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ORIGINAL ARTICLE

## Gendered health inequalities in mental well-being? The Nordic countries in a comparative perspective

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### Abstract

**Aims:** The aims of this study were to: (a) compare gender differences in mental well-being in the Nordic countries with gender differences in 28 other countries around the world; and (b) evaluate whether gender differences in the Nordic countries remain when other social and lifestyle factors are taken into account. **Methods:** Data were obtained from 32 countries around the world that participated in the 2011 health module of the International Social Survey Programme. Ordered logit regression models were used to evaluate whether gender differences remained significant when other social and lifestyle factors were considered. **Results:** Gender differences in mental well-being in the Nordic countries are not particularly small and the four countries do not cluster together. The gender differences remain when other social and lifestyle factors are taken into account. **Conclusions:** There appears to be a similar Nordic health paradox for mental well-being outcomes as for physical health outcomes. Although there may be multiple reasons for this, continued gender equality, including sex segregation in the labour market and gendered expectations, are considered to play a part.

**Key Words:** *Mental well-being, gender inequality, Nordic health paradox*

Decades of research on health and inequality show a consistent pattern: those who are more vulnerable in society have poorer health outcomes than those who enjoy more advantages [1]. The most consistent relationship has perhaps been found for the impact of education and income, whereas work on gender and immigration has yielded more mixed findings [2]. The gender paradox in health is well known: women live longer than men, but have more chronic and mental health problems throughout the life course [3]. Although biology plays some part in explaining these differences, social factors also have a key role. Researchers have pointed out that men generally engage in a riskier lifestyle and work in more dangerous occupations, whereas women's health suffers from inequality in paid and unpaid work [4].

The unequal status of men and women is a nearly universal pattern across time and place, yet what is viewed as appropriate for men and women in society as well as the effort societies put into correcting those

inequalities varies drastically. The classification of societies into welfare regimes has a long tradition that began with the categorization of liberal, conservative and social democratic societies by Esping-Andersen [5]. Countries such as the USA, the UK and Australia fall into the category of liberal welfare states; Germany, France and Italy represent conservative states; and Norway, Sweden and Denmark are examples of social democratic welfare states. Esping-Andersen's focus was on how much societies do to make individuals capable of surviving outside the market, with a focus on various policies designed to relieve individuals of insecurities created by the market. Although hugely influential, his work was rapidly criticized by feminist scholars for its lack of attention to gender [6,7]. This has led to a reformulation of his original classification where more attention is paid to gender [8]. For example, Korpi and colleagues [9,10] divided countries into the dual-earner family model, the market-oriented model and the traditional family

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policy model. In Esping-Andersen's typology, these roughly match the social democratic, liberal and conservative models, respectively. With respect to gender, the dual-earner family model countries encourage women's participation in the labour force and promote policies that allow men and women to combine parenthood and paid work; the market-oriented model countries do not discourage women from participation in the labour force, but leave it to the market to control how gender relations play out, with an emphasis on private, market-based solutions to care work; and the traditional family policy model countries have historically allocated care work to the family, providing little support for women participating in the labour force.

Although the regime approach has enjoyed great popularity among scholars engaged in cross-national work, there has been an increased reliance on specific policies and indicators, which are better able to trace the specific mechanisms that affect inequality. Along those lines, Pascall and Lewis [11] have identified five policy areas that promote gender equality. They are: (a) policies to promote political representation (e.g. proportional representation and gender quotas); (b) policies to promote gender-equitable use of time (e.g. equal value for part-time work and school scheduling); (c) family policies (e.g. parental leave and child and elder care policies); (d) policies to promote equal income (e.g. equal opportunity in earnings and division of pension rights on divorce); and (e) employment policies (e.g. labour market regulations to increase equality and equal pay). Although it is important to consider different and potentially contradictory ways in which societies can promote gender equality, one fact consistently remains: the Nordic countries clearly do the most to create and maintain equality between men and women. This effort should have health implications, exemplified in the theory of the fundamental causes of disease, where it is clear that as long as we have societal inequality, we will have health inequality [12,13]. Consequently, if a society attempts and succeeds in reducing some type of inequality, there should be less health inequalities of that type in that society. Yet research on the health advantages of the Nordic countries has yielded mixed findings.

Perhaps the most perplexing finding from studies in the Nordic context is that although theoretical expectations would lead us to think that citizens in these countries should enjoy better health and less health inequality than those elsewhere in the world, this has not proved to be the case. In fact, this finding has been consistent enough to be referred to as the health paradox of the welfare state [14]. This paradox, emerging from a pattern first found in the 1980s,

indicated that health inequalities were not smaller in larger welfare states in general and the Nordic countries in particular [15] and this finding has been confirmed for the 1990s [16] and again in the 2000s [17,18].

Focusing on gender, Bamba et al. [19] found evidence that both supported and countered welfare state theory. Examining self-rated health, they showed that, as expected, women in the social democratic countries were less likely to report poor health than women in the southern regime (Portugal, Spain and Italy), yet they were more likely to do so than women in conservative countries. Using a measure that captures the total inequality in life expectancy, researchers have shown that the Nordic countries have the highest life expectancies and lowest inequalities for men in 37 countries, but the same was not true for women [20]. Moving to the less studied outcome of mental health, research has shown that the family-friendly work policies of Finland [21] may result in better mental health for women and that women living in US states with better reproductive rights have lower levels of depression [22].

Despite the sociological focus on the relationship between individuals and society, sociologists have only relatively recently started to theoretically and empirically test the impact of macro-level institutional arrangements on health and health inequalities [23,24]. The last decade has witnessed a surge in cross-national health research, albeit more frequently focused on class-based than gender-based inequalities [25,26]. In a review of work that has examined the upstream determinants of health inequalities between men and women, Borrell et al. [27] identified 19 papers that empirically examined the impact of gender equality policies, gender or welfare state regimes, or compared policies across countries, states or macro-administrative units. The most likely health outcome to be examined in those papers was self-rated health, with only three of them focusing on mental health outcomes. It is important to consider a variety of health measures to gain a fuller understanding of health and health inequalities across countries. I therefore used three measures of mental well-being in this research, which aligns well with how the World Health Organization (WHO) suggests we should think about health around the world. More specifically, the WHO defines health as: 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' [28].

I used data from the 2011 International Social Service Programme (ISSP) Health module to explore two interrelated research questions: (a) how large is the gender difference in mental well-being in the Nordic countries (Denmark, Finland, Norway and

Sweden) compared with 28 other countries across the globe; and (b) if gender differences are observed in the Nordic countries, do they remain even when other social demographic and lifestyle factors are introduced? These questions are important, as theory would expect smaller gender differences in the Nordic countries, yet numerous studies have determined the Nordic health paradox, especially in terms of physical health outcomes [14–18,20]. In this study, I relied on relatively new data from the ISSP and join the few comparative studies that focus on mental health outcomes, rather than the much more frequently used physical health outcomes.

### Data and methods

The data were taken from the 2011 ISSP. The ISSP is a collaboration of survey researchers in more than 40 countries with an emphasis on theoretical, methodological and conceptual coordination. Each survey module is designed collaboratively and a standard English questionnaire is agreed upon by representatives from each country. The questionnaire is then translated into different languages and adapted to the national culture and context. The ISSP guidelines require a nationally representative sample, but the countries have different fielding plans that are adjusted to each context. Each country fielding plan must be approved by the ISSP methodological committee prior to joining the ISSP and no deviation is allowed unless they are specifically approved by the committee. The ISSP has rotating modules that focus on issues of key concern to social scientists. In 2011, the focus was on health and included questions on health care reform, attitudes towards medical doctors, health behaviour and health outcomes.

The health module was fielded in 32 countries and although the focus of this paper is on the Nordic countries, they are all used as comparison cases for gender differences. Specifically, the participating Nordic countries were: Denmark ( $N=1388$ ), Finland ( $N=1340$ ), Norway ( $N=1834$ ) and Sweden ( $N=1158$ ). The non-Nordic comparison countries were: Australia ( $N=1946$ ), Belgium ( $N=3083$ ), Bulgaria ( $N=1003$ ), Chile ( $N=1559$ ), China ( $N=5620$ ), Croatia ( $N=1210$ ), Czech Republic ( $N=1210$ ), France ( $N=3319$ ), Germany ( $N=1681$ ), Israel ( $N=1220$ ), Italy ( $N=1186$ ), Japan ( $N=1306$ ), Lithuania ( $N=1187$ ), the Netherlands ( $N=1472$ ), Philippines ( $N=1200$ ), Poland ( $N=1115$ ), Portugal ( $N=1022$ ), Russia ( $N=1511$ ), Slovak Republic ( $N=1128$ ), Slovenia ( $N=1082$ ), South Africa ( $N=3004$ ), South Korea ( $N=1535$ ), Spain ( $N=2712$ ), Switzerland ( $N=1212$ ), Taiwan ( $N=2199$ ), Turkey ( $N=1559$ ), UK ( $N=936$ ) and USA ( $N=1550$ ).

### Dependent variables

The mental well-being of the respondents was captured by three questions asking: ‘During the past four weeks how often (1) have you felt unhappy and depressed, (2) have you lost confidence in yourself and (3) have you felt you could not overcome your problems?’ The five response categories were: (1) never; (2) seldom; (3) sometimes; (4) often; and (5) very often.

### Independent variables

Gender was the key variable of interest in this paper and was measured by a dummy variable (1=female; 0=male). To evaluate the impact of gender on mental well-being in the Nordic countries, the analysis controlled for additional social demographics and lifestyle. The other social demographics were: (1) marital status (married or cohabitating=1; not married=0); (2) age; (3) education (1=college educated; 0=non-college educated); (4) labour force status (1=in the labour force; 0=not in the labour force); and (5) health status (1=long-standing or chronic illness or disability; 0=no such condition). The measures for lifestyle were: (1) smoking behaviour (1=smokes at least one cigarette a day; 0=never smoked or has quit smoking); (2) alcohol consumption; (3) physical activity; and (4) fruit or vegetable consumption. The exact wording for the three last variables was: ‘How often do you: (1) drink four or more alcoholic drinks on the same day; (2) do physical activity for at least 20 minutes that makes you sweat or breathe more heavily than usual; and (3) eat fresh fruit or vegetables’. The response categories were: (1) never; (2) once a month or less often; (3) several times a month; (4) several times a week; and (5) daily.

### Analysis

The analysis proceeded in two steps. The first step was to evaluate the gender differences in mental well-being in the Nordic countries compared with other ISSP countries. The difference was calculated by subtracting the country mean for women from the country mean for men. If the number was positive, the men had reported better mental well-being than the women and vice versa if it was negative. This analysis also tested whether the gender differences were significant or not. The second step was to take a closer look at gender differences in mental well-being in the Nordic countries by conducting a series of country-specific ordered logit regressions, where other variables associated with mental well-being were introduced to evaluate whether the gender

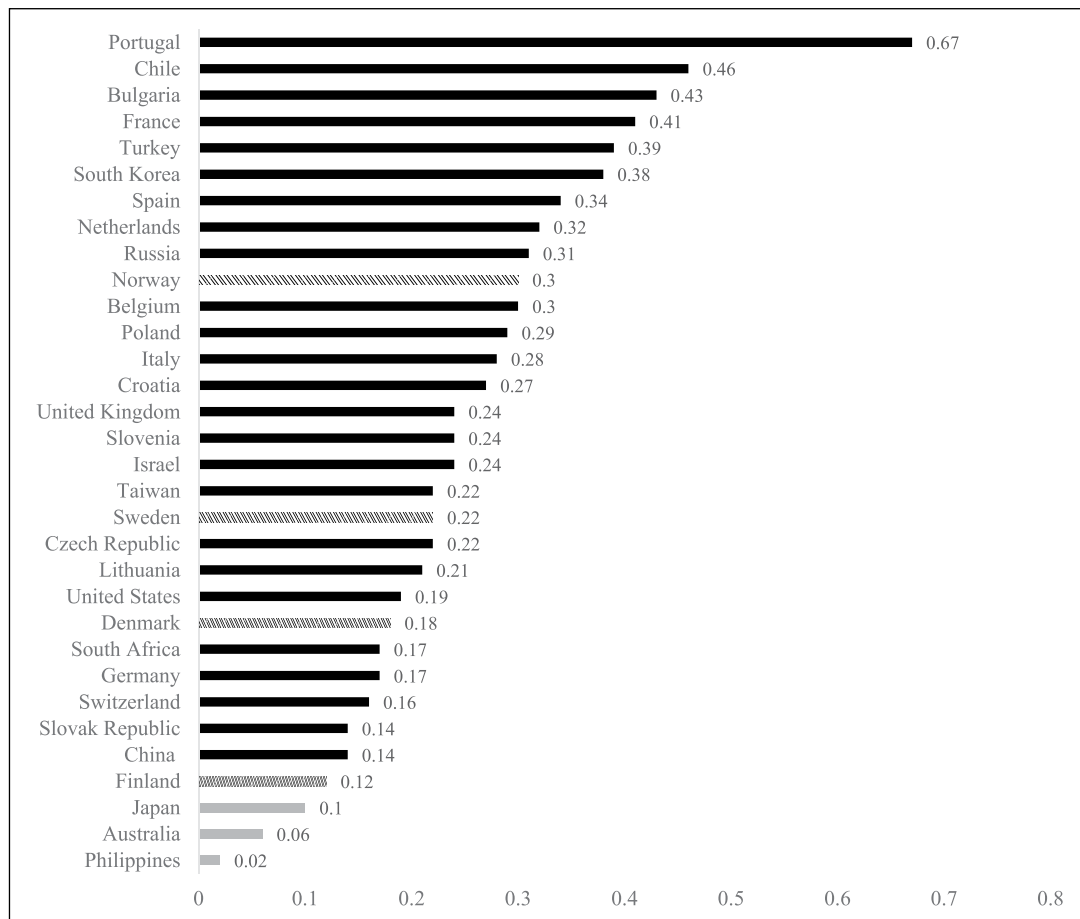


Figure 1. Gender differences in the Nordic countries in a comparative perspective: Reporting feeling unhappy or depressed. Patterned bars indicate significant gender differences in the Nordic countries; black bars indicate significant gender differences outside the Nordic countries; grey bars indicate non-significant gender differences in all countries.

differences remained. Ordered logit regressions as used here are the most appropriate method for ordered variables; however, a problem associated with such models is that the assumption of parallel lines/proportional odds does not hold [29]. This assumption was broken (but only barely so) in only two (depression in Finland and depression in Sweden) of the 12 regression models. Consequently, and with caution regarding those two models, the analysis relies on ordered logit regression models.

## Results

### *Mental well-being in the Nordic countries in a comparative perspective*

The first step of the analysis was to evaluate whether there were significant gender differences in mental well-being in the Nordic countries, as well as how these countries compared with other ISSP countries. The high levels of gender equality in the Nordic countries should, at least in theory, result in

fewer gender differences than expected in less equal countries, yet current research has found mixed evidence for how the extensive social policies in the Nordic countries impact health and health inequalities. Figures 1–3 explore the size of the gender differences in the 32 countries. A patterned bar indicates a significant gender difference in a Nordic country, a black bar indicates a significant gender difference in a non-Nordic country and a grey bar indicates a non-significant gender difference in any country.

Figure 1 shows the gender differences for reporting feeling unhappy or depressed. The figure shows relatively large cross-national variation and that women are significantly more likely to report such feelings in all but three countries (Japan, Australia and the Philippines). The gender differences were largest in Portugal, Chile and Bulgaria. Although there was some indication that countries with higher levels of inequality were towards the top and some countries with lower levels were closer to the

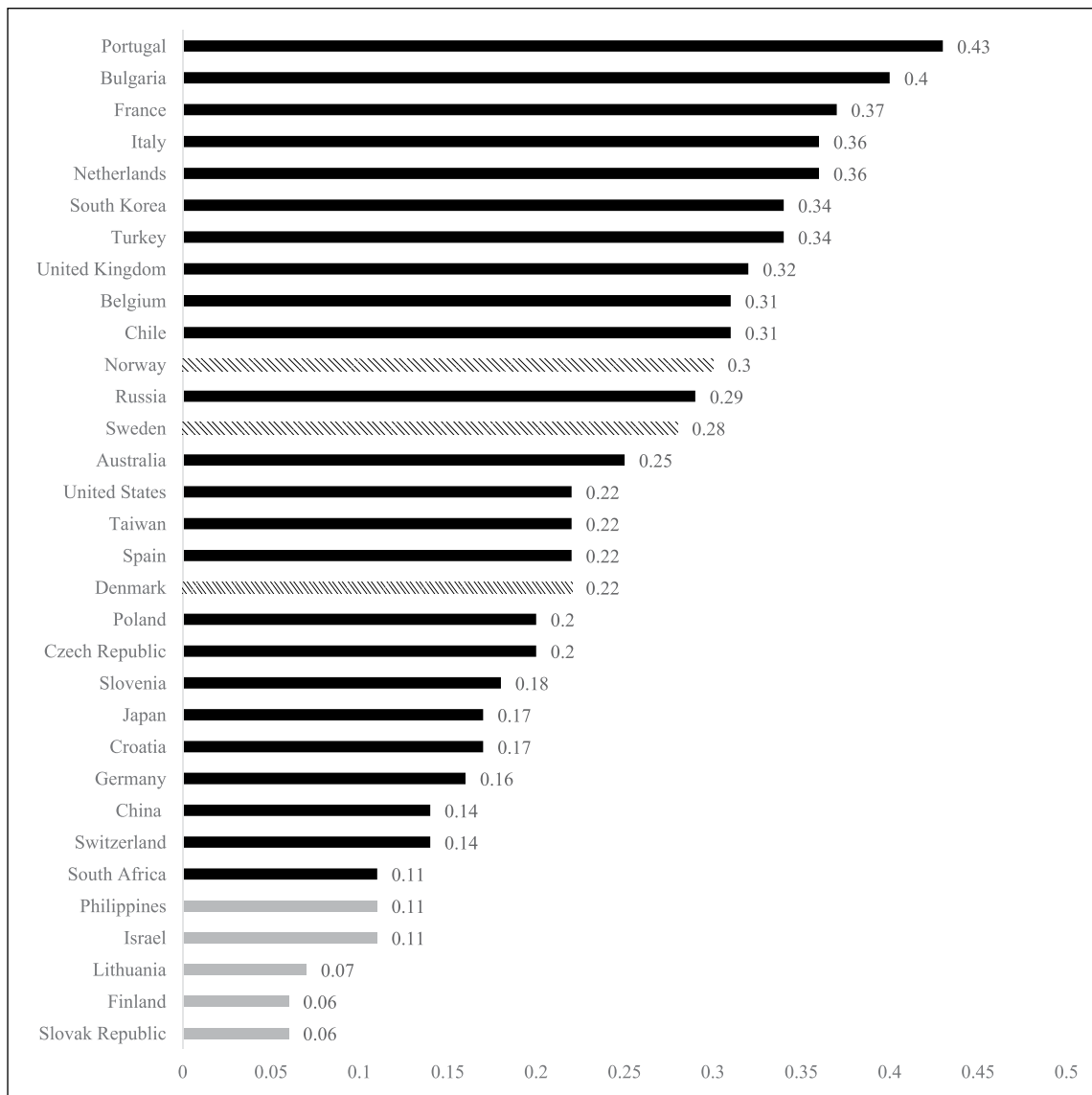


Figure 2. Gender differences in the Nordic countries in a comparative perspective: Reporting having lost confidence in oneself. Patterned bars indicate significant gender differences in the Nordic countries; black bars indicate significant gender differences outside the Nordic countries; grey bars indicate non-significant gender differences in all countries.

bottom, the pattern was far from clear. Even more importantly, the Nordic countries neither had particularly small gender differences, nor did they cluster together with similar levels of difference. Specifically, Norway had the tenth largest gender differences (0.3), followed by Sweden (0.22), then Denmark (0.18) and finally Finland, which was the country with the fourth smallest gender differences (0.12).

Figure 2 examines the gender differences in reporting to have lost confidence in oneself. A similar picture emerges to Figure 1. Women were more likely to report a lack of confidence in themselves than men and the gender differences were significant in all

countries except for five. The gender differences were largest in Portugal, Bulgaria and France, all countries that also had high gender differences for feeling unhappy or depressed. Within the Nordic countries, the pattern from Figure 1 re-emerged; the difference was greatest in Norway, then Sweden, Denmark and finally Finland. However, although the gender differences were small but significant in Finland previously, they were not for this measure.

Figure 3 shows the gender differences for feeling that one could not overcome one's problems. Once again, a similar picture emerges with relatively large cross-national differences and no clear patterning of nations according to levels of gender inequality.

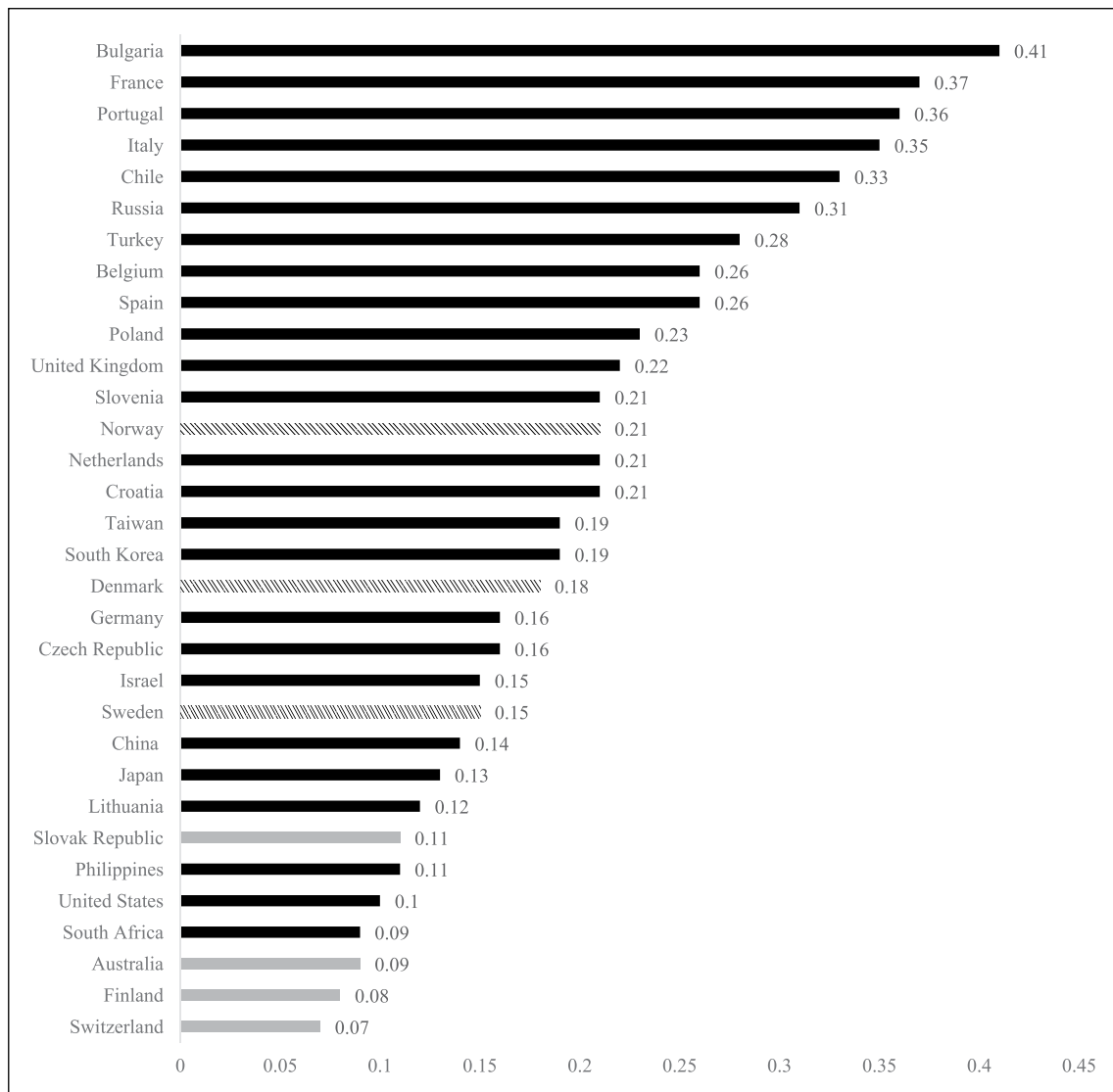


Figure 3. Gender differences in the Nordic countries in a comparative perspective: Reporting unable to overcome one's problems. Patterned bars indicate significant gender differences in the Nordic countries; black bars indicate significant gender differences outside the Nordic countries; grey bars indicate non-significant gender differences in all countries.

Overall, women were more likely to report that they have been unable to overcome their problems. The gender difference was not significant in only four countries: Switzerland, Finland, Australia and the Slovak Republic. Again, we saw the largest gender differences in Bulgaria, France and Portugal. Focusing on the Nordic countries, the largest gender difference was again in Norway, followed by Denmark, then Sweden, with non-significant gender differences in Finland. As a whole, this comparison showed that the Nordic countries neither clustered together, nor did they have particularly low levels of gender difference in all cases, something that might be expected from the high levels of gender equality in those countries.

#### *A closer look at the Nordic countries: gender, social demographics and lifestyle*

The cross-national comparison between the four Nordic countries and 28 other countries around the world established significant gender differences for all of the measures for mental well-being in most of the Nordic countries. A second step of the analysis was to evaluate what happens to those gender differences when other factors are introduced, specifically other social demographic variables and lifestyle factors. The overall results showed that the gender differences remained (or appeared) when those other factors were considered simultaneously. Table I turns to more specific findings for the likelihood of

Table I. Ordered logit regression of reporting feeling depressed or unhappy in the Nordic countries (2011 ISSP).

	Denmark	Finland	Norway	Sweden
<b>Female sex</b>	<b>0.432**</b>	<b>0.375**</b>	<b>0.618**</b>	<b>0.507**</b>
Social demographics				
Married	-0.343**	-0.164	-0.335**	-0.427**
Age	-0.007	-0.002	-0.006	0.000
College	-0.201	0.109	-0.188*	-0.094
In the labour force	-0.291*	-0.447**	-0.394**	-0.129
Long-standing illness	0.649**	0.568**	0.795**	0.867**
Lifestyle				
Smoking	0.196	0.306*	0.305*	0.505**
Alcohol consumption	0.049	0.105	-0.018	-0.007
Physical activity	-0.123**	-0.152**	-0.083	-0.143*
Fruits and vegetables	-0.206**	-0.202**	-0.308*	-0.235*
Cut 1	-1.988	-1.761	-2.837	-2.801
Cut 2	-0.407	-0.231	-1.167	-0.969
Cut 3	1.019	1.318	0.597	0.956
Cut 4	2.187	2.794	1.735	2.051
Log-likelihood	-1611.880	-1571.950	-2111.818	-1265.276
LR test	110.387	88.323	203.131	106.401
Pseudo $R^2$	0.085	0.074	0.123	0.109
$N$	1314	1201	1630	967

\* $p < 0.05$ ; \*\* $p < 0.01$ .

Pseudo  $R^2$  values are McKelvey and Zavonia's  $R^2$  values.

reporting feeling depressed or unhappy in the four Nordic countries.

Table I shows that women were significantly more likely than men to report having felt unhappy or depressed in the past four weeks in all the Nordic countries. In fact, it was one of only three factors that was significantly associated with depression in all four countries. The other factors that always mattered for depression were having a long-standing illness and not consuming fruits and vegetables regularly. Not surprisingly, those who reported a long-standing chronic illness or disability report higher levels of unhappiness and depression, in contrast with those who consumed more fruits and vegetables. Other relationships were as to be expected, but not consistently significant. With respect to social demographics, married people were less likely to report unhappiness in Denmark, Norway and Sweden, and the same was true for those with a college education in Norway and those in the labour force in Denmark, Finland and Norway. Turning our attention to lifestyle, the analysis showed that those who smoked were more likely to report depression in Finland, Norway and Sweden, and those who exercised more were less likely to do so in Denmark, Finland and Sweden.

Table II shows the results of the ordered logit for the likelihood of reporting loss of confidence in oneself. Again, women in all four Nordic countries were more likely to report loss of confidence than men, those with long-lasting illness were more likely to do

so in all four countries, and those who consumed fruits and vegetables regularly were less likely to do so. Here, there was also a consistent pattern regarding labour market status; specifically, those in the labour force in all four Nordic countries were less likely to have lost confidence in themselves. Other patterns were less consistent. Married people were less likely to report loss of confidence in Sweden, as were older people in Denmark, Finland and Norway and those with a college degree in Denmark. For lifestyle variables, those who drank more were more likely to report loss of confidence in Finland and those who exercised were less likely to do so in Finland and Sweden.

Table III presents the results from the ordered logit regression on the likelihood of feeling unable to overcome the problems one faces. As with the two other measures of mental well-being, women in all countries were more likely to report a lack of ability to overcome problems than men. The same consistent patterns appeared as for lack of confidence: those in the labour force and those who consumed fruits and vegetables more frequently were less likely to report being unable to overcome their problems, whereas those who had a long-standing illness were more likely to do so. Looking at other variables, married people were less likely to report that they could not overcome problems, as were older people in Norway. College educated people were also less likely to report being unable to overcome problems in Norway and Sweden. Looking at lifestyle factors,



Table II. Ordered logit regression of reporting to have lost confidence in oneself in the Nordic countries (2011 ISSP).

	Denmark	Finland	Norway	Sweden
<b>Female sex</b>	<b>0.590**</b>	<b>0.300*</b>	<b>0.615**</b>	<b>0.693**</b>
Other social demographics				
Married	-0.095	-0.079	-0.122	-0.331*
Age	-0.017**	-0.013**	-0.011**	-0.008
College	-0.344*	-0.052	-0.034	-0.213
In the labour force	-0.390**	-0.589**	-0.486**	-0.379**
Long-standing illness	0.556**	0.446**	0.511**	0.747**
Lifestyle				
Smoking	0.254	0.030	0.101	0.327
Alcohol consumption	0.021	0.211**	0.081	0.034
Physical activity	-0.087	-0.164**	-0.026	-0.190**
Fruits and vegetables	-0.259**	-0.189**	0.241**	-0.211*
Cut 1	-2.269	-1.668	-1.625	-2.062
Cut 2	-0.837	-0.217	-0.144	-0.578
Cut 3	0.575	1.418	1.425	0.980
Cut 4	1.488	2.389	2.867	2.018
Log-likelihood	-1514.248	-1404.331	-1940.701	-1167.582
LR test	123.004	87.069	118.324	116.197
Pseudo $R^2$	0.099	0.077	0.076	0.120
$N$	1310	1202	1620	963

\* $p < 0.05$ ; \*\* $p < 0.01$ .

Pseudo  $R^2$  values are McKelvey and Zavonia's  $R^2$  values.

Table III. Ordered logit regression of reporting to be unable to overcome one's problems in the Nordic countries (2011 ISSP).

	Denmark	Finland	Norway	Sweden
<b>Female sex</b>	<b>0.439**</b>	<b>0.323**</b>	<b>0.419**</b>	<b>0.306**</b>
Other social demographics				
Married	-0.181	0.024	-0.218*	-0.170
Age	-0.004	-0.002	-0.009**	-0.004
College	-0.299	-0.043	-0.279**	-0.360**
In the labour force	-0.440**	-0.555**	-0.580**	-0.399**
Long-standing illness	0.598**	0.486**	0.835**	0.962**
Lifestyle				
Smoking	0.238	0.136	0.152	0.618**
Alcohol consumption	0.002	0.074	-0.097	-0.178*
Physical activity	-0.095	-0.146*	-0.069	-0.173**
Fruits and vegetables	-0.206**	-0.269**	-0.336**	-0.223**
Cut 1	-1.591	-1.494	-2.650	-2.145
Cut 2	-0.020	-0.154	-1.201	-0.759
Cut 3	1.304	1.345	0.231	0.656
Cut 4	2.290	2.450	1.380	1.569
Log-likelihood	-1490.903	-1406.796	-1924.845	-1126.183
LR test	101.041	83.220	209.757	135.001
Pseudo $R^2$	0.082	0.074	0.131	0.143
$N$	1311	1205	1617	956

\* $p < 0.05$ ; \*\* $p < 0.01$ .

Pseudo  $R^2$  values are McKelvey and Zavonia's  $R^2$  values.

those who smoked were more likely to report being unable to overcome problems, but those who consumed more alcohol were less likely to report this in Sweden, as were those who exercised more in Finland and Sweden. Taken together, the findings show that gender was a persistent predictor of mental well-being in all the Nordic countries and the pattern was

clear: women were less likely to report mental well-being than their male counterparts.

## Discussion

I examined the size of gender differences in mental well-being in the Nordic countries compared with 28

other countries around the world and tested whether the gender differences remained when several other factors were taken into account. The results indicated that high levels of gender equality may not be as successful in eliminating inequalities in mental well-being as theory would expect. Specifically, the gender differences in mental well-being were neither particularly small in all four Nordic countries, nor did the countries cluster together as a coherent regime. In addition, observed gender differences may be due to differences in other types of status and lifestyle between men and women, yet models controlling for these do still show significant gender differences.

How do we explain these patterns? The most obvious explanation may be that despite high levels of gender equality in many areas of social life, perfect equality between genders has still not been achieved. For example, there are still inequalities in pay between men and women and research has shown that even though Nordic men do more housework than their counterparts in other countries, their female counterparts still do more [30,31]. However, the most important factor, especially in explaining how the Nordic countries compare with other countries, may be at least two-fold. First, the way that the labour market is organized maintains the traditional division of labour between the genders. Scholars have pointed out that the labour market in the Nordic countries is highly sex-segregated, even more so than in many other countries, including the liberal welfare states [32]. Some have argued that social policy in the Nordic countries, with its emphasis on female labour force participation, has in reality simply removed women from their traditional place within the home to a similar place within the public sector – that is, rather than taking care of children, the sick and the elderly through unpaid work within the home, they now do the same in the public sector, rewarded with salaries that are generally lower than those that men enjoy in the private sector or in more highly paid positions in the public system.

Second, there may be a mismatch between expectations and reality for women living in the Nordic countries and this may be especially important for mental well-being. From a young age, Nordic women are taught that they are equal to men in every way, that they can do the same jobs in the labour market and deserve the same opportunities and rewards as their male counterparts. Yet they are still likely to hit the glass ceiling at some point, like their counterparts in other countries, and they are still likely to have partners who do less than them when it comes to housework and the care of children and elderly relatives. Consequently, although they may objectively experience more equality than women in most other

societies, this may be accompanied by even greater expectations of a perfectly equal world. Along those lines, Sachweh and Olafsdottir [33] compared the perceptions of reality regarding stratification and aspirations of stratification in Sweden and Germany. They found that although the Swedes correctly identified their society as more equal than their counterparts in the USA and Germany, they had even greater aspirations than the citizens in those countries and were more likely to want even greater equality in their society. This mismatch is likely to have health implications for both men and women and those may be even more consequential for mental health than for physical health as they go to the core of how we experience ourselves and our role in society.

This study is not without limitations. First, I relied on self-reported items of mental well-being embedded in cultural experiences and expressions. Nevertheless, research has generally shown that self-rated health is a good measure to compare health across societies and my inclusion of three measures that capture mental well-being constitutes a strength. Moreover, in the comparison I relied on the gender differences rather than arguing that the mental well-being of women is better in one country than in another. Second, although the theoretical motivation for the paper is the underlying assumption that gender differences should be smaller in the Nordic countries, the paper does not explicitly test the impact of welfare state arrangements and policies. Rather, this paper is a first step in considering and empirically testing what impacts the mental health of men and women in the Nordic countries and how they compare with their counterparts in other societies. It is important for future work to build on existing theories and provide more nuanced empirical evidence for how the societal and individual factors come together to create gender-based health inequalities.

To conclude, this paper constitutes an early step in considering how the Nordic welfare state may relate to the mental health of men and women. It highlights two important research trajectories, one of continued work that compares a large number of countries and one of more detailed work that looks at within-country differences. It also underscores the importance of paying attention to multiple sources of inequalities within and across societies. Much of the cross-national work undertaken on inequality and health focuses on class-based inequalities, yet we know that there are multiple other important axes of inequalities that exist, including those based on gender, race/ethnicity, immigration, religion and sexual orientation. Moving beyond this paper, what is even more important is to develop research agendas that explore the intersections of inequalities, and to consolidate

our knowledge about class and health versus gender and health versus race and health. Only then will we start to get a complete picture of how and why inequality has such a profound impact, not only on whether we live or die, but even more importantly on the quality of our lives throughout our life courses.

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