Relationship between gender and health

Sex, Gender and Health

Introduction

One of the main objectives of the National Health Service set out in the 1940's was " To ensure that everybody in the country-irrespective of means, age, sex, or occupation-shall have equal opportunity to benefit from the best and most up to date medical and allied services available (Ministry of Health, 1944). Although the words equity and equality do not feature in documents from the early days of the NHS, there are many reasons to conclude that the service was intended to provide equal access or actual treatment for those in equal need (Delamothe, 2008). This concept had been refined since then, and an equitable health service is understood to mean " one where individuals' access to and utilisation of the service depends on their health status alone." (Dixon et al., 2003). There are many explanations for factors attributable to differences in the equity of care, such as income, income inequality, social connectedness, and social capital, which have all shown some association with health and illness (Berkman & Syme, 1979; Fiscella & Franks, 1997; Kawachi et al., 1997; Lomas, 1998; Naidoo & Wills, 2000). This paper shall examine the meaning of gender as another of these determinants of health. The differences between the terms sex and gender shall first be discussed. Secondly pathways through which gender effects health shall be examined, paying particular attention to risk behaviours, gender roles, and gender discrimination. Finally, the differential exposure and differential vulnerability hypotheses shall be discussed.

Sex and Gender

Raymond Williams argued that vocabulary involves not only ‘ the available and developing meaning of known words’ but also ‘ particular formations of meaning-ways not only of discussing but at another level seeing many of our central experiences’ (Williams, 1983 p15). Language in this sense embodies ‘ important social and historical processes’ in which new terms are introduced or old terms take on a new meaning. Often ‘ earlier and later senses coexist, or become actual alternatives in which problems of contemporary belief and affiliation are contested’ (Williams, 1983 p22). The introduction of ‘ gender’ in English in the 1970s as an alternative to ‘ sex’ was to counter the implicit and explicit biological determinism pervading scientific lay language (Krieger, 2003). Sociologists describe sex as the relatively unchanging biology of being male or female, while gender refers to the roles and expectations attributed to men and women in a given society, roles which change over time, place and life stage (Phillips, 2005). Genetic profile and hormone profile are both examples of sex, a constant set of biological characteristics that remain the same across societies, whereas expectations about the imperative to bear children, the nature of parenting, or the status of being a mother are more to do with gender roles and expectations. Gender has an impact on health in a variety of ways.

Gender inequalities in health

While women generally experience poorer health than men, the pattern of gender differences in health is varied (Arber & Cooper, 1999). Women have lower rates of mortality but, paradoxically, report higher levels of depression, psychiatric disorders, distress and a variety of other chronic illnesses than men (McDonough & Walters, 2001). The direction and magnitude of gender

differences in health vary according to the symptom/condition and phase of life cycle (Denton et al., 2004). Female excess is found consistently across the lifespan for distress, but is far less apparent, even reversed, for a number of other physical conditions and symptoms (Matthews et al., 1999).

Gender inequalities in income and wealth make women especially vulnerable to poverty. In some parts of the world this makes it difficult for them to acquire the necessities for health, especially during the reproductive years when family needs are greatest (Doyal, 2001). Social norms about the diversions of responsibility mean that many women have very heavy burdens of work, especially those who combine employment with domestic duties, pregnancy and child rearing (Naidoo & Wills, 2001). Often, women in the house receive very little support and many are abused by their family members. It has been estimated that 19% of the total disease burden carried by women aged 15-44 in developed countries is the result of domestic violence and rape (World Bank, 1993). Further to this, anxiety and depression are reported more in women than in men in most parts of the world, yet there is no evidence that women are constitutionally more susceptible to such illness (Doyal, 2001). In Africa, powerlessness and lack of control underlie much of the exposure to HIV/AIDS amongst the female population. Disproportionate barriers (relative to men) in access to resources such as food, education and medical care disadvantage women in much of the developing world. In males risk taking behaviour is the norm amongst males in the developing world.

Risk taking behaviour and its effects on male health

There are now many links on the interaction between masculinity and health emerging (Schoefield et al, 2000). The development and maintenance of a heterosexual male identity usually requires the taking of risks that are seriously hazardous to health (Doyal, 2001). One of the most obvious examples of this regards the working environment. In many societies it is traditional for the man to assume the role of the provider, thus putting males at risk of dying prematurely from occupational accidents (Waldron, 1995), and although there are more women in the labour force, men from the poorest communities still do the most dangerous jobs.

Further to the risks of the workplace, men often feel compelled to engage in risky behaviour to " prove their masculinity", thus they are more likely than women to die in a car crash or dangerous sporting activities (Canaan, 1996). Men are also more likely than women to drink to excess and smoke, which increases ones physiological predisposition to early heart disease and other related problems (Doyal, 2001). They are also more likely than women to desire unsafe sex. A study in Ontario, Canada examined the causes of male deaths between birth and age 45. There reported 1, 812 male deaths, of which 1, 372 (76%) are due to motor vehicle accidents, suicide, and AIDS, leaving 440 deaths unrelated to behaviour. Although the male excess of deaths from car accidents may, in part be attributable to greater distances driven and not behaviour while driving, the male " relationship" with the automobile is almost certainly another aspect of gender roles. Only 308 (33%) of the 936 female deaths are explained by such behaviour. When non-risk taking causes of death are isolated from the data, women under age 45

have a mortality which is 1. 43 times that of men’s. Over age 45 the leading causes of death for both men and women are chronic diseases. Men die of heart disease in equal numbers but at a younger age than do women. With increasing age the number of deaths for women creeps upward to equal that of men (Phillips, 2005).

Differential exposure and differential vulnerability hypotheses

Since gender is a measure of both biological and social differences, it is likely that the health inequalities between men and women reflect both sex-related biological and social factors, and the interactions between them (Denton et al., 2004). There are two general hypotheses that account for these gender based inequalities in health. The differential exposure hypothesis suggests that women report higher levels of health problems because of their reduced access to the material and social conditions of life that foster health (Arber & Cooper, 1999), and from greater stress associated with their gender and marital roles. Many studies have shown that women occupy different structural locations than men: they are less likely to be employed, work in different occupations, and are more likely to be on lower incomes, and to do domestic labour and to be a single parent than men (Denton & Walters, 1999). There are also gender differences in exposure to lifestyle behaviours, such as those previously mentioned (that men are more likely to smoke, consume alcohol) as well as having an unbalanced diet and being overweight, while women are more likely than men to be physically inactive (Denton & Walters, 1999). De Vries and Watt (1996) also suggest that women report higher levels of health problems because they are exposed to a higher level of demands and obligations in their social roles, as

well as experiencing more stressful life events. Women also have lower levels of both perceived control and self esteem than men (Turner & Roszell, 1994), though women report higher levels of social support (Umberson et al., 1996).

The differential vulnerability hypothesis on the other hand suggests that women report higher levels of health problems because they react differently than men to the material, behavioural and psychosocial conditions that moderate health (Denton et al., 2004). Multivariate analyses have shown that men and women differ in vulnerability to some, but not all, of the social determinants of health (Denton et al., 2004). That is, the moderating effect of gender is determinant specific. Having a high income, working full time, caring for a family, and having good social support have been shown to be more importance predictors for predicating health in women than men (Prus & Gee, 2003). Smoking and alcohol consumption are more important as discussed previously, are more important determinants of health for men than women, while body weight and being physically inactive are more important for women (Denton & Walters, 1999). Furthermore, the effects of stress may be experienced and personified by men and women in a variety of different ways. The literature appears to show that women react more to ongoing strains than men do, and are more likely to report and react to stressors experienced by others (Turner & Avison, 1987), while men are more likely to mention and react to economic stressors (Wheaton, 1990). Zuzenak & Mannell (1998) argues that women have a greater vulnerability to the effects of chronic stressors on health due to the greater stress associated with their family and marital roles.

Denton et al., (2004) used multiple indicators of health and its social structural, behavioural, and psychological determinants to gain a comprehensive understanding of the role that social factors play in determining health. They report that women's poorer health is partly due to the reduced access, on average, to the material and social conditions of life that foster health, to their differential exposure to stressful life events and to everyday stressors associated with a women's social roles. Men's health also seems to be reduced by their greater likelihood to partake in risk taking behaviours such as smoking and excessive drinking. These, as well as physical activity are more important to men's health.

Conclusion

Gender is a social construct, and sex is a biological construct. They are each distinct, and are not interchangeable terms. The use of the term gender facilitates discussion of the effects of social norms and expectations on the health of both males and females. It is clear that gender has many effects upon health and well being, and that this is a complex issue, with behavioural and psychosocial determinants of health growing out of the social context of peoples lives. This paper has discussed the social and structural context of peoples lives for health benefits – clearly a strong and well studies theme in the literature (Denton & Walters, 1999; Denton et al., 2004). It seems that behavioural determinants play less of a role in predicting health, yet there effects also tend to be mediated by social structure (e. g. those with a low income are more likely to smoke, drink excessively, and be overweight and inactive. These factors can then, collectively, lead to chronic health problems later on in life. It also seems

reasonable to conclude that men and women suffer from different types of stressor. They also both cope in different ways. For example, the exposure hypothesis proposes that gender-based health inequalities are the result of the differing social location between men and women. There different life style behaviour's and the differing number of chronic stressors and life experienced by men and women. The vulnerability hypothesis proposes that women's health differs from men's because they also react in different ways to factors that determine health. It seems then, that although there are many other sociological factors that can have an impact on health, there are many gender differences to account for also, making this a very complex issue.

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