

Effects of Self-Rated Health on Union Formation and Dissolution in Six Countries

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The German data come from the Socio-Economic Panel (SOEP) study. The SOEP is a representative longitudinal study of private households, conducted by the German Institute for Economic Research (DIW Berlin). The data used in this study were accessed via the Research Data Center (FDZ) of the SOEP at DIW Berlin. *Citation:* Socio-Economic Panel (SOEP), data for years 1984-2020, SOEP-Core v37, EU Edition, 2022. <https://doi:10.5684/soep.core.v37eu>

The Korean data come from the Korean Labor & Income Panel Study (KLIPS) conducted by the Korea Labor Institute. *Citation:* Korean Labor & Income Panel Study, Waves 1–24. Korea Labor Institute.

The Swiss data come from the Swiss Household Panel (SHP), which is based at FORS (the Swiss Centre of Expertise in the Social Sciences). The SHP is financed by the Swiss National Science Foundation. *Citation:* Tillmann, Robin, Marieke Voorpostel, Eleonora Antal, Ursina Kuhn, Florence Lebert, Valérie-Anne Ryser, and Dominique Joye. 2023. Swiss Household Panel (SHP), W1-W22. FORS. <https://doi.org/10.23662/FORS-DS-0011-12>.

The UK data come from the British Household Panel Survey (BHPS) and Understanding Society – the UK Household Longitudinal Study, originally collected by the Institute for Social and Economic Research at the University of Essex. The data were made available through the UK Data Service. *Citation:* University of Essex, Institute for Social and Economic Research (2025). Understanding Society: Waves 1-14, 2009-2023 and Harmonised BHPS: Waves 1-18, 1991-2009. 19th Edition. UK Data Service. SN: 6614. <http://doi.org/10.5255/UKDA-SN-6614-20>

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The Russian data come from the Russia Longitudinal Monitoring survey (RLMS), conducted by the National Research University Higher School of Economics and ZAO "Demoscope" together with the Carolina Population Center, University of North Carolina at Chapel Hill and the Institute of Sociology RAS. *Citation:* Higher School of Economics & University of North Carolina at Chapel Hill (2023). Russia Longitudinal Monitoring Survey—HSE, 1994–2022. <https://www.cpc.unc.edu/projects/rlms-hse>

Abstract: Many studies demonstrated protective effects of marriage on health, but studies on the reverse pathway are more limited and provided mixed findings. Using large-scale data from annual longitudinal panel surveys, the current paper estimates discrete-time event-history models to analyze how self-rated health affects transitions in and out of marriage and cohabitation. Harmonized panel data are used for Australia, Germany, (South) Korea, Russia, Switzerland, and the UK. The study finds adverse effects of poor self-rated health on all transitions: union formation, marriage formation, separation, divorce, and repartnering. Effects were smaller for the formation than for the dissolution of unions and smaller for the transition to cohabitation than to marriage. Few gender differences were found but health effects on union dissolution declined with age. With exceptions, the impact of health was strikingly similar across the six countries. In general, the findings suggest an accumulation of health-related inequalities in the marriage market.

Running head: Health effects on union transitions

The vast majority of studies examining health and marriage have focused on the pathway from marriage to health, analyzing the effects of the entry into marriage or the effects of divorce, typically done in separate studies. In general, there is much evidence supporting a protective effect of marriage, but findings do depend on whether 'loss or gain' is analyzed (i.e., formation or dissolution), whether mental or physical health is considered, and whether short- or long-term effects are studied (Carr and Springer 2010, Kalmijn 2017, Lin et al. 2019, Mikucka, Becker and Wolf 2021, Monden and Uunk 2013, Umberson, Crosnoe and Reczek 2010, Waite and Gallagher 2000, Williams and Umberson 2004, Williams and Dunne-Bryant 2006, Williams 2003).

In the slipstream of this research tradition, a second hypothesis emerged, an idea that has been tested as well but not developed as extensively as the original idea. People's health may improve when they are embedded in strong and supportive networks, but people in poor health may also be less likely to develop such networks or may even lose ties in their network when their health declines (Schaefer, Kornienko and Fox 2011). The notion that poor health may damage relationships is general, applying to a range of ties. In the current study, the research question is if and to what extent self-rated health affects the formation and dissolution of unions?

Studies have examined aspects of this relationship, typically for single countries, and especially in the US. As reviewed below, evidence for reverse causality has been more convincing for union dissolution than for union formation and more consistent for mental health than physical health (Metsä-Simola et al. 2021, p. 674). The current state of the art leaves considerable room for improvements in the test of the key hypothesis, and that is where the current study contributes. We use an event-history approach where the risk of making union transitions is regressed on health in long-running annual panels, along with good controls for correlated determinants such as employment and income. We provide a

robust set of findings on the key effect of health on unions in a harmonized data set covering six countries (Turek, Kalmijn and Leopold 2021). Moreover, we analyze a broad set of transitions with similar measures and designs: cohabitation, marriage, separation, divorce, and repartnering. Our key health measure is self-rated health, a measure that predicts mortality well (DeSalvo et al. 2005, Idler and Benyamini 1997) and is strongly correlated with mental and physical health conditions (Hamplová, Klusáček and Mráček 2022).

The question of reverse causality is relevant for several reasons. First, health effects are important in the context of aging. People live longer, more people experience health problems, and many require informal care. If poor health corrupts relationships, there is a risk of underutilizing social support in this important stage of the life course. For both mental and physical health problems in old age, this can provide a challenge: people need support, but simultaneously, relationships become more challenging and unstable. Second, health effects are relevant for the Second Demographic Transition (SDT). The SDT is characterized by declining marriage, increasing divorce, and an increasing prevalence of repartnering, also in old age (Lesthaeghe 2014). In general, the partner relationship has become more unstable over time, but the search and selection of a partner have become more conscious, stringent, and competitive as marriage increasingly symbolizes status and success in life (Cherlin 2009). In addition, the growing societal emphasis on good health, combined with rising negative attitudes toward people with mental health problems (Schomerus et al. 2012) may have made health considerations increasingly important for partner selection and may give rise to new inequalities in the marriage market.

The six countries studied are Australia, Germany, (South) Korea, Russia, Switzerland, and the UK. The choice of countries was pragmatic: these are countries with long-running annual panel surveys with comparable measures of respondents' economic, demographic, and social characteristics. The primary goal is to explore how general the effects of health are on

unions, and for this reason, it is important to see if the effect can be found in multiple countries. Most studies in the past are based on a single country, with evidence for the US being dominant. Four of the countries are typical SDT countries (Lesthaeghe 2014), whereas two are more special, with Korea as an example of the Asian marriage pattern (Raymo et al. 2015) and Russia as a post-transition country with historically a different marriage pattern (Gerber and Berman 2010). There can be differences between countries in the magnitude of the health effects, and these differences can be associated with country-level characteristics, such as economic development, family values, and health policies. However, testing cross-level interactions in a multilevel framework – between individual health and country-level characteristics – is beyond this paper as it would require a substantially larger number of countries.

BACKGROUND

Theoretical Mechanisms

Several theoretical mechanisms have been suggested to explain how health may affect marriage. For marriage formation, health may function as a screening or selection criterion in the marriage market (Goldman 1993, Goldman and Hu 1993) alongside other traits such as education, income, personality, and physical attractiveness. Health and attractiveness are correlated, and their relevance to partner selection has been interpreted in genetic and social terms. Genetically, health screening can be an unconscious evolutionary strategy to enhance a person's reproductive value (Buss and Schmitt 2019). In social terms, health screening can enhance the resources and protection a partner may offer during the relationship (Weeden and Sabini 2005). When considering a wider range of health issues, including disability, it is important to also consider discrimination. Studies have documented negative attitudes toward people with disabilities and mental illness, with possible adverse implications of health

problems for the opportunities that people have in the partner market (Goreczny et al. 2011, Mehta et al. 2009). In online dating research, health is not commonly mentioned as an explicit criterion, but there is explicit selection based on BMI, which is correlated with health (Skopek 2023).

Health problems may also make marriage, once formed, more difficult. Especially when health problems are severe and chronic, poor health may reduce a person's mobility and increase care needs, making a relationship more demanding. A vast body of literature on the burden of care has documented the adverse effects of partner health on individual well-being (Pinquart and Sörensen 2011). Such effects do not automatically imply a heightened risk of relationship dissolution since many partners are known to stay in a relationship despite declines in individual well-being (Penning and Wu 2019). Other mechanisms beyond care burden play a role as well, such as reduced pleasure and communication in the relationship when there are health issues, more conflict about day-to-day life, and withdrawal tendencies on the part of the ill person (Karraker and Latham 2015, Lam, Vidal and Baxter 2020, Schaefer, Kornienko and Fox 2011). Supporting evidence for these latter mechanisms can be found in studies showing adverse effects of the partner's (physical and mental) health problems on the respondent's perceived relationship quality (Lewin 2017, Min et al. 2020, Yorgason, Booth and Johnson 2008).

Some authors have argued for adverse health selection into marriage (Kulu, Franke and Mikolai 2024, Lillard and Panis 1996). If marriage benefits health, men and women with poor health may be more likely to seek marriage and be motivated to stay married in order to reap the benefits of marriage for their health and well-being. Marriage, in this reasoning, is viewed as an individual health input. Arguments about adverse and positive selection may both be true, with less healthy people being more strongly motivated to seek a partner while

simultaneously being less attractive in the marriage market as a potential partner (Guner, Kulikova and Llull 2018, Meyler, Stimpson and Peek 2007, Monden 2007).

Past Findings

Studies addressing reverse health effects have most often been done for divorce. Many studies found that depression, distress, and mental or psychiatric disorders were associated with an elevated risk of divorce (Idstad et al. 2015, Kessler, Walters and Forthofer 1998, Mastekaasa 1995, Mojtabai et al. 2017, Percheski and Meyer 2018). Longitudinal analyses in the UK showed increases in mental health problems already in the years before divorce, not only after divorce, suggesting either selection effects or anticipated divorce effects (Wade and Pevalin 2004). One instrumental-variable analysis, in contrast, found opposite effects for men, with poor health making marriage more stable (Lillard and Panis 1996).

Other studies have focused on physical health problems and offered a mixed picture. A panel study in Australia found positive effects of health disabilities on divorce in Australia (Lam, Vidal and Baxter 2020), but a panel study among older couples in the US found no effects for husbands and only marginally significant effects for wives (Latham-Mintus, Holcomb and Zervos 2022). Epidemiological studies often use a two-wave design or a design with a baseline health measure and follow-up data for divorce. These studies have provided inconsistent evidence. Cancer did not appear to elevate the divorce risk (Carlsen et al. 2007, Dorval et al. 1999, Ganz et al. 1998, Syrjala et al. 2005, Syse and Kravdal 2007), but other serious medical conditions such as stroke, Parkinson's disease, and multiple sclerosis did increase the risk of divorce, suggesting that health effects depend on the nature of the disease (Landfeldt et al. 2018, Metsä-Simola et al. 2021, Trygged, Hedlund and Kåreholt 2011).

Studies on marriage formation suggest that positive selection into marriage may be modest. Some early studies found strong effects of well-being on marriage formation

(Mastekaasa 1992), but included aspects of life satisfaction in the measure, making the design less helpful in examining the role of health. Studies directly examining mental health measures (i.e., depression) so far found weak or inconsistent effects on marriage formation (Lamb, Lee and DeMaris 2003). Evidence for broader health issues is inconsistent as well. A Dutch study found no effect of self-rated health on marriage formation (Joung et al. 1998), but a British study did find negative effects of poor self-rated health and health problems on early marriage formation (Cheung and Sloggett 1998). There is also evidence that goes in the opposite direction, showing that health problems increased the probability of entering a union (Kulu, Franke and Mikolai 2024, Lillard and Panis 1996).

Since marriage formation often occurs at younger ages, physical health issues will not be common and, hence, more difficult to analyze in longitudinal survey research. The case of repartnering could therefore provide a more relevant view of selection effects since physical health issues play a more pronounced role, especially given the increase in late-life divorce (Brown and Lin 2012). Few studies have analyzed the effects of health on repartnering. One analysis of repartnering after a late-life divorce showed weak and insignificant effects of physical health problems on repartnering and no difference between the marriage and cohabitation routes into a new union (Brown et al. 2019). A cross-sectional study in Canada showed that remarried persons less often had a chronic illness compared to single divorced persons of similar age (Schimmele and Wu 2016), suggesting positive selection into remarriage.

Overall, it appears that the evidence for health effects on union formation is not fully clear, whereas there is more supportive evidence for the effects of poor health on union dissolution. In addition, the evidence appears more convincing for mental health issues than for physical health problems (Glantz et al. 2009). Interestingly, this conclusion mirrors the evidence for the effects in the other direction – of marriage on health – which appear more

consistent for dissolution than for formation (Kalmijn 2017, Mikucka, Becker and Wolf 2021). Studies on the transition from cohabitation to marriage and the likelihood of repartnering are scarce.

Hypotheses

The current study examines multiple union transitions. Based on the theory and previous studies discussed above, we can suggest a number of hypotheses about possible differences in health effects among the transitions. First, there is the contrast between formation and dissolution. In the search for a partner, health problems may not always be visible, whereas within a union, health problems will become directly apparent and also affect how the union functions, with negative interaction and care burden as a potential outcome. As a result, one would expect the effects of health to be stronger on the dissolution of a union than on the formation of a union.

We also have expectations regarding the difference between marriage and cohabitation. As explained above, people will evaluate the expected future burden of health problems when considering potential partners. Because the marriage transition requires a greater degree of commitment and a longer time horizon, whereas cohabiting unions may have a more experimental nature, allowing some degree of uncertainty (Blossfeld et al. 2005), one would expect that health effects are stronger on marriage than on cohabitation. This is also suggested by research showing that marriage requires a stronger economic underpinning than cohabitation (Kravdal 1999). The dissolution of cohabiting unions can also be more strongly affected by health problems than divorce, since possible health effects emerging during the trial stage have already been weeded out after the transition to marriage.

For repartnering, finally, health effects will be plausible as well. People can be more critical the second time around, especially when they are older, and health problems can be

more salient in people's mind. As a result, one would expect stronger effects of health on repartnering than on first union formation.

The current study also explores heterogeneity by gender and age. Some authors have argued that men's health would be more impactful, especially in a male breadwinning context, given the importance of health for a family's socioeconomic status (Lam, Vidal and Baxter 2020, Teachman 2010). There is evidence that men's health problems have a stronger effect on divorce (Metsä-Simola et al. 2021), but there are also studies finding that women's illness has a stronger effect (Glantz et al. 2009). Most studies, however, found only modest gender differences in the effects of direct health indicators on union dissolution (Karraker and Latham 2015, Wade and Pevalin 2004). For the entry into marriage, some authors have argued that in traditional gender role settings, good health belongs to the typical 'female' qualities men value more in the marriage market (Amador et al. 2005, Johannesen-Schmidt and Eagly 2002). In contrast to such ideas, most studies point to similarities rather than differences in how men and women rank health as a selection criterion in the partner market (Buss and Schmitt 2019).

Age is a potential source of heterogeneity as well. In the younger years, health problems are less common and – partly because of that – not normative (Karraker and Latham 2015). Moreover, health problems at younger ages may signal uncertainty regarding the future course of a relationship, making it more difficult to commit (Oppenheimer 1988). For the risk of divorce and separation, age may also play a role. At older ages, health problems are more likely to be expected and, therefore, less difficult to deal with when in a union. Moreover, both spouses may expect to develop health issues, fostering the mutual acceptance of each other's health problems.

Another reason for expecting age differences lies in the length of the union. At longer durations, couples will develop a certain amount of loyalty, making it easier for partners to

deal with adversity. Or, to turn it around, when people have invested little in the relationship, health problems may be perceived as a more legitimate reason to end the relationship. Since union duration and age are positively correlated, this is another reason why health problems will affect older couples less than they affect younger couples.

DATA AND METHODS

Data

We use national longitudinal panel data from Australia, Germany, Korea, Russia, Switzerland, and the UK. A selection of variables from the original data in the national panels was combined and harmonized into a single panel data set (Turek, Kalmijn and Leopold 2021). For the original panel studies, see the reference list. All panels were nationally representative, included all adult ages, had refreshment samples along the way, and included specific oversamples, for example, for minority groups. For this study, data were selected for which relevant health information was annually available: Australia (2001-2020), Germany (1994-2020), Korea (2003-2021), Russia (2004-2021), Switzerland (1999-2020), and the UK (1991-1998 and 2001-2020).

The starting sample included 261,413 respondents who participated at least twice in the relevant panel period. We deleted person-years for which health information was missing, leaving 259,345 respondents, and persons with missing information on marital status anywhere in the panel, leaving a sample of 257,596 respondents. Before making these selections, we used health information from the previous wave if it was missing in one wave but valid in the previous wave. After listwise deletion of missing values (see below), the remaining sample size was 255,991. The analytical sample sizes differ, depending on the transition analyzed. The average age of the respondents in the panel was 48.1, with a range of 18-105. Summary statistics of key variables are presented in Table 1.

Dependent Variables and Design

Three outcome variables were analyzed in the paper (see also Table 1 for details). First, we analyzed the *entry into a union*, conditional on living alone and being ‘never married.’ Second, we analyzed *union dissolution*, defined as the transition from living with a partner (while being either married or ‘never married’), to living without a partner. Third, we analyzed *repartnering*, defined as being divorced or widowed while living alone, to living with a partner. For Korea, information on cohabitation was missing, so here, all transitions were based on the marital status variable: the transition from being never married to being married, the transition from being married to being divorced, and the transition from being widowed/divorced, to being married. The limitation to marital transitions is unproblematic given that unmarried cohabitation has been rare in Korea (Raymo et al. 2015).

To keep the main findings transparent, we analyzed the distinction between marriage and cohabitation in separate models. Specifically, we used a competing risk analysis for the distinction between direct marriage and cohabitation. Specifically, we analyzed the transition from being single and ‘never married,’ to (a) living with a partner while not being married vis-à-vis (b) living with a partner and being married. Next, for people who were living with a partner while being ‘never married,’ we analyzed the likelihood of marriage. Finally, we added (time varying) marital status (cohabiting versus married) to the model of union dissolution, along with an interaction of marital status and health. This model allows us to assess differences between the dissolution of marriage and cohabitation (Table 4). More details are again provided in Table 1.

For all models, a person-wave (long) file was created for all respondents to estimate the models. The risk period in each file begins when respondents were at risk of experiencing an event (as defined in the previous two paragraphs). Respondents were observed until they

experienced the relevant event or, if they did not experience the event, were censored at the last year in which they participated. For the analysis of union dissolution, respondents were censored if they became widowed. No information was available on the death of a cohabiting partner but given the ages at which cohabitation occurs, this will not be a common event. For the analysis of the transition from cohabitation to marriage, respondents were censored if they dissolved their union.

Using the person-wave file, we estimate discrete-time event-history models (logit models) predicting the risk of making a transition in a given year (cf., Lam, Vidal and Baxter 2020). Health was measured each year, and we tested whether persons with different levels of health were more or less likely to make a union transition in the *following* wave. The standard errors were clustered for the dependence of annual observations within persons. Weights were not applied since many of the variables used in the weights are in the model.

To model time dependence, we used detailed age categories in all models. The categories were defined differently for union formation and dissolution since less detail was needed for union dissolution in the lower ages. Union duration is a relevant variable for union dissolution, but this information was incomplete in the data. In Appendix 1, we examine data from the German part of the panel, augmented with the marital histories of the panel (Hamjediers, Schmelzer and Geschke 2020). These data have the starting date of marriages, which allows us to estimate the risk of divorce correctly, even with left censoring (Guo 1993). The analyses in Appendix 1 show that omitting union duration in the analysis of divorce produced no bias in the health effect.

Health Effects

Our key independent variable is self-rated health (SRH) assessed in five categories (Idler and Benyamini 1997), with slightly different labels in the different countries, but generally

ranging from excellent or very good, to bad or very bad (1-5). The self-rated health variable was used as a continuous variable in all models for a number of reasons. First, earlier studies suggested that a linear approach to self-rated health is a parsimonious way to estimate health effects (Perneger et al. 2013). Second, the categories were not fully similar across countries, which would require an undesirable collapsing of categories. Third, we tested linear and discrete versions of the health effects using the BIC and found overwhelming evidence that the fit of a linear model was better (see Appendix 2). To evaluate effect sizes across models and countries, we standardized health variables within countries using all data in each country ($M = 0$, $SD = 1$). We assessed how much lower the odds of union formation were for each standard deviation increase in poor health (i.e., $1 - e^\beta$). Similarly, we assessed how much higher the odds of dissolution were for a standard deviation increase in poor health (i.e., $e^\beta - 1$). In a logit model estimated on a person-period file, OR's are similar to hazard ratios (George, Stead and Ganti 2020, Yamaguchi 1991).

Control Variables

We used a number of control variables that can be correlated with health and that are known to affect the formation and/or dissolution of unions (Härkönen 2014, Kalmijn 2011, Lyngstad and Jalovaara 2010). The following variables were included: (a) employment status (distinguished in employed, retired, enrolled, unemployed, and other), (b) standardized household income, (c) education (lower, middle, and higher), (d) religious affiliation (yes or no), (e) cohabitation status (for the analysis of union dissolution), (f) the number of children (for the analysis of union dissolution), (g) widowed versus divorced (for the repartnering analysis), (h) period (year of observation), and (i) race/ethnicity (UK). Employment was interacted with gender since the effects of employment are known to differ for men and women (Killewald 2016, South 2001, Van Damme 2010).

The socioeconomic variables (employment status and income) can play a mediating and confounding role. A disadvantaged socioeconomic position may have been one of the causes of health problems, but poor health may also lead to lower employment and income. In the former case, socioeconomic variables confound the health effects, and in the latter case, they mediate the health effects. For this reason, we estimated models without (Model 1) and with (Model 2) the socioeconomic variables but abstained from a formal mediation analysis.

Missing values on the control variables were first imputed with information from one previous wave, if available. After this, the proportions of missing values were 0.4% for education, 0.5% for income, 1.5% for children, less than 0.1% for employment, and 15.8% for religiosity. Since only religiosity was missing frequently, it was decided to use (country-specific) mean imputation for this variable, along with a separate indicator variable for religiosity being missing. Health and marital status were not imputed. After this, we applied listwise deletion.

FINDINGS

The numbers of events for all transitions are presented in Table 1. The results of the event-history models are presented in Table 2 for union formation, Table 3 for marriage versus cohabitation, Table 4 for union dissolution, and Table 5 for repartnering. Full regression results can be found in Appendix 3.

Union Formation

The estimates of the event-history models for union formation are presented in Table 2. Estimates for Model 1 are not adjusted for employment status and income. In five of the six countries, there were negative effects of poor health on union formation, and in four, the

effects were significant. Effect sizes were modest to large when looking at the relative degree by which the odds of union formation were reduced per standard deviation increase in poor health ($1 - e^\beta$). The relative effect was 7.8% in Australia, 12.5% in Korea, 4.2% in Russia, 9.2% in Switzerland, and 8.6% in the UK. The effects were smaller after controlling for employment and income in Model 2 but still significant in four countries. In Germany, the health effects were insignificant and negligible in size in both models.

People who enter a union can be married or unmarried. Table 3 presents a multinomial logit model for this contrast, controlling for socioeconomic variables. The health effects on marriage were negative and significant in all six countries, with substantial effect sizes, ranging from 12.0% in Russia to 23.1% in Switzerland (Model 1). The effects of poor health on cohabitation were smaller than they were on marriage and in some cases even slightly positive. Tests show that the contrast between the health effects on marriage and cohabitation was significant in Germany and Russia and marginally significant in Switzerland and the UK.

For those who were unmarried at the beginning of their union, we examined the transition to marriage, with dissolution being censored. These models, presented at the bottom of Table 3, yielded negative and significant effects of poor health in all countries (Model 1). The poorer a person's health, the smaller the likelihood of cohabitation being formalized into marriage. Note that for both the initial state and the subsequent transition to marriage, effects of health were reduced between Model 1 and Model 2, showing that health effects on marriage can in part be attributed to socioeconomic differences.

Union dissolution

Turning to union dissolution, we observed an interesting pattern of findings (Table 4). The difference in the dissolution risk between people with varying levels of health was significant

in five of the six countries (Model 1). In Russia, the effect of poor health was not significant and also trivial in magnitude. Effect sizes in the other countries were substantial. The relative increase in the odds of dissolution per standard deviation increase in poor health was 17.0% in Australia, 13.3% in Germany, 15.3% in Switzerland, and 19.4% in the UK. In Korea, the effect of poor health was substantially stronger (29.2%). In general, the effects were smaller when adding employment and income (Model 2). However, effects were still significant, and the remaining effect sizes were substantial.

To explore differences between dissolutions of marriage and cohabitation, interaction effects were included between health and the type of union, which was included as a time-varying covariate. Only in Russia did we find a significant interaction. The effect of poor health on divorce was negative and not significant ($\beta = -.041$) whereas the effect of poor health on the dissolution of cohabitation was positive ($\beta = -.041 + .141 = .100, p = .017$), amounting to an increase in the odds of union dissolution of 10.5% per standard deviation increase in poor health. The stronger health effect on the stability of 'trial marriages' is in line with expectations but apparently limited to Russia. Another implication of this finding is that there is now also evidence for a health effect in Russia, something not visible in the main model collapsing union types.

Repartnering

After divorce and widowhood, substantial numbers of people repartner, although men more often than women (Ivanova, Kalmijn and Uunk 2013). To what extent does health play a role for union formation when people are divorced or widowed? This question was answered by analyzing the effects of poor health on repartnering (Table 5). The analyses were conditional on people having dissolved a marriage, either via divorce or widowhood. As Appendix 3

shows, repartnering was less likely after widowhood than after divorce, and women were less likely to repartner than men.

For all six countries, we found that the risk to repartner was reduced for people in poor health (Table 5). Effect sizes were substantial, ranging from a reduction of 11.8% in Russia to 16.5% in Australia. In Switzerland, the effect was also negative but small and insignificant. When controlling for employment and income (Model 2), effects were still significant and meaningful in size.

Heterogeneity

Heterogeneity was first addressed by examining gender differences. We interacted the health variables with gender for union formation and dissolution (Table 6). Interactions were estimated with and without controlling for employment and income to assess if possible gender differences in health effects were suppressed by socioeconomic differences. Selected estimates of the logit models are presented in Table 6. Marginal effects were also estimated, and these yielded the same conclusions and were therefore not presented. The main effects in Table 6 apply to women; the interaction effects inform us how much stronger or weaker the effects were for men.

Of the 12 interaction effects estimated, two were significant and these pertain to union formation in Russia and Switzerland. In these two countries, the effects of poor health on union formation were weaker for men than for women. For example, in Russia, the effect of women's poor health on union formation was $\beta = -.085$ whereas this effect was virtually absent for men ($\beta = -.085 + .096 = .011$). A similar pattern was found in Switzerland where women's health was an impediment for union formation, but men's health was not ($\beta = -.160$ versus $\beta = -.019$). Controlling for socioeconomic variables did not change the interaction

effects. Since no interactions were found in the other four countries or in any country for union dissolution, evidence for gender heterogeneity remains limited.

To explore heterogeneity by age, we interacted the health effects with the age categories and present margins for different age groups in Figure 1 for union formation and Figure 2 for union dissolution. Margins were calculated for those in good health and those in poor health (defined a two standard deviations below and above the mean). Evidence can be observed for age heterogeneity. In three countries (Australia, Switzerland, and the UK), we found weak effects on union formation for very young people, increasing effects for people in their twenties and early thirties, and declining effects again when people were older. For union dissolution risks, presented in Figure 2, age interactions were stronger and more systematic. In all countries, the gaps in the risk of union dissolution between people in poor and good health declined gradually with age. This pattern was most systematic in Australia, Germany, Korea, and the UK.

Control variables

In general, the effects of the control variables (Appendix 2) were in line with what is known from the research literature (Härkönen 2014, Kalmijn 2011, Lyngstad and Jalovaara 2010). Employment effects were gendered, with positive effects of men's employment on union formation and negative effects on union dissolution. Gender and employment interactions were (marginally) significant for both formation and dissolution in several countries (Van Damme 2010). After calculating the implied effects for women (i.e., the main effect plus the interaction effect), there appeared to be few effects of women's employment on union formation and positive effects of women's employment on union dissolution in a few of the countries. Income effects were positive for direct marriage and for marriage after cohabitation while negative for dissolution. There were also positive effects of higher

education on union formation and negative effects on union dissolution in most countries, which is in line with the literature (Matysiak, Styrc and Vignoli 2014). Religiosity primarily affected the choice between marriage and cohabitation as the first mode of union entry (Eggebeen and Dew 2009). The models for repartnering show that employed men were more likely to repartner, while these effects were often smaller for women. While income had the expected positive effects on repartnering, no effects emerged of education on repartnering.

CONCLUSION AND DISCUSSION

While there is a large body of literature on the beneficial effects of marriage on health, comparatively few studies have examined the reverse pathway from health to marriage. This paper contributes to the literature by analyzing the effects of self-rated health on unions by using long-term annual longitudinal data from six countries and studying multiple union transitions with a similar set of time-varying variables. Our findings lead to robust conclusions. In virtually all countries, poor health affected union transitions. In general, effects were stronger without controls for employment status and income, suggesting that part of the overall effects were confounded or mediated by socioeconomic factors. However, even after controlling for these variables, the effects remained sizeable and significant for all transitions.

Several theoretical interpretations were offered for the overall effect of health. Poor health may function as a direct or indirect selection criterion in the partner market in light of the expected benefits of having a healthy partner or the expected practical or emotional burden of having a partner with health issues. Health problems may not always be visible at the dating stage, but if they are, it would not be difficult to continue searching for a partner. For dissolution, mechanisms are similar, but the process is different. During a union, health

problems may affect how a relationship functions and thus be more directly felt. Care burden plays a role, but authors have also pointed to reduced marital quality.

Our study estimated the effects of health on multiple transitions. Figure 3 summarizes the findings, displaying the effects of poor health for all countries and transitions. We chose the odds ratio (OR) as the key effect size, each time comparing people with a standard deviation difference in self-rated health (scaled in a 'positive' direction and adjusted for all covariates). Effects were broadly similar in magnitude across the transitions, but there were also differences in degree. The odds ratios were higher for union dissolution than for union formation and somewhat higher for repartnering than for first union formation. Moreover, in most countries, we found stronger effects on marriage than on cohabitation and additional health effects on the transition from cohabitation to marriage.

Why do the effects differ across transitions? One explanation we suggested of why effects were stronger for marriage lies in the nature of cohabitation. Cohabitation is often considered a trial marriage, which leaves more room for uncertainty. Marriage requires more commitment (Hiekel, Liefbroer and Poortman 2014), which would explain why health effects are stronger for marriage formation than for union formation. Why were the effects stronger for the dissolution than for the formation of unions? One reason is that health problems may have a more immediate and recognizable impact during a union. Moreover, feedback loops can be involved in the process. Marital quality may decline first, negatively affecting mental health, which in turn reduces marital quality (Umberson et al. 2006). The reciprocal link between marital quality and mental health may increase the magnitude of the health effects on union dissolution, which may be one reason why the effects are stronger on union dissolution than on union formation. The difference between marriage and cohabitation may play a role as well. Union formation has the option of a trial union – cohabitation – and this may lead to smaller overall health effects on this transition. When comparing health effects

on union dissolution to health effects on *marriage* formation, no clear differences were observed (Figure 3).

Figure 3 also displays the countries. With a few exceptions to be discussed shortly, there were striking similarities in the relative effect sizes of health across countries, both on formation, dissolution, and repartnering. We tested country differences for these three outcomes by pooling the countries and comparing models with and without interaction effects of health and country. In each case, the model without health and country interactions had a lower BIC, and hence, a better fit, than the model with interactions, confirming the conclusion that effects are relatively similar across countries (see bottom of Figure 3).

We conclude that the theoretical mechanisms discussed are general and not dependent on the context. Korea was the most apparent exception, with considerably stronger effects of poor health on marriage dissolution. The effect on marriage formation was also stronger in Korea than it was in most other countries. Interpretations of this finding may be sought in the less efficient dating market in Korea combined with greater involvement of the family network in marriage (Raymo et al. 2015). Two other exceptions can be observed, but these need to be qualified. No effect of poor health was found on union formation in Germany, but there was still the expected health effect on marriage. Similarly, there was no health effect on union formation in Russia, but this effect was still found for women.

Mixed evidence was found for demographic heterogeneity in the role of health. For gender differences, there were contrary expectations beforehand, with some authors expecting the health of men to matter more for marriage from an economic point of view, while others expecting women's health to matter more given traditional mate selection preferences. We found little evidence of gender differences. We were able to include good controls for employment status and income, ruling out economic mechanisms that would be especially relevant for men. However, even without these controls, few gender differences in

health effects emerged. Where we did find interactions (Germany, Russia), they favored the notion that women are more severely ‘punished’ for health issues in the partner market.

Substantially more evidence was found for age heterogeneity. The effects of self-rated health on union formation, especially on union dissolution, were stronger in the middle ages than in the older ages. These interactions can be interpreted in terms of more significant uncertainty and higher expected future burden when a younger partner is in poor health than when an older partner is in poor health. Health problems are also less common and, therefore, less normative at younger ages. The effects of health on union dissolution are further related to the length of the union, with older couples having invested more in the relationship, reducing the risk of dissolution when problems arise. The association with union duration may explain why the age interactions were stronger for dissolution than for formation.

The current study added to previous research by using a strong and uniform longitudinal design in six countries with a broad set of transitions, but it also has limitations. First, we used only one health measure, and while this measure is widely used and recognized as reliable and relevant, it combines different dimensions of health in one index (Fayers and Sprangers 2002). For future research, it would be helpful to disentangle mental and physical health since mental health problems (e.g., depressive symptoms) may be a consequence of declining relationship quality, whereas physical health problems may not be as sensitive to how the union functions. To do so, we would need in-depth single-country analyses of panels that include information on marital quality. Second, couple effects could not be studied, something which could be relevant for the analysis of separation and possibly, for the transition from cohabitation to marriage. We examined gender differences – which turned out to be small – but could not compare men and women within couples. One large study previously found no interactions between husbands’ and wives’ self-rated health on divorce (Torvik et al. 2015), suggesting that at least a one-sided perspective is not biased. Third, no

(complete) information was available for the starting date of unions. Clearly, the separation risk depends on the length of the union (e.g., Kulu 2014). Using the German part of the data, we showed that there was no omitted-variable bias in the health effects as a result of union duration. Still, we could not separate age and duration, something that remains important for a better understanding of age heterogeneity in the health effects on separation.

Our findings have a number of implications. Reverse health effects on marriage first suggest that an important source of support is diminished when, as a result of health issues, such support is needed (Broese van Groenou, Hoogendijk and van Tilburg 2013). More generally, to the extent that marriage brings social, emotional, and economic benefits, our findings imply an accumulation of inequality, with people disadvantaged in terms of health missing out on other advantages (McLanahan 2004). The current study focused on one specific type of relationship, but the theory is more general. Our findings are in line with studies on social networks showing that while the association between health and relationships is reciprocal, depression and mental health have stronger effects on networks than the other way around (Elmer and Stadtfeld 2020, Schwartz and Litwin 2019). Especially the significant impact of health on union dissolution, in combination with the negative effect on repartnering in our study, highlights an additional vulnerability within the divorced population, which may be particularly pronounced for women and men who experience divorce in later life.

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Table 1.- Descriptive information on person-period files

	Australia	Germany	Korea	Russia	Switzerland	UK
Self-rated health						
(1) +	28,716 10.7	61,285 10.6	9,177 3.7	3,718 1.7	28,047 21.3	93,726 17.5
(2)	93,775 34.9	233,741 40.4	121,501 48.3	71,403 32.3	84,282 63.9	197,516 36.8
(3)	97,646 36.4	184,906 32.0	81,496 32.4	115,758 52.3	17,128 13.0	147,843 27.6
(4)	38,931 14.5	77,459 13.4	32,642 13.0	26,559 12.0	2,190 1.7	70,268 13.1
(5) -	9,286 3.5	20,517 3.6	6,502 2.6	3,697 1.7	275 0.2	26,893 5.0
Union entry						
No event	39,161 91.5	76,943 94.2	35,615 96.2	29,351 89.9	19,355 94.0	83,787 94.3
Event	3,640 8.5	4,772 5.8	1,395 3.8	3,287 10.1	1,228 6.0	5,088 5.7
Initial state						
No event	39,161 91.5	76,943 94.2	0 .	29,351 89.9	19,355 94.0	83,787 94.3
Marriage	484 1.1	941 1.2	0 .	1,515 4.6	145 0.7	1,178 1.3
Cohabitation	3,156 7.4	3,831 4.7	0 .	1,772 5.4	1,083 5.3	3,910 4.4
Marriage after cohabitation						
No event	26,797 90.3	23,603 87.4	0 .	12,464 88.2	5,968 89.1	27,536 85.9
Event	2,881 9.7	3,406 12.6	0 .	1,673 11.8	730 10.9	4,512 14.1
Separation						
No event	147,989 97.7	330,673 98.6	151,648 99.6	110,247 98.0	71,154 98.5	288,934 98.3
Event	3,494 2.3	4,537 1.4	654 0.4	2,248 2.0	1,078 1.5	4,885 1.7
Repartnering						
No event	31,452 96.1	57,809 96.4	30,209 99.1	38,764 96.8	13,417 97.1	64,593 97.1
Event	1,272 3.9	2,153 3.6	264 0.9	1,283 3.2	404 2.9	1,937 2.9

Note: CPF harmonized file. Person-year files for different risk sets. Self-rated health for full sample. Union entry is defined as the transition from being never married and living without a partner, to living with a partner. For the initial state, this event is distinguished into being married and cohabitating (defined as being never married while living with a partner). Marriage after cohabitation is defined as the transition from being never married and living with a partner, to being married while living with a partner. The transition to living without a partner is censored. Separation is defined as the transition from living with a partner and being never married or being married, to living without a partner. Being widowed is censored. Marital status is a time-varying covariate that is included to address the difference between divorce and separation. Repartnering is defined as the transition from being divorced or widowed while living without a partner, to living with a partner.

Table 2.- Event-history models of union entry transitions: Logit coefficients and p-values

<i>Model 1</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Poor health (z-score)	-.082** (.000)	-.002 (.910)	-.134** (.000)	-.041 (.072)	-.097** (.005)	-.089** (.000)
Chi-2	854.4	2040.7	809.2	724.9	644.1	1984.9
N	42801	81715	37010	32638	20583	88875
<i>Model 2</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Poor health (z-score)	-.067** (.001)	.006 (.748)	-.088* (.015)	-.006 (.794)	-.086* (.013)	-.055** (.001)
Chi-2	952.5	2253.7	877.5	915.7	687.5	2090.2
N	42801	81715	37010	32638	20583	88875

Note: CPF harmonized file. Model 1 includes control variables, Model 2 adds socioeconomic variables. For Korea, only marital transitions.

* $p < 0.05$, ** $p < 0.01$

Table 3.- Event-history models of marriage versus cohabitation: (Multinomial) logit coefficients and p-values

<i>Multinomial model 1</i>	Australia	Germany	Russia	Switzerland	UK
Marriage					
Poor health (z-score)	-.155** (.002)	-.188** (.000)	-.128** (.000)	-.263** (.009)	-.145** (.000)
Cohabitation					
Poor health (z-score)	-.071** (.001)	.041* (.034)	.026 (.352)	-.075* (.038)	-.072** (.000)
Test	2.39	28.34*	14.96*	3.16~	3.57~
Chi-2	1155.6	2319.7	1631.3	670.9	2833.5
N	42801	81715	32638	20583	88875
<i>Multinomial model 2</i>	Australia	Germany	Russia	Switzerland	UK
Marriage					
Poor health (z-score)	-.114* (.033)	-.170** (.000)	-.101** (.003)	-.246* (.016)	-.088* (.013)
Cohabitation					
Poor health (z-score)	-.061** (.004)	.046* (.017)	.071* (.014)	-.064 (.076)	-.045* (.021)
Test	0.87	24.46*	17.03*	2.83~	1.12
Chi-2	1268.0	2557.8	1802.5	712.8	2938.1
N	42801	81715	32638	20583	88875
<i>Logit model 1</i>	Australia	Germany	Russia	Switzerland	UK
Cohabitation to marriage					
Poor health (z-score)	-.208** (.000)	-.121** (.000)	-.294** (.000)	-.138** (.002)	-.132** (.000)
Chi-2	82.1	30.2	82.7	9.3	90.8
N	29678	27009	14137	6698	32048
<i>Logit model 2</i>	Australia	Germany	Russia	Switzerland	UK
Cohabitation to marriage					
Poor health (z-score)	-.049* (.041)	-.047* (.037)	-.044 (.201)	-.031 (.492)	-.085** (.000)
Chi-2	1001.9	515.7	599.3	285.2	545.4
N	29678	27009	14137	6698	32048

Note: CPF harmonized file. Test across outcomes based on Chi-2 test in multinomial logit model.

~ p < 0.10, * p < 0.05, ** p < 0.01

Table 4.- Event-history models of separation transitions: Logit coefficients and p-values

<i>Model 1</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Cohabiting	1.320** (.000)	1.772** (.000)		1.579** (.000)	1.598** (.000)	1.025** (.000)
Poor health (z-score)	.157** (.000)	.125** (.000)	.256** (.000)	.006 (.833)	.143** (.000)	.177** (.000)
Chi-2	3267.5	6062.1	236.3	2150.7	1425.6	4475.2
N	151483	335210	152302	112495	72232	293819
<i>Model 2</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Cohabiting	1.282** (.000)	1.738** (.000)		1.567** (.000)	1.588** (.000)	.987** (.000)
Poor health (z-score)	.127** (.000)	.115** (.000)	.216** (.000)	.011 (.685)	.138** (.000)	.148** (.000)
Chi-2	3420.6	6227.5	377.6	2173.5	1477.6	4685.0
N	151483	335210	152302	112495	72232	293819
<i>Model 3</i>	Australia	Germany		Russia	Switzer- land	UK
Cohabiting	1.283** (.000)	1.733** (.000)		1.604** (.000)	1.589** (.000)	.983** (.000)
Poor health (z-score)	.088** (.004)	.131** (.000)		-.041 (.247)	.124** (.006)	.172** (.000)
x cohabiting	.069 (.077)	-.036 (.314)		.141** (.007)	.030 (.648)	-.065* (.050)
Chi-2	3456.4	6208.9		2158.9	1481.8	4642.6
N	151483	335210		112495	72232	293819

Note: CPF harmonized file. Model 1 includes control variables, Model 2 adds socioeconomic variables.

For Korea, divorce transitions.

* $p < 0.05$, ** $p < 0.01$

Table 5.- Event-history models of repartnering transitions: Logit coefficients and p-values

<i>Model 1</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Poor health (z-score)	-.180** (.000)	-.120** (.000)	-.141* (.031)	-.126** (.000)	-.051 (.305)	-.157** (.000)
Chi-2	1179.8	2112.7	462.3	1517.5	379.4	1955.5
N	32724	59962	30473	40047	13821	66530
<i>Model 2</i>	Australia	Germany	Korea	Russia	Switzer- and	UK
Poor health (z-score)	-.139** (.000)	-.095** (.000)	-.078 (.263)	-.100** (.007)	-.024 (.639)	-.105** (.000)
Chi-2	1238.5	2100.5	476.7	1591.8	373.6	2067.3
N	32724	59962	30473	40047	13821	66530

Note: CPF harmonized file. Model 1 includes control variables, Model 2 adds socioeconomic variables. For Korea, remarriage transitions.

* $p < 0.05$, ** $p < 0.01$

Table 6. Interactions of gender and health

<i>Union formation</i> <i>Model 1</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Male vs. female	-.225** (.000)	-.420** (.000)	-.354** (.000)	.018 (.666)	-.192** (.003)	-.242** (.000)
Poor health	-.050 (.058)	-.012 (.602)	-.097 (.055)	-.085** (.003)	-.160** (.000)	-.080** (.000)
x gender	-.066 (.076)	.022 (.505)	-.072 (.301)	.096* (.018)	.141* (.034)	-.021 (.516)
<i>Union formation</i> <i>Model 2</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Male vs. female	-.431** (.001)	-.566** (.001)	-1.180** (.000)	-.258* (.023)	-.391 (.248)	-.627** (.000)
Poor health	-.043 (.107)	-.014 (.528)	-.069 (.186)	-.059* (.049)	-.148** (.001)	-.058* (.010)
x gender	-.050 (.188)	.046 (.174)	-.038 (.603)	.114** (.008)	.140* (.038)	.006 (.854)
N	42801	81715	37010	32638	20583	88875
<i>Union dissolution</i> <i>Model 1</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Male vs. female	-.024 (.499)	-.113** (.000)	.285** (.000)	-.481** (.000)	.088 (.170)	-.252** (.000)
Poor health	.161** (.000)	.114** (.000)	.323** (.000)	.023 (.486)	.092* (.038)	.178** (.000)
x gender	-.010 (.790)	.025 (.433)	-.129 (.117)	-.044 (.383)	.110 (.088)	-.001 (.971)
<i>Union dissolution</i> <i>Model 2</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
Male vs. female	.224 (.062)	.421** (.001)	.661 (.076)	.061 (.699)	.330 (.255)	.231 (.063)
Poor health	.151** (.000)	.104** (.000)	.286** (.000)	.026 (.444)	.080 (.076)	.160** (.000)
x gender	-.051 (.183)	.025 (.458)	-.137 (.119)	-.037 (.481)	.126 (.052)	-.032 (.322)
N	151483	335210	152302	112495	72232	293819

Note: CPF harmonized file. Model 1 includes control variables, Model 2 adds socioeconomic variables. Main health effect applies to women. Interaction indicates how much smaller or larger the health effect is for men. Marginal effects models yield the same significance tests for the interactions.

* $p < 0.05$, ** $p < 0.01$

Appendix 1.- Event-history models of divorce in Germany with augmented life histories

	Without duration	With duration
Marriage year (centered)	.026** (.000)	.003 (.335)
Marriage year squared	-.001** (.000)	-.001** (.000)
30-39	-.143* (.032)	.062 (.373)
40-49	-.378** (.000)	.087 (.280)
50-59	-.927** (.000)	-.248* (.012)
60-69	-1.240** (.000)	-.439** (.001)
70+	-.889** (.000)	.000 (.998)
Woman vs man	-.019 (.843)	.018 (.855)
Poor health	.145** (.000)	.146** (.000)
Medium educated	-.002 (.967)	-.021 (.718)
Higher educated	-.133 (.054)	-.164* (.017)
Household income (ln)	-.088 (.090)	-.080 (.117)
Employed	.030 (.758)	.025 (.802)
x woman	.302** (.005)	.334** (.002)
Unemployed	.354* (.012)	.323* (.021)
x woman	.140 (.413)	.148 (.386)
Children at home	-.124** (.005)	-.031 (.495)
Religiosity	-.268** (.000)	-.248** (.000)
Duration		-.062** (.000)
Duration squared		.000** (.009)
Constant	-3.565** (.000)	-3.070** (.000)
Chi-2	2962.0	3118.5
N	342087	342087
bic	31974	31831

p-values in parentheses

* *p* < 0.05, ** *p* < 0.01

Appendix 2.- Comparing linear and non-linear effects of self-rated health

<i>Union formation</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
<i>Linear effects</i>						
BIC	23905	34093	10529	20221	8714	36756
N	42801	81715	37010	32638	20583	88875
<i>Union formation</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
<i>Discrete effects</i>						
BIC	23932	34122	10537	20206	8729	36785
N	42801	81715	37010	32638	20559	88875
<i>Union dissolution</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
<i>Linear effects</i>						
BIC	29712	42358	8334	19928	9973	45541
N	151483	335210	152302	112495	72232	293819
<i>Union dissolution</i>	Australia	Germany	Korea	Russia	Switzer- land	UK
<i>Discrete effects</i>						
BIC	29738	42364	8368	19957	9990	45558
N	151483	335210	152302	112495	72125	293819

Note: CPF harmonized file. Discrete effects using 5-1 dummy variables. Linear effects based on 1-5 scale (standardized).

Appendix 3. Full regression results

Union formation	Australia	Germany	Korea	Russia	Switzerland	UK
Woman	.443** (.001)	.570** (.001)	1.174** (.000)	.233 (.054)	.401 (.239)	.624** (.000)
Employed	.671** (.000)	.795** (.000)	1.323** (.000)	.769** (.000)	1.011** (.000)	.871** (.000)
x woman	-.279* (.041)	-.233 (.190)	-.952** (.000)	-.318* (.014)	-.205 (.553)	-.437** (.001)
Unemployed	.225 (.113)	.236 (.129)	.392 (.153)	.078 (.530)	.292 (.418)	.282* (.040)
x woman	.031 (.871)	.223 (.270)	-.755* (.046)	.235 (.157)	.139 (.769)	-.268 (.103)
Enrolled	-.644** (.002)	-.231 (.138)	-.987** (.008)	-.726** (.000)	.053 (.872)	-.085 (.543)
x woman	.306 (.228)	.116 (.561)	-.414 (.372)	.753** (.000)	.247 (.563)	-.115 (.458)
Medium educated	-.165** (.002)	.304** (.000)	.700** (.000)	-.117* (.035)	.326** (.003)	.093 (.058)
Higher educated	-.064 (.276)	.605** (.000)	.827** (.000)	-.126* (.048)	.600** (.000)	.266** (.000)
Income (centered)	-.085** (.000)	-.094** (.000)	.019 (.374)	.078** (.000)	-.025 (.271)	-.073** (.000)
Religiosity	-.238** (.000)	-.116** (.002)	.105 (.105)	.256** (.003)	-.090 (.278)	-.214** (.000)
Poor health	-.067** (.001)	.006 (.748)	-.088* (.015)	-.006 (.794)	-.086* (.013)	-.055** (.001)
Black						-.583** (.000)
Asian						-.211** (.000)
Constant	-2.780** (.000)	-3.875** (.000)	-6.776** (.000)	-2.787** (.000)	-4.316** (.000)	-3.456** (.000)
Chi-2	952.5	2253.7	877.5	915.7	687.5	2090.2
N	42801	81715	37010	32638	20583	88875
Competing risk	Australia	Germany	delete	Russia	Switzerland	UK
Marriage						
Woman	1.011* (.047)	1.150** (.005)	1.150** (.005)	.309 (.091)	-.418 (.770)	.363 (.117)
Employed	1.562** (.001)	.987** (.007)	.987** (.007)	.692** (.000)	1.726 (.090)	1.040** (.000)
x woman	-.961 (.064)	-.666 (.110)	-.666 (.110)	-.402* (.037)	.430 (.764)	-.333 (.166)
Unemployed	.863 (.123)	.227 (.580)	.227 (.580)	.002 (.992)	1.024 (.404)	.373 (.143)
x woman	-.282 (.674)	-.006 (.989)	-.006 (.989)	.210 (.387)	.666 (.701)	-.023 (.943)
Enrolled	-.232 (.783)	-.186 (.651)	-.186 (.651)	-1.219** (.000)	1.219 (.280)	.081 (.761)
x woman	.177 (.852)	-.321 (.502)	-.321 (.502)	.980** (.002)	.342 (.832)	-.173 (.580)
Medium educated	.276 (.092)	-.236* (.010)	-.236* (.010)	.101 (.239)	-.064 (.843)	.028 (.773)
Higher educated	.670** (.000)	-.006 (.958)	-.006 (.958)	.117 (.217)	.084 (.816)	.180 (.069)
Income (centered)	.079* (.020)	.027 (.243)	.027 (.243)	.126** (.000)	-.043 (.530)	-.007 (.772)
Religiosity	1.460** (.000)	.539** (.000)	.539** (.000)	.615** (.000)	.419 (.104)	.710** (.000)
Poor health	-.114* (.033)	-.170** (.000)	-.170** (.000)	-.101** (.003)	-.246* (.016)	-.088* (.013)
Black						.152 (.205)
Asian						.952** (.000)
Constant	-7.718** (.000)	-6.624** (.000)	-6.624** (.000)	-4.500** (.000)	-7.318** (.000)	-6.259** (.000)
Cohabitation						

Woman	.406** (.003)	.412* (.035)	.412* (.035)	.159 (.308)	.489 (.164)	.679** (.000)
Employed	.591** (.000)	.761** (.000)	.761** (.000)	.867** (.000)	.942** (.001)	.806** (.000)
x woman	-.220 (.119)	-.110 (.577)	-.110 (.577)	-.258 (.119)	-.269 (.452)	-.447** (.004)
Unemployed	.169 (.249)	.238 (.152)	.238 (.152)	.154 (.339)	.222 (.558)	.242 (.136)
x woman	.046 (.813)	.306 (.171)	.306 (.171)	.263 (.231)	.083 (.866)	-.323 (.092)
Enrolled	-.680** (.001)	-.233 (.163)	-.233 (.163)	-.374 (.061)	-.075 (.831)	-.117 (.477)
x woman	.312 (.237)	.244 (.271)	.244 (.271)	.659** (.006)	.250 (.577)	-.101 (.574)
Medium educated	-.206** (.000)	.439** (.000)	.439** (.000)	-.277** (.000)	.374** (.001)	.111* (.044)
Higher educated	-.178** (.005)	.766** (.000)	.766** (.000)	-.311** (.000)	.665** (.000)	.290** (.000)
Income (centered)	-.110** (.000)	-.125** (.000)	-.125** (.000)	.043* (.035)	-.023 (.337)	-.094** (.000)
Religiosity	-.459** (.000)	-.254** (.000)	-.254** (.000)	.081 (.424)	-.153 (.076)	-.493** (.000)
Poor health	-.061** (.004)	.046* (.017)	.046* (.017)	.071* (.014)	-.064 (.076)	-.045* (.021)
Black						-1.016** (.000)
Asian						-1.454** (.000)
Constant	-2.656** (.000)	-3.892** (.000)	-3.892** (.000)	-2.821** (.000)	-4.364** (.000)	-3.413** (.000)
Chi-2	1268.0	2557.8	2557.8	1802.5	712.8	2938.1
N	42801	81715	81715	32638	20583	88875
Cohabitation to marriage	Australia	Germany	delete	Russia	Switzerland	UK
Woman	.128 (.417)	.032 (.870)	.032 (.870)	-.163 (.305)	-.304 (.565)	-.240 (.052)
Employed	.393** (.006)	-.162 (.381)	-.162 (.381)	.074 (.602)	-.326 (.437)	-.275* (.015)
x woman	-.202 (.218)	-.134 (.506)	-.134 (.506)	-.003 (.987)	.333 (.534)	.201 (.119)
Unemployed	-.010 (.966)	-.556* (.010)	-.556* (.010)	-.228 (.269)	-.548 (.377)	-.598** (.000)
x woman	.042 (.885)	.370 (.133)	.370 (.133)	.359 (.171)	.643 (.422)	.228 (.269)
Enrolled	.645* (.048)	-.457 (.073)	-.457 (.073)	-.763 (.096)	-.149 (.852)	-.726** (.006)
x woman	-1.105* (.017)	.258 (.377)	.258 (.377)	.389 (.444)	-.985 (.369)	.526 (.086)
Medium educated	.196** (.002)	.030 (.679)	.030 (.679)	.364** (.000)	.287 (.403)	.031 (.555)
Higher educated	.302** (.000)	.140 (.075)	.140 (.075)	.426** (.000)	.405 (.240)	.077 (.163)
Income (centered)	.211** (.000)	.117** (.000)	.117** (.000)	.139** (.000)	.198** (.000)	.129** (.000)
Religiosity	.362** (.000)	.408** (.000)	.408** (.000)	.172 (.085)	.187 (.096)	.392** (.000)
Poor health	-.049* (.041)	-.047* (.037)	-.047* (.037)	-.044 (.201)	-.031 (.492)	-.085** (.000)
Black						.239* (.049)
Asian						.659** (.000)
Constant	-3.226** (.000)	-2.629** (.000)	-2.629** (.000)	-1.643** (.000)	-3.097** (.000)	-2.394** (.000)
Chi-2	1001.9	515.7	515.7	599.3	285.2	545.4
N	29678	27009	27009	14137	6698	32048
Dissolution	Australia	Germany	Korea	Russia	Switzerland	UK

Woman	-.214 (.081)	-.417** (.001)	-.616 (.098)	-.070 (.662)	-.356 (.222)	-.228 (.067)
Kids in household	.052** (.002)	.047** (.006)	-.213** (.000)	-.249** (.000)	.014 (.722)	-.042* (.011)
Religiosity	-.180** (.000)	-.188** (.000)	-.250** (.006)	-.191* (.036)	-.365** (.000)	-.247** (.000)
Medium educated	-.053 (.247)	-.127** (.007)	.117 (.328)	.037 (.586)	-.299* (.034)	.071 (.076)
Higher educated	-.351** (.000)	-.255** (.000)	-.619** (.000)	-.108 (.159)	-.468** (.002)	-.096* (.030)
Employed	-.301** (.010)	-.258* (.034)	.157 (.666)	-.532** (.000)	-.007 (.979)	-.639** (.000)
x woman	.287* (.026)	.611** (.000)	.692 (.071)	.607** (.000)	.270 (.366)	.521** (.000)
Unemployed	.242 (.113)	-.016 (.908)	.811 (.074)	-.053 (.762)	.548 (.132)	-.163 (.239)
x woman	.221 (.248)	.617** (.000)	-.265 (.666)	.246 (.250)	.371 (.396)	.534** (.001)
Retired	-.193 (.205)	-.393* (.024)	-.200 (.630)	-1.015** (.000)	-.312 (.365)	-.464** (.001)
x woman	-.148 (.408)	.482** (.008)	.800 (.145)	.843** (.001)	.759 (.069)	.246 (.112)
Income (centered)	-.145** (.000)	-.053** (.000)	-.343** (.000)	.014 (.447)	-.003 (.933)	-.078** (.000)
Poor health	.127** (.000)	.115** (.000)	.216** (.000)	.011 (.685)	.138** (.000)	.148** (.000)
Cohabiting	1.282** (.000)	1.738** (.000)		1.567** (.000)	1.588** (.000)	.987** (.000)
Black						1.012** (.000)
Asian						-.045 (.499)
Constant	-3.182** (.000)	-3.642** (.000)	-4.567** (.000)	-3.300** (.000)	-2.995** (.000)	-2.880** (.000)
Chi-2	3420.6	6227.5	377.6	2173.5	1477.6	4685.0
N	151483	335210	152302	112495	72232	293819
Repartnering	Australia	Germany	Korea	Russia	Switzerland	UK
Woman	-.554** (.000)	-.908** (.000)	-.308 (.371)	-.254 (.167)	-.733* (.022)	-.267** (.009)
Widowed	-.814** (.000)	-.789** (.000)	-1.100** (.000)	-1.023** (.000)	-.516** (.006)	-.791** (.000)
Employed	.328* (.017)	.018 (.884)	.565 (.059)	.491** (.004)	.648* (.029)	.479** (.000)
x woman	-.049 (.759)	.503** (.000)	-.250 (.491)	-.366 (.067)	.116 (.732)	-.190 (.112)
Unemployed	.118 (.655)	-.301 (.068)	.556 (.310)	-.170 (.443)	1.388* (.027)	-.135 (.486)
x woman	.064 (.851)	.612** (.001)	.704 (.305)	.508 (.072)	-.777 (.312)	.193 (.414)
Medium educated	-.146 (.075)	.026 (.708)	.302 (.093)	-.160 (.095)	.457 (.110)	.110 (.081)
Higher educated	-.092 (.272)	.084 (.310)	.151 (.573)	-.198 (.069)	.465 (.118)	.134* (.048)
Income (centered)	.097** (.001)	.054* (.022)	.062 (.267)	.084** (.000)	.071 (.145)	.051* (.029)
Religiosity	.022 (.793)	-.050 (.380)	.018 (.901)	.089 (.533)	-.046 (.733)	-.123* (.035)
Poor health	-.139** (.000)	-.095** (.000)	-.078 (.263)	-.100** (.007)	-.024 (.639)	-.105** (.000)
Black						-.342* (.011)
Asian						.208* (.043)
Constant	-1.435** (.000)	-1.456** (.000)	-3.232** (.000)	-1.465** (.000)	-2.345** (.000)	-2.124** (.000)
Chi-2	1238.5	2100.5	476.7	1591.8	373.6	2067.3
N	32724	59962	30473	40047	13821	66530

Note: CPF harmonized file. Age and period effects included but not printed.
 * $p < 0.05$, ** $p < 0.01$

Figure 1. Probability of union formation by age and self-rated health

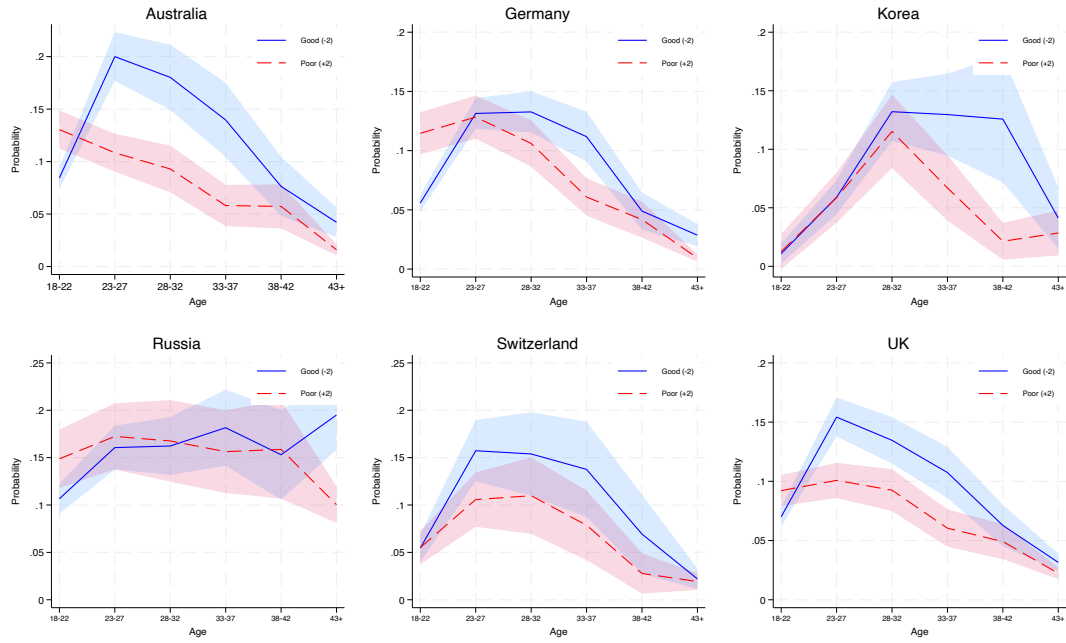


Figure 2. Probability of separation by age and self-rated health

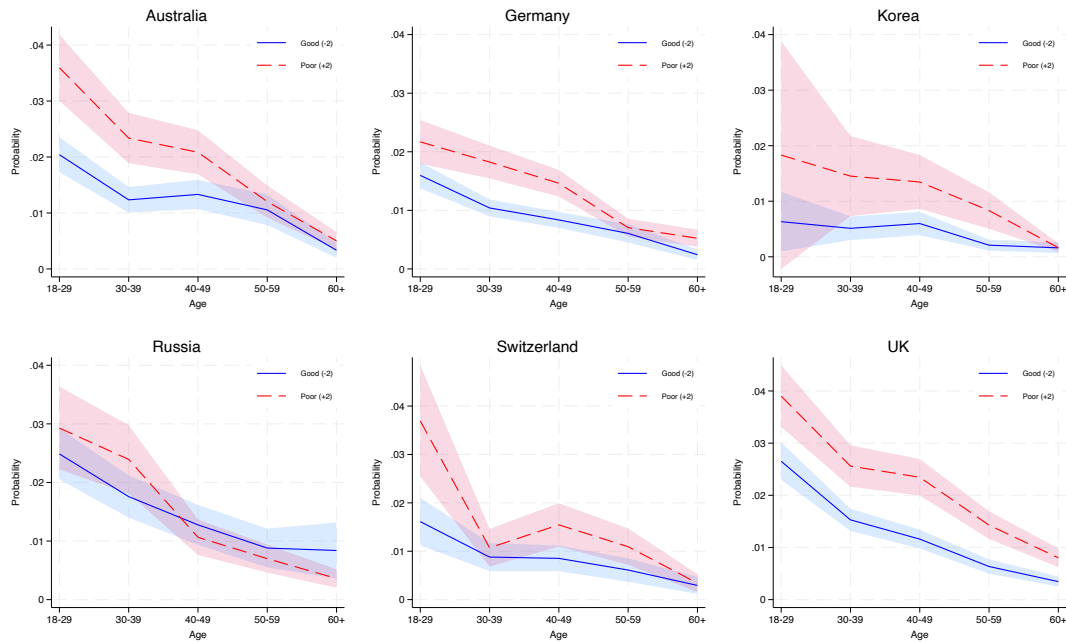
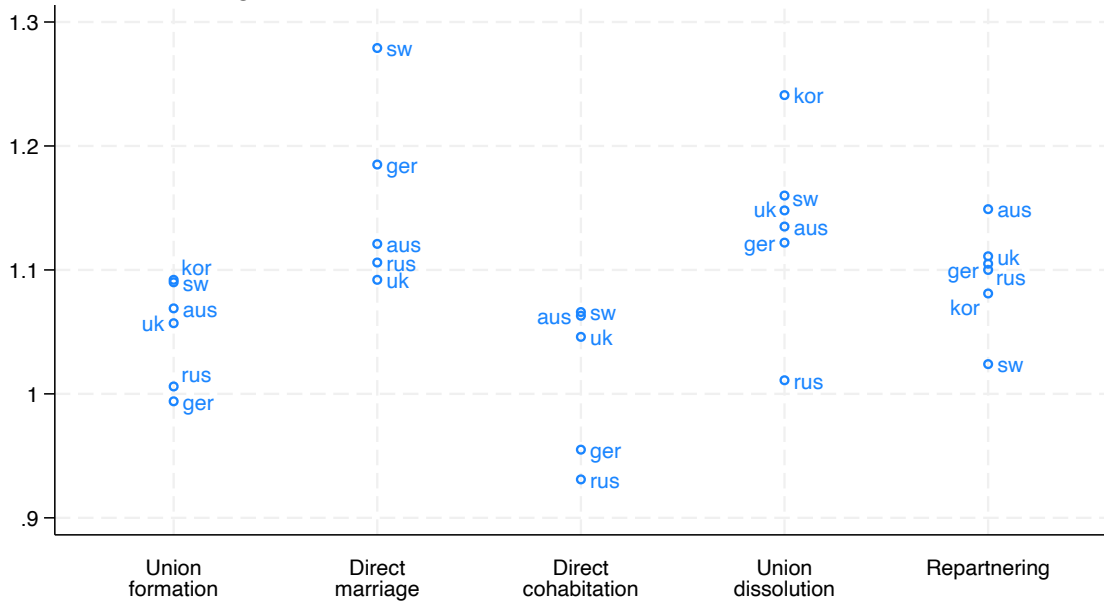


Figure 3. Odds ratio's in all countries for three transitions



Note: CPF harmonized file. Effects from Model 2 in Tables 2, 4, and 5. Odds ratio's per standard deviation change in health. Odds ratio's reversed for union formation and repartnering (i.e., 1/OR). A model for union formation with country constraints in health effects has a BIC of 133854, whereas a model allowing health effects to differ has a higher BIC (133901). For union dissolution, the BIC with country constraints is 150625, and the BIC without country constraints is 150571. For repartnering, the BIC with country constraints is 56214, and the BIC without country constraints is 56273.