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From Women's Health to a Gender Analysis of Health

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The health experiences of women differ from those of men. These differences primarily reflect gender roles relating to the social, cultural, and economic circumstances of women's and men's lives. This chapter explores how gender roles and relationships affect health, and points to some of the ways in which changes in gender roles over time and between societies influence gender differences in health. Gender is one important dimension of social life which intersects with others, especially social class, ethnicity, and age. Thus, the chapter also examines health divisions among women and among men.

Gender roles are socially constructed and therefore change over time and vary between societies. The cultural and religious norms of a society have a profound influence on the roles, attitudes, and behavior of men and women within that society. Gender ideology prescribes and circumscribes the social behavior of men and women, and of different age or ethnic groups of men and women. Social myths and stereotypes about appropriate or supposedly "natural" behavior for women and men impact on their health and well-being, such as body image and weight control. Gender permeates all aspects of life. Lorber (1997: 3) summarizes the importance of gender roles for health:

Because gender is embedded in the major social organizations of society, such as the economy, the family, politics, and the medical and legal systems, it has a major impact on how the women and men of different social groups are treated in all sectors of life, including health and illness, getting born and dying. Gender is thus one of the most significant factors in the transformation of physical bodies into social bodies.

The chapter begins by noting that whilst greater attention is paid to women's reproductive health, much of women's other health issues are masked by the

assumption that white, male bodies are the norm for human health. Recently there has been a shift to a gender analysis of health, which emphasizes the social relations between men and women and their consequences for health. The chapter considers the evidence for, and explanations of, differences in mortality and morbidity between men and women. Finally, the chapter addresses to what extent cross-cutting social structures, such as class, family structure, and age, have a similar influence on health inequalities among women and men.

WOMEN'S HEALTH

In the 1970s and early 1980s, the primary focus of interest within medical sociology was on women's health rather than a gender analysis of health. This mirrored the provision of health services based on biological differences, linked to women's distinctive reproductive systems, and resulting in extensive specialized services for childbirth, contraception, abortion, and infertility.

The relationship between biological sex and gendered social roles is most marked in the area of reproductive health. A major gender-specific cause of death in the past has been maternal mortality, and in many developing countries reduction in the maternal mortality rate remains a central aim of national health care programs. The medical domination of health care programs in these countries, and the dominant role of acute hospital medical care, has often led to a lack of expenditure on community health care and the training of traditional birth attendants (Doyal 1995, 1999). However, in western countries, maternal mortality is now at a very low level and other concerns are paramount for medical sociologists interested in reproductive health, particularly issues associated with medicalization.

Criticism of midwifery services has centered on the medicalization of reproduction at the expense of women's experiences and preferences. Maternity care is seen as organized around a search for pathology rather than women's experience of birth and parenthood. There is tension between sexual and reproductive experiences as normal, social events and the provision of care framed by professional agendas and often provided in clinical settings (Thomas 1998).

Women's sexual and reproductive health and behavior is both a private matter and a subject of public and social concern. This is rendered more complex by the tension between responsibility and power. For example, women are expected to take responsibility for using contraception, making changes in health behavior during pregnancy, and attending for cervical screening, yet their ability to affect these actions is constrained by their relative powerlessness in heterosexual relationships and in interactions with health professionals (Thomas 1998). Women's needs for safe, effective contraception may be at odds with their male partners' wishes. Women who are lesbian, or who live in poverty, or who experience racist stereotyping may experience additional constraints on the achievement of their fertility aspirations and on the willingness of services to meet their requirements.

Many women in developed countries expect pregnancy and birth to be a normal event and are primarily concerned with the social context. However,

their experience of maternity care is of a medicalized search for pathology (Graham and Oakley 1981). Women's dissatisfaction with the maternity services has a long history, much of which has been concerned with the place and circumstances of birth (Garcia 1982). Research in the late 1970s and 1980s focused on women's experiences of maternity care (Graham and McKee 1979; Oakley 1979), while others contrasted user and provider perspectives (Graham and Oakley 1981), and described conflicts concerning the image of pregnancy presented by the providers (Comaroff 1977; Graham 1977).

Women's postnatal health is the least recognized, least glamorous aspect of pregnancy and birth. Once the drama of the birth is over, a woman's own health appears to take second place in the eyes of health professionals (Thomas 1998). Surveys paint a dismal picture including physical trauma arising from the birth, continuing gynaecological problems, exhaustion from interrupted sleep, and mental health problems, particularly postnatal depression (MacArthur et al. 1991).

Medicalization in other areas of women's lives has received less attention from sociologists compared with maternity care. There are rising rates of hysterectomy, whilst the menopause provides a new stage of the female life course for medical intervention. It is estimated that one in five women in Britain will have a hysterectomy by the age of 75 (Teo 1990), although few hysterectomies are performed for life-threatening conditions. Teo suggests that the large increase in the number of hysterectomies performed for menstrual problems could be due to an increase in menstrual problems, to changes in social acceptance of such problems, or to a greater willingness to use hysterectomy as a treatment. There are marked international and regional variations in the frequency with which hysterectomy is performed, which demonstrates how social and economic factors influence the decision to operate (McPherson et al. 1981).

Much research on women's reproductive health has tended to neglect differences among women in relation to the effects of poverty, class, race and ethnicity, and sexual orientation. It is important to examine how gender divisions intersect with wider social inequalities which put some women at greater risk during the "normal" processes of pregnancy and childbirth. The impact of gender roles on reproductive health needs to take center stage. For example, women's capacity to control their fertility through contraception and abortion is influenced by partners, other family members, governments, religious and other social institutions.

WOMEN AND THE MALE "STANDARD" PATIENT

The focus on women and reproductive health has led to a lack of attention to women as patients within mainstream areas of health. This stems from treating men as the "norm" and basing standards of health care and medical research mainly on the "male patient." The bio-medical or scientific model of disease assumes that disease is a deviation from normal biological functioning. However, what is regarded as normal depends on who is being compared to whom, and in many cases men are considered the "norm" and women compared to this standard (Lorber 1997). Medical norms have primarily been based on white,

male, middle-class, working-age bodies. Definitions of health are often related to muscular strength and aerobic capacity, which are superior in men, and not to metabolic and digestive efficiency, stamina, and pain endurance, which may be superior in women.

Epidemiological research and clinical trials have often failed to include women in sufficient numbers or women have been excluded altogether (Rosser 1994), for example, in research on coronary heart disease (Sharp 1994) and on AIDs (Doyal 1995, 1999). It is important to consider the implications of this exclusion. The lack of research on whether men and women with the same medical condition present symptoms differently means that less is known about the effects of drug or surgical treatment regimes for women with heart disease (Sharp 1994).

McKinlay (1996) points out that differences in men's and women's reported illness rates may be the result of gender differences in the process of seeking care – “illness behavior” – as well as in the receipt of a diagnosis and treatment by physicians. Both are likely to occur for heart disease. The reported gender difference in coronary heart disease may partly reflect doctor's behavior. There is evidence in the US of referral bias, with women significantly less likely than men to be diagnosed as having heart disease or undergo coronary angiography or bypass surgery (McKinlay 1996; Sharp 1998). In addition, twice as many women as men aged 45–64 have undetected or “silent” myocardial infarctions (McKinlay 1996). Thus, the rates of illness measured in health services research may differ from the “true” social patterning of ill health in systematic and gender related ways.

The image of heart disease as predominantly affecting men is prevalent in the media, medical advertising, and among the medical profession. There is less publicity and discussion about the risk of CHD for women than for men, which contrasts with the high public profile of breast cancer. This contradicts reality, since coronary heart disease is the most common cause of death for women. Similarly, there is a high public concern with female-specific cancers, such as breast cancer and cervical cancer, and less publicity and research attention on other cancers, such as stomach and lung cancer among women. However, almost as many women in the UK die of lung cancer each year as of breast cancer (ONS 1998).

THE EMERGENCE OF MEN'S HEALTH

There is an imbalance between the greater amount of literature on women's health and the relative invisibility of work on men's health, which has its origins in a number of interrelated areas. Sociologists, whilst ostensibly addressing gender and health, have highlighted the experience of women at the hands of the medical profession and drawn attention to the centrality of health matters, particularly reproductive issues, for women's lives. However, as Annandale (1998) has pointed out, this empirical work is often not located clearly with reference to patriarchy, power, or social class. She argues:

This neglect can partly be explained by feminists' insistence that women's *subjective* experience should always be put at the centre of research in order to highlight the very real suffering that they have experienced in attempting to care for their own health and the health of others. However, while recourse to subjective experience is crucial, by itself it is an insufficient challenge to patriarchy. (Annandale 1998: 62)

The root of the problem is seen as the modernist legacy of a binary division between male and female, men and women. Women's position is thus defined in relation to that of men.

As a fundamental opposition, gendered difference underwrites (i.e. supports) other oppositions which attach to it, for example men are rational, women are irrational; women are caring, men are uncaring, and so on. It is by this process that the positively valued "health" attaches to men, while the negatively valued "illness" becomes the province of women. (Annandale 1998: 78)

Annandale argues that such contrasts have consequences for the way in which women and men are seen in relation to health and illness. Women are not easily seen as healthy and men are not easily viewed as ill. As such men's ill health has remained a largely neglected area. Assumptions that women are sicker than men have been challenged (Macintyre et al. 1996) and will be discussed later, but the enduring impression from the literature is of women with more symptom episodes, a greater number of visits to health care practitioners, and the overwhelming responsibility for health care in domestic settings. An additional problem is that men have consequently been cast as a homogeneous group (Cameron and Bernardes 1998).

Cameron and Bernardes (1998) have considered other possible reasons for the neglect of men's health. They point out that in Britain men's health was not an area of concern for health policy until the 1990s (Department of Health 1992). Whilst some conditions often associated with men, such as heart disease and lung cancer, have been highlighted, other areas, such as prostate problems or mental health, have been given little priority until recently.

Empirical work on ill-health conditions specific to men reveal a variety of problems which stem from the social invisibility of men's illness. Cameron and Bernardes (1998), in a study of prostate problems, reported that men of all ages regarded health as women's responsibility, knew little about men's health, and tended not to talk to others about any prostatic health problems they had experienced. Prostate problems appeared to represent a threat to the men's sense of masculine self. Amongst the younger men, there was a view that prostate disease was an old man's disease, and they had usually delayed seeking help for the problem. Cameron and Bernardes noted that the men's experiences could usefully be explored within a framework of concepts of masculinities and negotiated gender.

In all societies, whether symptoms and pains are perceived as illness by individuals is influenced by cultural values, gender roles, and family interactions. Health professionals also play a key role in defining presented symptoms as

“sickness,” sanctioning entry into the “sick role,” and decisions about treatment, all of which may be influenced by gendered norms and assumptions.

In summary, medical sociologists should seek to follow Lorber's (1997: 2) injunction:

to show how gender, in conjunction with the socially constructed categories of race, ethnicity, class, and sexual orientation, creates different risks and protections for physical illnesses, produces different behavior when ill, elicits different responses in health care personnel, affects the social worth of patients, and influences priorities of treatment, research, and financing.

A shift to a gender analysis of health implies a move away from a concern with women's health to one which examines both women's and men's health, and one which critically assesses to what extent similar or different factors are associated with the health of women and men.

GENDER ANALYSIS OF HEALTH

The social and economic relationships between women and men affect both women's and men's health. In patriarchal societies, women on average have less power, status, and financial resources than men, as well as less autonomy and independence. Women are more likely to be unpaid carers for their families, providing both domestic labor and health care for partners, children, and parents, when required.

Care-giving for frail or disabled family members is gendered. Women provide the majority of care for chronically sick children and for frail or disabled relatives (Green 1988; Arber and Ginn 1991). Care-giving places a major burden on carers, results in opportunities foregone, and has both physical and mental health consequences (Braithwaite 1990). The role of unpaid carers in the community is becoming increasingly significant within health care provision, as length of stay in hospital becomes shorter, shifting the costs of care to the private domain of the home. The political rhetoric of community care and deinstitutionalization has therefore had gendered impacts, resulting in greater adverse effects on women, who form the majority of carers.

Many women perform the “double shift” of household work and paid labor, so it is important to assess how combining paid and unpaid work affects their health, and how this varies with socioeconomic circumstances (Doyal 1995). Men's health may benefit from the unpaid labor of their wife in providing domestic services and health care; there is substantial evidence that married men have better health and health behaviors than never married or previously married men (Morgan 1980; Wyke and Ford 1992; Cooper et al. 1999). Therefore, a gender analysis of health needs to take into account the effects of gender roles for both women and men.

In all societies, women experience violence at the hands of men, mainly their male partners, but the extent and nature of that violence varies among and within societies (Heise 1993; Doyal 1995). Domestic violence was accepted in

the past in western societies and is still often condoned today. The health consequences of domestic violence are enormous. In the US, wife battery accounts for more injury to women than car accidents, muggings, and rape combined, as well as leading to psychiatric problems (Heise 1993).

Violence is more common where men's masculinity is defined in terms of dominance, and women are relatively powerless economically and socially. It is more common in many developing societies, especially in Asia, the Middle East, and Africa (Counts et al. 1992). In India, dowry-related murder is the most visible symbol of a continuum of violence against women. Rape, child sexual abuse, and forced prostitution have profound physical and mental health consequences for women. Rape may have even greater negative consequences in societies where it is seen as a crime against the honor of a woman's family or her husband (Heise 1993), and is particularly devastating in Asian cultures which equate a young woman's worth with her virginity, leading to raped women becoming outcasts or killed because of the "dishonor" that rape has brought on their families.

Another form of culturally-sanctioned violence against women, which has serious health consequences, is female circumcision. In many parts of Africa and the Middle East, female circumcision, which removes all or part of the clitoris and other external genitalia, is life threatening (Heise 1993; Doyal 1999). It results in deaths, as well as pain, chronic urinary problems, higher levels of maternal and child mortality, and sexual problems. Although female genital mutilation has been made illegal in some countries, it is embedded in patriarchal cultural practices and continues to be a widespread practice in middle Africa and Egypt.

A gender analysis is needed which sees both women's and men's health within the wider context of relations between women and men. It requires recognition of women's disadvantage in terms of power and economic resources and the implications of gender inequalities for both men's and women's health.

GENDER ROLES AND THE LIFE COURSE

Gender roles, responsibilities, and norms about culturally acceptable behavior are socially constructed, and vary across the life course and for different birth cohorts (Arber and Ginn 1995). During this century there have been radical changes in actual and expected gender roles, especially related to women's participation in paid work and in the political sphere. We may therefore expect the nature of gender inequalities in health to vary between age groups and over time.

The health and other characteristics of women and men are influenced by their prior life course (Wadsworth 1997). For example, the extent to which women forego paid employment to raise children will lead to financial penalties both during their working life and in retirement because of lower private pension contributions (Ginn and Arber 1996, 1998), but the extent of these penalties is likely to vary by social class and according to the woman's marital relationship, with lone mothers suffering the greatest financial penalties of parenthood.

Gender inequalities in health within one life stage may be predicated on gender inequalities in another.

For women in mid-life their health and well-being is influenced by their history of childbearing and their role as parents. Increasingly, health during working life is structured according to position in the labor market, which itself is closely linked to earlier success in the educational sphere (Lahelma and Rahkonen 1997). Thus, a life course approach is advocated which "emphasizes the inter-linkage between phases of the life course, rather than seeing each phase in isolation" (Arber and Evandrou 1993: 9). The following sections examine gender differences in mortality and morbidity, highlighting how these relate to gender roles and relationships.

GENDER INEQUALITIES IN MORTALITY

In nearly all countries women outlive men. Four broad patterns of sex differences in mortality rates can be identified, each of which is related to gender roles:

1 *Women outlive men by 5–7 years.* This pattern is exemplified by western countries in the late twentieth century. For example, in the UK in 1995, the expectation of life for women was 79.4 years and for men 74.1, women outliving men by 5.3 years (ONS 1998). The comparable figures for the US are 78.9 for women and 72.5 for men, a female excess of 6.4 years. In Sweden, women outlive men by 5 years (expectation of life of 81.5 and 76.5 respectively), and in Japan by 6.6 years (83.6 and 77 years respectively) (UN 1999). Many Asian and South American societies have also achieved this pattern, e.g. Brazil, Peru, and Korea.

The "norm" of women having a 5–7 year longer life expectancy than men is the product of women's biological advantage and of men's greater mortality from occupational hazards and risky behaviors, such as smoking, drinking, dangerous sports, fast driving, and violence (Hart 1988). As women in western countries have entered the work force in larger numbers over the last 30 years and the male excess in smoking is now very small, there has been a reduction in the gender disparity of mortality (Hemstrom 1999). For example, in the UK, the sex difference in expectation of life was 6.2 years in 1971 falling to 5.3 years by 1995 (ONS 1998). This trend is expected to continue, as lifestyles of women and men converge and women undertake more risky health behaviors (Hemstrom 1999).

2 *Women outlive men by 2–4 years.* This pattern is exemplified by European countries in the mid-nineteenth century (Hart 1988), and is now typical of many developing societies, particularly in Africa and much of Asia. For example, in Kenya the expectation of life of women is 61.4 and men is 57.5 (a 3.9 year difference), and in China is 52.9 for women and 50.1 for men (UN 1999). This pattern of a modest female mortality advantage is typical of transitional societies, where the previously high maternal mortality rate is falling, and where women occupy a disadvantageous structural position with adverse effects on

their health. As countries move toward greater economic development and more education for women, there is a trend to an increased sex gap in mortality.

3 *No gender difference or men outlive women.* In some developing countries, there is very little gender difference or men outlive women. Bangladesh is one of the few countries where men outlive women, with an expectation of life of 58.6 for men and 58.2 for women, and in Nepal, men outlive women by 2 years (although the most recent data is for 1981 – UN 1999). In Pakistan and India the sexes have almost equal life expectancy (in Pakistan, life expectancy is 59.0 for men and 59.2 for women, and in India, 59 for men and 59.7 for women), while in Algeria and in Afghanistan, women outlive men by only a year (Algeria, 65.7 for men and 66.3 for women, and in Afghanistan, 43 for men and 44 for women) (UN 1999).

This pattern of approximate gender equality in mortality or excess female mortality is found in countries where women's social status is very low (Santow 1995). In these societies, women are more likely to have poor nutrition, less access to health care, are subject to frequent births, and have high maternal mortality (Doyal 1995). In some states in India, the higher mortality of women has resulted in a sex ratio which favors men. Sen (1990) examined sex ratios of men and women in different countries, and concluded that societies where the sex ratio is in balance or is favorable to men discriminate against women, especially India. He argues that this is the result of gender-related practices which disadvantage women, in particular female foeticide and infanticide, selective malnourishment of girls, lack of investment in women's health care, and various forms of violence against women.

4 *Women outlive men by 8 or more years.* This final pattern is exemplified by countries in the former Soviet Union as well as blacks in the US, and partly reflects a deterioration in life expectancy of men since 1980. In the US, the life expectancy of black men has fallen to 64.7 and for women is 73.7, a gender gap of 9 years (Kranzler 1995). In Russia, the expectation of life is only 58.3 for men and 71.7 for women (a startling 13 year female mortality advantage), with the respective figures for Latvia, 63.9 and 75.6 (UN 1999).

In some eastern European countries and the former Soviet Union mortality rates have risen for men over the past 20 years, but have fallen or remained stable for women across the age range (Leon et al. 1997). This shows how men and women can be affected differently by social and economic changes (Hemstrom 1999). There have been greater threats to the economic and psychosocial well-being of men in these societies, many of whom have lost a secure "bread-winning" role. The fall in life expectancy of black men in the US relates to socioeconomic disadvantages, unemployment, alienation, drug abuse, and violence (Lorber 1997). Parallel patterns are beginning to be evident among young men in the UK, where despite the decline in overall mortality, there has been a recent increase in the mortality rate of men aged 25–40 (Dunnell 1991; Tickle 1996).

Gender differences in mortality vary between stages of the life course. In the UK, men have a higher mortality rate than women at all ages across the life course, particularly in youth and early adulthood. For example, the death rate is

2.8 times higher for men than women aged 20–24 (Tickle 1996). Gender differences in mortality vary by cause of death, with the largest gender difference for accidents and violence. Cause-specific mortality rates show that men aged 15–45 have four times higher mortality rate than women from motor accidents, other accidents, and suicide (Tickle 1996; Dunnell et al. 1999). Thus, gender differences in mortality in youth and early adulthood relate to social and cultural roles, and risk-taking behavior of young men.

A gender-related cause of ill health and mortality is AIDS, which in western countries has hitherto mainly affected men. However, in less developed countries, especially sub-Saharan Africa, the rates are far higher and there is little gender difference unlike in developed countries (Doyal 1995, 1999). Women have been relatively neglected in AIDS research, with the result that women who contract AIDS in the US receive less treatment and have a higher death rate. Already, AIDS is the third largest cause of death for women aged 25–44 in the US, after cancer and unintentional injuries (Doyal 1999). There is increasing evidence that women have a greater biological vulnerability than men to contracting AIDS through unprotected sexual intercourse (Doyal 1999). Therefore the current gender difference in AIDS deaths may become more equal over time or result in a female excess. The prevalence of AIDS and of AIDS deaths varies enormously between countries. For example AIDS deaths are low in the UK; accounting for under 5 percent of male deaths aged 30–34 in 1992 and a smaller proportion for other age groups, and under 1 percent for women in all age groups (Tickle 1996).

EXPLAINING GENDER DIFFERENCES

Before examining gender differences in morbidity, we will review the kinds of explanations put forward to account for gender differences in mortality and in health.

1 *Biological*. Associated with genetic or hormonal differences between women and men. The range of gender differences in mortality identified above clearly demonstrates the importance of factors other than biology.

2 *Psychosocial differences*. Related to gender differences in personality, coping behaviors and self-efficacy, which influence the experience and reporting of symptoms. Emslie et al. (1999) analyze orientation to gender roles and health, showing that high “femininity” scores are associated with poor health.

3 *Risk behaviors*. Epidemiologists are particularly concerned with gender differences in health promoting and health-damaging behaviors. The higher levels of smoking and drinking among men are emphasized, including the adverse effects of binge drinking. In western countries women have a better diet (Cooper et al. 1999), and participate more in preventive health measures such as screening. The growing trend for women to engage in smoking, drinking, and more risky behaviors has been termed the “female emancipation hypothesis” (Hemström 1999).

4 *Occupational and work-related factors.* There are health hazards associated with both paid work and unpaid domestic work. Working-class men have traditionally been employed in more dangerous occupations with greater industrial hazards (Hart 1988). Less attention has been paid to the repetitive nature and lack of autonomy of much women's work, which may create greater stress and repetitive strain injuries (Doyal 1995). Bartley et al. (1992) discuss the health hazards of women's unpaid work in Britain, and in developing countries women are often involved in very hard physical work, such as carrying water long distances and heavy agricultural production (Doyal 1995).

5 *Social roles and relationships* differ between women and men and may impact on health (Fuhrer et al. 1999). Women in western countries often have better social networks than men, and can more easily rely on contact with close friends and relatives in times of crisis and stress. Marriage may provide a major source of social support, but in a differential way for men and women and across societies. In terms of social support, marriage may be good for men but less so for women. Men tend to rely more on their wife for social support and a confiding relationship, with divorced and widowed men reporting particularly poor health.

6 *Power and resources within the home.* Patriarchal control within the family and domestic settings may lead to exploitation of women and violence against them. Women's lack of power and influence in the home, and lack of access to valued resources (of food, opportunities for leisure, income), may have adverse health consequences.

7 *Social structural differences within society.* Women in most societies are more likely than men to be poor, have less education, and live in disadvantaged material circumstances, all of which are likely to impact on gender differences in health. Kawachi et al. (1999) report lower levels of women's mortality in states with higher levels of women's economic autonomy, higher levels of labor market participation, and higher political participation.

Gender inequality in the domestic setting may vary with class and ethnicity and may coexist with greater equality in the wider society (as in many western societies today). Alternatively, inequality in the domestic sphere may be predicated on and influenced by wider social, cultural, and economic inequalities at the societal level, as in India and Bangladesh. Women's health and well-being is jeopardized by women's unequal status both within the family and within society.

GENDER DIFFERENCES IN MORBIDITY

It has become accepted wisdom that "women are sicker, but men die quicker" (Lahelma et al. 1999). The higher morbidity rate but lower death rate of women was characterized by Nathanson (1975) as a "contradiction" which required explanation. Other US authors in the 1970s and 1980s repeatedly demonstrated that "females have higher rates of illness than males" (Verbrugge 1979: 61), and examined reasons for "the discrepancy between the male excess of mortality and the female excess for some morbidity measures" (Waldron 1983: 1107). A

number of the explanations put forward related to gender roles, for example, that women tend to over-report morbidity more frequently than men, and that women are more predisposed than men to rate their health as poor (Waldron 1983).

Survey data in Europe in the 1990s, however, suggests that gender differences in global measures of health and well-being are relatively modest, and of much less importance than the previous orthodoxy suggested (Macintyre 1993; Macintyre et al. 1996; Macintyre et al. 1999). Macintyre et al. (1996) examined different measures of health using various data sets and found a lack of consistency between health measures in whether there was a female excess in morbidity. In Finland, Lahelma et al. (1999) used eight measures of health and found no gender difference in self-assessed general health, but women reported more mental and more physical symptoms.

Despite the lack of gender difference in global measures of ill health, there are major gender differences in mental health (Macintyre et al. 1996). Women are more likely to report a range of neurotic disorders, e.g. anxiety and depressive disorders. However, Dunnell et al. (1999) show that when men's higher rates of alcohol and drug dependence are included, there is only a small gender difference in the prevalence of psychiatric disorders within five-year age groups.

Macintyre et al. (1996) show that gender differences in health vary according to the health measure used and stage of the life course. Therefore it is necessary to conduct studies of different age groups, rather than assume that the same relationships remain constant throughout the life course. A US study analyzed men and women aged 53 and showed that women had better self-assessed health than men, but women reported higher levels of functional limitation and symptom discomfort than men (Marks 1996). Lahelma et al. (1999) found a 20 percent higher level of disability among women than men over age 50.

Older women are more likely than older men to suffer from conditions which are non-fatal but result in chronic and disabling illnesses hindering their activities of daily living (Arber and Cooper 1999). In Britain in 1994, nearly twice as many women as men over 65 suffered from functional impairments sufficient to require help on a daily basis to remain living in the community – 15 percent of women and 8.5 percent of men (Arber and Cooper 1999). This gender difference in functional disability occurs for each age group of older people, but is particularly stark at ages above 85 among whom nearly 40 percent of women and 21 percent of men suffer from severe impairment. The findings of Marks (1996), Lahelma et al. (1999), and Arber and Cooper (1999) suggest a lack of gender difference in self-assessed health among older people, which co-exists with older women being much more likely than older men to experience severe disability.

A key concern is the extent of gender difference in “healthy life expectancy,” that is the period of life without disability or chronic ill health (Valkonen et al. 1997). Because of women's higher level of disability, there is a smaller gender difference in “healthy life expectancy” than in mortality.

GENDER DIFFERENCES IN ACCESS TO LONG-TERM AND SOCIAL CARE

The greatest threat to a person's autonomy and independence is generally considered to be entry into a nursing or residential home. The UK 1991 census showed that twice as many women as men over 65 lived in communal establishments, 3 percent of men and 6.4 percent of women (OPCS 1993). This gender differential is particularly pronounced over age 85, when 26 percent of women and 15 percent of men are residents (Ginn and Arber 1996).

Gender differences in residential living do not exist because of gender *per se*, but are influenced by social variables such as marital status, which acts as a proxy for the availability of informal carers. Two-thirds of older men are married whereas half of older women are widowed (ONS 1998), so older women are less likely to have a spouse to provide care should they become disabled, increasing their likelihood of entering residential care. Despite the higher level of functional disability of older women than men, men who are not married are more likely than women of an equivalent age and marital status to live in residential homes (Arber 1998).

Although older women have a longer expectation of life than men, they also have a longer period in which they can expect to be disabled or live in a residential setting. The gender differential in disability means that older women are more likely to require both care from relatives and from state health and welfare services (Arber and Ginn 1991). In Britain, nearly half of disabled older women live alone, which means they are heavily dependent on the unpaid work of relatives and other unpaid carers, as well as on state domiciliary services, mainly home care services and community nurses. Older women's disadvantage is compounded by their lower average income.

Changes in community-care policies in Britain in the 1990s have made it more difficult for older people to obtain state-funded residential care and state-provided home care (Walker 1993). Although such policies are put forward as gender-neutral, they have had greater adverse effects on older women. Older men not only have more financial resources to pay for care, but are more likely to have a wife who can provide care should they need it, whereas older women tend to live alone (Arber and Ginn 1991). Thus a gender analysis of health in any society needs to consider the gendered nature of access to caring resources and the gendered effects of social policies.

STRUCTURAL INEQUALITIES IN HEALTH AMONG WOMEN AND MEN

In the late 1970s, many researchers moved away from examining gender differences in health toward a more explicit focus on differences in health *among* women. Early work was cast in a role analytic framework, examining to what extent additional roles, such as the parental role and paid employment, had beneficial or adverse consequences for women's health (Nathanson 1980; Ver-

brugge 1983; Arber et al. 1985). Predating and alongside this strand of work was the growing body of research on inequalities in men's health, stimulated by the publication in Britain of the Black Report (Townsend and Davidson 1982). During the late 1980s and 1990s, feminist researchers have examined to what extent similar structural factors, associated with social class and material disadvantage, were associated with women's and men's health (Arber 1991, 1997; Macran et al. 1996; Lahelma and Rahkonen 1997; Bartley et al. 1999). Researchers stressed the importance of examining women both in terms of their structural position within society and their family roles.

This approach emphasized the need to examine how socioeconomic circumstances, together with marital and parental roles, influence health and assess any differences for women and men (Arber 1997). The key structural variables which influence an individual's health are related to labor-market position, i.e. occupational class and employment status, both of which are influenced by the individual's level of educational qualifications. Family roles are likely to influence health. However, whether a woman becomes a lone parent and her age at childbearing may also be influenced by her class and educational attainment. These relationships between family roles and structural variables are likely to be greater for women than for men. The effect of women's family roles on health must be seen within the context of the material resources available to her household and for bringing up children (Arber et al. 1985; Arber 1997).

Early research on marital status and health (Verbrugge 1979; Morgan 1980; Wyke and Ford 1992) found that the divorced and separated had poorer health than the married, and that single men, but not single women, report poorer health than the married. However, recent British research (Arber and Cooper 2000) shows that married men and women have better health than the never married, and the previously married have the worst health. The previous orthodoxy that married women have poorer health than single women no longer holds, possibly reflecting changes in the meaning of marriage in the late twentieth century and career opportunities for married women which 30 years ago were only viable for single women.

There has been less research on parental roles and health, especially in relation to lone parenthood. In the UK, a major change over the past 20 years has been the increasing number of lone mothers (ONS 1999). Arber and Cooper (2000) show that parenthood in disadvantaged material circumstances is associated with poor health, especially for single mothers. Single, divorced, and separated mothers in the 1990s report particularly poor health, which can be explained largely by their disadvantaged structural circumstances.

Among working-age men and women, educational qualifications and social class, based on the individual's own occupation, are closely associated with self-assessed health (Arber and Cooper 2000). Those whose current (or last) job is in a lower class occupation and who have less educational qualifications are most likely to report poor health. These patterns are broadly similar for men and women, although the class gradient is weaker for women, whereas the health gradient with educational qualifications is comparable for women and men. Matthews et al. (1999) also found no gender difference in the magnitude of health inequalities by social class at age 33 in Britain.

Among older women and men, occupational class continues to structure health inequalities in Britain (Arber and Ginn 1993; Arber and Cooper 1999) and in Norway (Dahl and Birkelund 1997). There are strong class inequalities, showing the continued influence on health of occupational position in the labor market during working life, which is somewhat stronger for older men than for older women.

A gender analysis requires consideration of differences in the power and structural position of women and men within societies. Women and men occupy different structural locations within society; there is occupational sex segregation (see Emslie et al. 1999), and women are more likely to have low incomes and to be lone parents than men (ONS 1999). It is therefore essential to examine the extent to which gender differences in health may at least in part be explained by women's social disadvantage in terms of education, income, and political influence. For example, Verbrugge (1989) analyzed how sex differences in over 40 measures of health for adults in Detroit changed when a range of factors were statistically controlled, including role statuses, role satisfaction, lifestyle (smoking, drinking, obesity, and physical activity), stress and health attitudes. Her multivariate analyses showed that the female excess of ill health diminished for most health measures and in some cases was reversed (although the resulting male excess was non-significant).

In later life, the concentration of poverty among women is particularly marked (Arber and Ginn 1991; Ginn and Arber 1996). On average, women are older than men, they are more likely to be widowed, have worked in lower social class occupations, and have less income. Therefore, any gender differences in health in later life may reflect the socioeconomic disadvantages of older women. For older people, there is no gender difference in self-assessed health once socioeconomic and demographic characteristics are controlled, but the disadvantage of older women in terms of functional disability remains substantial (Arber and Cooper 2000). This research revealed a "new paradox" that older women have a more positive self-assessment of their health status than men, once age, class, income, and women's higher level of functional disability were taken into account.

CONCLUSION

Medical sociologists up until the 1980s paid particular attention to women's reproductive health and the medicalization of women's health. Broader issues associated with women's health were masked by the assumption that white, male bodies are the norm for human health. Parallel to this was a neglect of issues associated with men's ill health

A gender analysis of health needs to be sensitive to the ways in which social, economic, and political factors affect gender roles and relationships, and the consequences of these for health. The chapter considered gender differences in mortality and morbidity, including how the gendered nature of social roles and relationships impact on health inequalities.

In the quarter of a century since Nathanson (1975) published her article on “the contradiction” between sex differences in mortality and morbidity rates there have been far-reaching structural changes in women’s lives in western societies. Major changes in gender roles over that period of time lead to the expectation that previous sex differences in morbidity will also have changed. Women have entered the paid labor force in increasing numbers, have gained greater financial independence and few women remain full-time housewives for more than a few years when their children are young. Because of these gender role changes it is unsurprising that the orthodoxy of women being “sicker” than men has increasingly been questioned (Hunt and Annandale 1999).

Women in most societies are more likely than men to be poor, have less education, and live in disadvantaged material circumstances. The feminization of poverty in the US and UK has been widely acknowledged, and is particularly associated with lone motherhood and older women. Gender differences in health in western societies, therefore, partly reflect these disadvantages which women are more likely to face. The chapter also examined to what extent cross-cutting social structures, such as class, family roles, and age, have a similar influence on the nature of health inequalities among women and men. We conclude that the nature of inequalities in women’s and men’s health is likely to differ over time and between societies in concert with the way in which gender roles and relationships vary historically and cross-nationally.

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