

WHY DO ITALIAN PEOPLE RATE THEIR HEALTH WORSE THAN FRENCH PEOPLE ?
EXPLORING CROSS-COUNTRY DIFFERENTIALS OF SUBJECTIVE HEALTH

Studies on self-rated health (SRH) have developed in two main directions: on one hand, a wealth of studies has reported that perceived health is a good predictor of mortality (Idler & Benyamini, 1997; Benyamini & Idler, 1999; Egidi & Spizzichino, 2006). On the other hand, many authors have examined what are the determinants of SRH (Segovia, Bartlett & Edwards, 1989; Fylkesnes & Forde, 1992; Kaplan & Baron-Epel, 2003). Those studies give evidence that SRH is strongly associated with morbidity (Farmer & Ferraro, 1997; Goldberg, Gueguen, Schmaus, Nakache & Goldberg, 2001; Golini & Calvani P, 2001; Lanoe & Makdessi-Raynaud, 2005) and disability (Rakowski, Cryan, 1990; Johnson & Wolinsky, 1993; Ferraro, Farmer, Wybraniec, 1997). But they also suggest that self-rated health is a complex construct that relies on many other components (psychological, psychosocial, socio-demographic...). In addition, the subjective perception of health may be influenced by contextual factors whether social, economical, political or cultural. The literature provides several examples of how such factors may exert their influence. Culture may influence one's sensitivity to symptoms and one's interpretation of their severity and significance. Zola (Zola, 1966) found that Italians are much more likely to report a number of symptoms while the Irish mention only a few. Other authors (Ellaway, Macintyre, 1990; Kawachi, Kennedy & Glass, 1999) have investigated the contextual mechanisms by which social capital impact on health outcomes.

The prevalence of good and bad SRH varies greatly across European countries (European Union Opinion Group, 2003). To what extent do contextual factors contribute to those variations? Do they reflect country specificities in the frame of reference used to rate one's health? Are they solely due to the fact that the structure of those populations is different? We believe that cross-country comparisons, since they aim at answering such questions, can help elucidate what lies behind the simple self-assessment of health.

Table 1: Bad or very bad self-rated health. Percentages of the adult French and Italian non-institutionalized population by sex and age group

	Females		Males		Both sexes	
	France	Italy	France	Italy	France	Italy
45-74	6,8%	12,6%	5,9%	9,0%	6,4%	10,9%
75+	16,2%	33,5%	12,9%	27,3%	15,0%	31,2%
45+	8,7%	16,8%	6,9%	11,6%	7,9%	14,4%

Source: France HIS 2002/2003, Italy HIS 1999/2000

In the present study we compare two European countries: France and Italy. We use the data from the Health Interview Surveys (HIS) that were conducted in France in 2002-2003 and in Italy in 1999-2000. This data (table 1) indicates that the prevalence of bad health in the Italian adult population aged 45 and over is almost twice as high as in the same French population segment (14.4% vs 7.9%).

To avoid possible bias due to differential institutionalisation in France and Italy, we focus on the adult population aged 45-74. Thus, our aim is to explain why at those age, 10.9 % of the Italian people acknowledge bad health as compared to 6.4% of the French people.

This difference may result from a different profile of the two populations regarding the various factors that impact on SRH (“*Structural effect*”). It may also be that the effect (direction and/or intensity) of those factors on the likelihood to declare bad or very bad health is not identical in the two countries (“*Intensity effect*”). To test the validity of the first hypothesis, we compare the structure of both countries regarding a number of variables selected among the possible determinants of SRH. These variables can be broadly classified into three categories: sociodemographic characteristics, morbidity and disability measures, and lifestyle factors. For the “intensity” hypothesis, we use several logistic regression models. In all models the dependant variable is the SRH response and the covariates are the aforementioned variables. Self-rated health is measured in the two countries with a question that is very close to the WHO-question (“*How is your health in general? Very good, good, fair, bad, very bad*”) but it is well known that even slight differences in the wording of the question may strongly affect the way people answer it. Differences also arise when examining the survey method that, in both countries, combines face-to-face interview and self-administered questionnaire with, for some questions, the possibility to use a proxy respondent. As a consequence, the first part of our study consists of an in-depth examination of how far those methodological differences may have contributed to the fact that French people rate their health better than Italian people.

All the models are testing the probability to rate one’s health as bad or very bad. We first use separate models for each country. We then pool the data of the two countries and construct an intermediate model where, in addition to the variables that prove to be significant in at least one country, we include a variable named “Country “ that aims at measuring the residual unexplained variance between France and Italy. We finally include in that model as many interaction terms with the “Country” variable as there are covariates.

Our analysis shows that the association between self-rated health and the individual characteristics under consideration has the same direction in France and Italy. We take this result to indicate that the frame of reference used by people when answering the SRH question is similar in both countries. Some characteristics are significant in Italy only but it might be that the French sample is too small to reach statistical significance. Among the selected individual characteristics, morbidity and disability measures are the strongest predictors of how people assess their overall health.

Results from the final model with pooled data and interaction terms suggest that the set of variables under consideration is sufficient to explain the gap between the two countries. When compared with the model with no interaction terms, the goodness-of-fit of model B improves slightly but significantly. Thus, the “intensity hypothesis” cannot be rejected but its impact is weak and we cannot determine whether it tends to increase or to moderate the gap between France and Italy. In contrast, the

“structural effect” is globally favourable to France and its contribution to the observed situation is stronger.

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