Interpartner Health Links from a Dyadic Perspective: A Comparison of Different-Sex Married, Different-Sex Cohabiting and Same-Sex Couples in the National Health Interview Survey

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Extended Abstract

Introduction

A well-established finding in population health is that marriage is conducive to mental, physical health and longevity and that there are gendered pathways through which the health of married men and women benefits from marriage (Waite & Gallagher 2000). However, much of the theorization and empirical work of the relationship between marriage and health is built on the heteronormative assumption of gender role specialization in heterosexual marriages. Recently, examinations of health concordance among married couples have made significant contributions to our understanding of intimate relationships and health (Meyler, Stimpson & Peek 2007) but these studies also operated under such heteronormatively gendered assumptions. Moreover, the existing literature did not give sufficient attention to the rapidly growing population of heterosexual cohabiting and same-sex couples, who tend to attach less to gender role specialization (Brines & Joyner 1999; Goldberg 2013).

Emerging work on inter-spouse health concordance has challenged the gender role specialization model and adopted the gender-as-relational perspective to compare health and health behavior concordance among different-sex vs. same-sex couples (e.g. Holloway, Umberson & Donnelly 2017; Umberson, Donnelly & Pollitt 2018). Despite fruitful findings in

these emerging studies on nuanced gendered patterns of inter-spouse health concordance, they did not consider cohabiting couples and regional samples were used instead of nationally representative samples. To bridge these research gaps, the current study uses dyadic data to examine differences in inter-partner health links among different-sex married, different-sex cohabiting and same-sex couples from the National Health Interview Survey, 1997-2017.

Gendered Sexuality, Union Type and Health Concordance

Research shows that men and women benefit via gendered pathways in heterosexual marriages: married men reap health benefits from their wives' social control of health behavior and better household management skills whereas married women gain health advantage from their husbands higher earning power (Umberson 1992; Waite 1995). The gender-as-relational perspective suggests that how men and women enact health controls in intimate partnerships not only depend on their own gender, but also the relational context (different-sex vs. same-sex partnerships) (Goldberg 2013; Springer, Hankivsky & Bates 2012). Recent empirical findings showed that women in different-sex marriages were more likely to regulate their spouses' health habits than their counterparts in same-sex marriages whereas men in same-sex marriages exhibited more social control of health behavior than their peers in different-sex marriages, indicating that health controls depended on the relational contexts constructed by both individuals' own and their spouses' gender (Umberson, Holloway & Pollitt 2018).

The comparison of different-sex versus same-sex married couples in these recent studies fundamentally challenged the gender-role-specialization explanation for marriage-health link. Indeed, research suggests that different-sex cohabiting and same-sex partnerships tend to operate under the principle of equality more than gender role specialization, which characterizes different-sex marriages (Brines & Joyner 1999; Goldberg 2013). This further suggests that

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compared different-sex cohabiting and same-sex couples, different-sex married couples show greater interdependence on each other's specialized strengths to maintain their well-being. This greater interdependence would indicate that the health of couples in different-sex marriages could be more synchronized with each other than their peers in different-sex cohabiting and same-sex partnerships. In a similar vein, such gendered interdependence should be stronger in different-sex cohabiting than same-sex partnerships. Thus, the health concordance between different-sex cohabiting partners will be stronger than their same-sex counterparts. Furthermore, in light of gendered patterns of health behavior, it is also expected that there will be gendered patterns in the difference in interpartner health links by various union types.

Methods and Data

Data used in this study were pooled from the National Health Interview Survey (NHIS), 1997-2017. The Integrated Health Interview Series, a streamlined version of the NHIS, created partner IDs for married participants or those living with unmarried partners, which greatly facilitated the matching of partnered individuals in the NHIS samples. A total of 883,056 partnered individuals (i.e. 441,528 couples) were identified, who were at least 18 years old at the time of surveys and civilians. The average age was 47.52. Among the 441,528 identified couples, 1,818 were gay partnerships, 1,955 lesbian, 394,199 different-sex married and 43,556 different-sex cohabiting.

Actor-partner interdependence models in a multilevel framework were employed to estimate interpartner links in self-reported health. The analyses presented the unadjusted model, which included only partners' self-reported health, union types (different-sex marriage = 0) and interaction terms between partners' self-reported health and union types. Later models were further adjusted for sociodemographic covariates, including survey years, age, gender,

race/ethnicity, immigration status, south residence and education. Significant interactions between partners' self-reported health and union types suggest significant difference in interpartner health links between different union types. A series of three-way interactions among partners' self-reported health, union types and gender were also included in the model to assess whether difference in interpartner health links also varied by gender.

Results

Table 1 presented the intra-class correlation coefficients (I.C.C.) from unconditional multilevel models by union types where a higher I.C.C. indicates stronger health concordance between partners. The results indicated that different-sex married couples showed the strongest interpartner health link than the other union types.

[Table 1 about here]

Table 2 reported results from the actor-partner interdependence models. The unadjusted model indicated that compared to different-sex marriages, different-sex cohabiting and same-sex unions showed significantly weaker health concordance between partners. Adjusted further for sociodemographic covariates, Model 2, the baseline model indicated that while same-sex couples showed significantly weaker health concordance compared to different-sex married couples, there was no significant difference between different-sex married versus different-sex cohabiting relationships.

[Table 2 about here]

Further analyses of three-way interactions in Model 3 showed distinct gendered patterns in the difference in health concordance by union types. While there was significant difference in health concordance between different-sex marriages and same-sex partnerships, it was primarily among men in gay partnerships. There was no significant difference in interpartner health links

between women in different-sex marriages and their counterparts in lesbian unions. In a similar vein, the significant difference between different-sex marriages and different-sex cohabiting unions primarily existed among men where the health concordance was weaker for men in different-sex cohabiting unions. Women in different-sex cohabiting unions showed significantly stronger health concordance than their peers in different-sex marriages.

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Table 1. Intra-Class Correlations from Unconditional Multilevel Models by Union Types

Union type	I.C.C.
Gay partnerships	0.574
Lesbian partnerships	0.590
Different-sex marriages	0.642
Different-sex cohabiting unions	0.627

Table 2. Actor-Partner Models of Health Concordance by Union Types (N=883,056)

	Model 1: unadjusted model	Model 2: baseline model	Model 3: gender interaction model
Partner's SRH	0.642 (0.001)***	0.577 (0.001)***	0.589 (0.001)***
Partner's SRH × same-sex partnership	-0.059 (0.009)***	-0.032 (0.009)***	-0.058 (0.013)***
Partner's SRH × different-sex cohabiting	-0.015 (0.003)***	-0.0003 (0.003)	-0.014 (0.004)***
Partner's SRH × female			-0.024 (0.002)***
Partner's SRH × same-sex partnership × female			0.046 (0.018)*
Partner's SRH × different-sex cohabiting × female			0.029 (0.005)***
Same-sex partnership × female			-0.236 (0.071)**
Different-sex cohabiting × female			-0.202 (0.021)***
Union type (different-sex married=0)			
Same-sex partnership	0.257 (0.036)***	0.070 (0.035)*	0.200 (0.053)***
Different-sex cohabiting	0.054 (0.011)***	-0.068 (0.011)***	0.031 (0.015)*
Survey year		-0.002 (0.0001)***	-0.002 (0.0001)***
Age (centered at 18 y.o.)		-0.009 (0.0001)***	-0.009 (0.0001)***
Female (male=0)		-0.014 (0.002)***	0.087 (0.007)***
Race/ethnicity (non-Hispanic white=0)			
Non-Hispanic black		-0.085 (0.003)***	-0.085 (0.003)***
Non-Hispanic other races		-0.085 (0.004)***	-0.085 (0.004)***
Latino		-0.058 (0.003)***	-0.058 (0.003)***
Immigrant (U.S. born=0)		0.052 (0.003)***	0.052 (0.003)***
Living in the South (no=0)		-0.025 (0.002)***	-0.025 (0.002)***
Education (less than high school =0)			
High school graduate		0.157 (0.003)***	0.156 (0.003)***
Some college		0.213 (0.003)***	0.213 (0.003)***
College graduate or above		0.362 (0.003)***	0.362 (0.003)***
Intercept	1.348 (0.003)***	4.999 (0.276)***	4.979 (0.276)***

Note: *p<0.005 **p<0.001 ***p<0.0001; missing cases were flagged and controlled with dummy indicators.