Self-Rated Health, Gender, and Mortality in Older Persons: Introduction to a Special Section

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Self-rated health (SRH) is widely recognized as a comprehensive indicator of health. Its comprehensiveness is often referred to as surprising because the indicator is based on a single question. Yet, numerous studies have demonstrated that this question may include more relevant aspects of health than can be measured in a survey, however broad the range of health measures used. The most widely quoted proof of SRH’s comprehensiveness is its predictive ability for mortality, evidence for which has been found in many studies from different countries using various designs (Benyamini & Idler, 1999; Idler & Benyamini, 1997). However, little evidence exists for the reasons why SRH is such a good predictor of mortality. Possible explanations include (a) SRH, in addition to comprehensive health, also reflects preclinical, and so far unmeasurable, aspects of health; (b) SRH, in addition to current health, dynamically reflects recent changes in health; (c) the way of responding to the SRH question is correlated with health behavior, for example, optimistic responses are linked with positive health behavior, which in turn are associated with better survival; (d) self-perceptions of health are related to the psychoneuroimmunologic responses that determine the susceptibility to diseases (see Idler & Benyamini, 1997).

Moreover, upon closer inspection, differences and inconsistencies in predictive ability can be observed among subgroups according to gender and age and also according to the duration of the mortality follow-up period. This special section explicitly addresses gender differences in the ability of self-rated health to predict mortality, as well as possible gender-specific differences with respect to age, cohort, and duration of mortality follow-up.

Idler and Kasl’s (1991) study of 2,812 older people in New Haven, Connecticut, provide an example of gender differences in the predictive ability for mortality. Their study showed that, in comparison with the reference category of “excellent” self-rated health, among men the adjusted odds ratio (OR) for poor (OR = 6.7), fair (OR = 4.1) and good (OR = 3.2) self-rated health was noticeably greater than among women (OR = 3.1 [poor], OR = 2.8 [fair], and OR = 2.4 [good]). Four other studies showed similar differences. However, McCallum, Shadbolt, and Wang’s study (1994) of 1,050 older people in Sydney, Australia, showed that whereas fair (OR = 2.4) and good (OR = 3.2) compared with excellent self-rated health remained predictive of mortality among women with sociodemographics, morale, and social support as covariates, self-rated health was no longer predictive among men. In more recent studies, lower self-rated health remained predictive of mortality in adjusted models among men but not among women (Hays, Schoenfeld, Blazer, & Gold, 1996; Franks, Gold, & Clancy, 1996; van Doorn, 1998; van Doorn & Kasl, 1998). In one study, lower self-rated health remained predictive of mortality among women but not among men (Simons, McCallum, Friedlander, & Simons, 1996).

The observed differences in predictive ability among subgroups might shed light on the “working elements” in SRH that contribute to the prediction of mortality. For possible explanations of the association between SRH and mortality when SRH predicts mortality in one, but not in another subgroup, researchers should examine the characteristics of the subgroups for factors that might further explain the association between SRH and mortality. However, the reported differences among subgroups are not

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consistent and, therefore, are difficult to explain without further study.

Why do gender differences seem a productive approach to a better understanding of the working elements of SRH? The first three of the possible explanations of the SRH–mortality relation proposed by Idler and Benyamini (1997) and listed previously in this article, consider subjective responses to health problems. The fourth one considers more objective biological mechanisms. Gender differences in subjective responses and biology, as well as in objective social conditions, may affect the way women and men rate their health. If the ensuing SRH differences correspond to gender differences in the association between SRH and mortality, a working element of SRH may be revealed.

First of all, older women and men clearly differ in the extent of their health problems. Whereas older men more often suffer from heart and lung conditions, older women more often suffer from almost every other condition, both somatic and mental, as well as from comorbidity and disability (Deeg, Portrait, & Lindeboom, 2002). This gender difference suggests a possible working element (i.e., that SRH might be more sensitive to some conditions that are more closely linked to either gender). Second, given a specific health problem, men are more likely to die than women are, and women are more likely to have limitations in functioning (Arber & Ginn, 1991). Thus, the fatality and incapacitation associated with health problems differ between women and men. The working element here might be a threshold in the sensitivity of SRH, such that it picks up either only fatal, or only incapacitating, health problems. Third, the social conditions of older women and men vary with respect to marital status, living arrangements, socio-economic status, past or present labor market experience, social activities, and life style (Lane & Cibula, 2000). These conditions may influence the way each gender perceives their health. The working element might be norms and standards that are shaped by these conditions. Fourth, the genders may differ in their sensitivity to symptoms and signs of diseases and impairments (Verbrugge, 1990), which in turn may influence their response to the SRH question. Fifth, the context in which the question on SRH is asked may elicit gender-specific ways of responding (Verbrugge, 1990). For example, one gender might respond to a face-to-face interview with more realistic answers than the other one does.

In this special section, data are presented from four studies based in different Western European countries and in Israel. General questions addressed are (a) Are gender differences demonstrated in the predictive ability of self-rated health for mortality? and (b) If gender differences are found, are they explained by covariates covering a wide range of health aspects?

Each study addresses additional, more specific questions:

2. Do gender differences persist across age strata? (Benyamini et al., 2003)
3. Does the gender-specific predictive ability vary with the specific content of the self-rated health question? (Benyamini et al., 2003; Deeg & Kriegsman, 2003)
4. Do gender-specific (observed or experienced) changes in SRH have better predictive ability than current SRH? (Bath, 2003; Deeg & Kriegsman, 2003)
6. Is SRH, for each gender, equally predictive for mortality and for functional disability? (Benyamini et al., 2003)

Not only do the studies differ with respect to cultural setting, but they also have different designs in terms of sample stratification, age range, duration of follow-up, and included covariates. Similar findings from such diverse studies would emphasize the scientific value of the findings. Vice versa, dissimilar findings would suggest ways to further examine gender differences in the predictive ability of SRH for mortality, first in terms of design characteristics and second by explicitly addressing cultural factors that vary across countries. This special section makes a start with such an enterprise by ending with a discussion of the four sets of findings (Idler, 2003).

References


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