot 2006). People with a higher socio-economic status live longer, have a higher quality of life, report better life satisfaction and happiness, suffer less from health problems and disability, while people with lower status die at a younger age, suffer more from certain diseases and generally have a lower quality of life (e.g. Adler, Rehkopf 2008, Demakakos 2008, Dalstra et al. 2005, Huisman et al. 2005, Mackenbach et al. 1997). The link between socio-economic status and health has been found in almost all industrialized nations. However, the strength of the association varies, for example, for ethnically diverse countries (e.g. Adler, Ostrov 1999). Kagamimori, Gaina and Nasermoaddeli (2009) explore the relationship between socio-economic status and health in Japan. They point out that socio-economic status must be understood and interpreted in the light of the country's economic, social, demographic and cultural context.

Given the above theoretical and empirical consideration, the paper will focus on the association between subjective well-being and perceived health condition of adult population in an age and gender comparative perspective. We will test whether perceived health status is influenced by subjective well-being, or a reciprocal relationship between health and well-being can be detected on the base of the assumption that both variables influence each other.

In the next section we present data from the European Value Survey and the indicators, which will be used in analysis. The results and interpretations are to be given in the results section; potential limitations and further research issues are to be also discussed.

Data and methodological considerations

We shall analyze data collected under the frame of the European Values Study that has been carried out in Europe since 1991. We shall make use of data from Czechia, Slovakia and Austria. Representative stratified random sample of the adult population of 18 years and older was drawn. Face-to-face interviews with a standardized questionnaire were conducted in four waves (1990/1991, 1998, 2008 and 2017/2018).

Variable to be used:

Subjective well-being*:* this measurement is operationalized by *perceived life satisfaction* (using a 10-point scale) and *happiness in life* (based on a 4-point scale).

Self-reported health status was assessed by an item which consisted of five categories (1 – very good, 2 – good, 3 – fair, 4 – poor, 5 – very poor). For the purpose of analysis, we recoded the variable into a dichotomous one (1 – good and 2 – poor).

Mediators variables: *socioeconomic status variables* – education, employment status, social class, *Inglehart autonomy index*

Additional individual demographic and attitudinal factors such as age, gender, marital status, perceived control over life have been also associated with the self-reported health condition and are to be included in the analysis as **control variables**.

For the aim of the paper, bivariate statistical analysis and logistic regression models were fitted to the data.

Analyses and results

The present extended abstract does not include any results as the data from the 4th EVS wave for the countries we analyzed have been just recently released. As we plan to work with the time dimension, we need to integrate all for waves for the three countries and weighting and other data preparation procedures are required.

We partially tested our assumptions on a reduced dataset for Czechia and Slovakia and we found some support for them.

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