Relationship between health status and gender

Examining the relationship between health status and gender must take into account the different reflections of gender construction in Australia (Lumb, 2003, p. 73-74). There are numerous expressions of masculinity and it can prove difficult to associate health status with this broad criterion (Smith, 2007, p. 20, 22-23). Traditionally, gender and health status relied upon there being a broad comparison between gender definitions and “ social roles” in which men would tend to be in full-time work while women are engaged in their caring role (Schofield, Connell, Walker, Wood & Butland, 2000, p. 251-252; Barry & Yuill, 2008, p. 149). Nowadays, it has become more fully recognised that such roles are no longer solely filled by either men or women; however the perception of them as “ masculine or feminine” remains (Macdonald, 2006, p. 456). In addition, social construction of both males and females may overlap with one another while examining men’s health status (Schofield et al., 2000, p. 247). It is important to identify men’s gender related issues as this would assist in understanding the impact on men’s health status enabling its’ improvement and diminishing associated the morbidity and mortality (Schofield et al., 2000, p. 249; Berry & Yuill, 2008, p. 151-153-154; Macdonald, 2006, p. 457; Smith, 2007, p. 23). This essay will analyse the relationship between health status of males in Australia. This essay will examine the impact of behaviour on attitudes towards health and will address the relationship between gender and morbidity. It will then discuss the gendering of medicine and disease and finally efforts to tackle the relationship between gender and disease.

Gender and attitudes towards health

The defining feature of many studies of men's health is frequently less simple than a tendency to avoid voicing concern about health issues (Hall, 2003, p. 402-403, 407). Different groups have displayed different features in regard to this feature: firemen, for example, have little reticence in seeking professional help for health issues despite having a very strong sense of " masculine identity" (Macdonald, 2006, p. 457; Hall, 2003, p. 403; Barry & Yuill, 2008, p. 155). However, in other cases, it is argued that men are stoical when faced with illness and delay seeking help until absolutely necessary (Hall, 2003, p. 403, 406). There is a perception that it is a more masculine endeavour to appear strong at times of illness (Hall, 2003, p. 401, 403, 406; Smith, 2007, p. 22; Berry & Yuill, 2008, p. 155). Recently, released statistics from the Australia Movember Foundation (2014) state that such an attitude may be more emphasised when dealing with mental health related issues such as depression.

Approaches with regards to stress or concerns related to health status are frequently result in a dependence on alcohol consumption and drugs use that may then lead to an increase in the mortality features of this group (Macdonald, 2006, p. 457; Barry & Yuill, p. 154). This can mean that a slight reluctance with regards to health related issue may result in a decreased health status (Macdonald, 2006, p. 457). This can be related to the projection of masculinity in Australia that tends to focus upon aggressiveness and independence (Saunders & Peerson, 2009, p. 94).

The feature of viewing men's experiences of health as normal is an important factor in determining the relationship between health status and gender (Macdonald, 2006, p. 456-457). There are a number of different

categories of masculinity mentioned in studies that require attention namely " hegemonic, complicit and subordinated masculinities" (Macdonald, 2006, p. 457; Smith, 2007, p. 22-23; Barry & Yuill, 2008, p. 147-147). It has been highlighted that " hegemonic masculinity" category is perceived as the one that may possess all the power, being aggressive and assertive in decision making and therefore to deemed to be successful in society (Barry & Yuill, 2008, p. 147, 155; Saunders & Peerson, 2009, p. 94). While the " complicit and subordinated masculinities" categories are considered to be less powerful and to some extent are unable to conform to the expectations related masculinity (Barry & Yuill, 2008, p. 147; Smith, 2007, p. 23). These divisions do not illustrate how health is considered in relation to masculinity, however, when it comes to " hegemonic masculinity" the health issues may be associated with gender health issues (Smith, 2007, p. 21, 22; Saunders & Peerson, 2009, p. 94). Even though the relationship between " subordinated masculinity" and " femininity" might seem evident in social context, it might result in different socio-economic roles that might not correspond to health status (Barry & Yuill, 2008, p. 147-148; Macdonald, 2006, p. 457; Smith, 2007, p. 23). For example, if masculinity is related to power, then this would imply that those men who do not hold power are essentially fulfilling a female role in society (Barry & Yuill, 2008, p. 155). The concept of masculinity is seen when the men are strong and capable with a lesser likelihood of seeking help for their health related issues (Barry & Yuill, 2008, p. 155; Smith, 2007, p. 23). There is likely to be overlaps between " assertive femininity" and " subordinated masculinities" (Barry & Yuill, 2008, p. 155). It is frequently presumed that in Australia, masculinity is essentially one of aggressive, risk taking behaviour; however, there is an extent to which this

can no longer be justified as representing the full spectrum in the present day (Smith, 2007, p. 23).

Gender and morbidity

Gender associated with morbidity (Barry & Yuill, 2008, p. 152). It is presumed that the life expectancy of males is less than that of women due to their behaviour pattern in society (Carl, Baker, Robards, Scott, Hillman & Lawrence, 2012, p. 171). The evidence would suggest a more complex relationship between these factors (Carl et al., 2012, p. 171). Masculine roles in society might involve a greater tendency towards behaviour that poses damage to health, such as more excessive drinking, a greater rate of smoking, and a greater likelihood to take risks (Smith, Braunack-Mayer & Witter, 2006, p. 82). When this is coupled with the reluctance to seek help for less-serious problems, the extent to which the relationship between morbidity is biologically rather than socially determined can be questioned (Smith et al., 2006, p. 82). It has been noted that the gap between the mortality rates of men and women is closing, and it seems plausible that this is related to a greater blurring of the relationship between sex and gender behaviours (Barry & Yuill, 2008, p. 152). For example, there is a greater equality in damaging health behaviours, with greater equality between smoking and drinking (Barry & Yuill, 2008; Carl et al., 2012, p. 171). Though at this stage the potential for a biological link cannot be entirely ruled out, the closing gap in morbidity between men and women may have more to do with gender than with sex (Smith et al., 2006, p. 82; Barry & Yuill, 2008, p. 152).

Gender holds the potential to overcome other factors of health status (Smith, 2007, p. 23). For example, a study was completed that examined the relationship between morbidity in Australia and different geographical areas (Saunders & Peerson, 2009, p. 94). This concluded that mortality rates a clearly related to the socio-economic characteristics of an area, which suggested that health inequality is related to class (Macdonald, 2006, p. 457). If this is associated with the notion that some patterns of work are considered masculine and therefore may require " high physiological and psychological demand", then it might be perceived that on a county-wide level men would have a lower health status due to high stress jobs (Macdonald, 2006, p. 457; Saunders & Peerson, 2009, 94).

It should also be possible to perceive that higher-paid jobs might result in lower levels of health because such work might rely upon the presentation of masculine qualities, such as assertiveness and independence (Saunders & Peerson, 2009, p. 94; Macdonald, 2006, p. 457). There is an extent to which explanatory variables concerning the relationship of health status with specifically masculine attributes are less simple when viewed in a wider context (Macdonald, 2006, p. 457-458).

The extent to which male tend not to refer to health specialists and take medicine has been considered a particular gender characteristic of the health status (Smith et al., 2006, p. 81). However, there is a biological factor that might impact upon this: women of reproductive age tend to consult doctors for matters relating to health issues, so there is greater contact even when there is no immediate health risk (Smith et al., 2006, p. 82; Galdas, Cheater & Marshall, 2005, p. 617-618). The unwillingness within men to

consult doctors seems to exist independent of this factor (Smith et al., 2006. p. 82). It is possible that feminine roles in society have come to include these features: there is a greater likelihood of contact with medical professionals when caring for the health of children. (Galdas et al., 2005, p. 617-618)

Conversely, masculinity in society may be associated with factors of independence and demonstration of strength that might preclude seeking attention for medical care (Barry & Yuill, 2008, p. 155; Saunders & Peerson, 2009, p. 94; Galdas et al., 2005, p. 619). However, it is possible that these features have been significantly over-emphasised (Saunders & Peerson, 2009, p. 94). If the issues are deconstructed, the only serious illness of concern may be those that might result in death, but whose symptoms are relatively benign at the beginning, such as cancer (Park, Kim, Koo, Park & Lee, 2008, p. 979, 983). It appears that differences between men and women were slight in this regard: if there was a serious illness, almost everyone seeks medical help regardless of gender (Park et al., 2008, p. 980-981; Barry & Yuill, 2008, p. 152). However, it was revealed that males still may procrastinate with cancer diagnostic tests that eventually may lead to the development of cancer (Park et al., 2008, p. 984).

Gender, medicine and disease

There is a potential difference in how the medical profession treats people on the basis of gender (Riska, 2011, p. 265-266). This has a number of causes: there may be the effect of different gender balances in the types of diseases that are encountered (Riska, 2011, p. 265). However, it should also be noted that medicine is essentially a gendered occupation: nursing is still regarded

as a feminine role, with doctors continuing to be dominated by men (Riska, 2011, p. 265; Carl et al., 2012, p. 82). This is more than the impact of different sex ratios in the profession, but the perception that medicine is a masculine role (Ozbilgin, Tsouroufli & Smith, 2011, p. 1588-1589). It has been argued that the ways in which doctors behave is formed by gender roles, with a more paternal role being undertaken in contrast to the maternal caring role of the nursing staff (Riska, 2011, 265; Ozbilgin et al., 2011, p. 1589; Carl et al., 2012, p. 82). Diseases are often viewed in specifically gendered fashion, with health drives being characterised as ‘ wars’ and combatting disease seen as a ‘ fight’ (Ozbilgin et al., 2011, p. 1589, 1592-1593; Park et al., 2008, p. 978, 985-986). Other diseases are gendered, in that they are seen as specifically male or female, even when this might not be the case in practice (Ozbilgin et al., 2011, p. 1588-1589). An example might be seen in breast cancer, which is widely perceived as a female disease even though it can occur in men (Park et al., 2008, p. 978). The fact that the emphasis on breast cancer is focused on women’s experiences leads the perception that this is a disease distinctive to one sex, which means that the survival rates of men are much lower (Park et al., 2008, p. 984-985). The definitions of health and illnesses are frequently gendered, and the medical institutions that treat diseases are also not external to society, and therefore reflect the gender concerns of the wider context (Park et al., 2008, p. 984).

Approaches to breaking down the relationship between gender and health status

Despite these arguments that suggest that the masculine approach to illness may be overstated, it is clear that the social construction of masculinity is an

issue requiring attention (Smith et al., 2006, p. 81-82; Smith, 2007, p. 21). A recent government report (Department of Health and Aging) (2010) reviews the social construction of masculinity can be reflected in the formulation of a men's health policy in Australia. This represents a development to parity and gender inclusiveness in how health issues are dealt with in the country (Smith, 2007, p. 21, 24; Macdonald, 2006, p. 457).

In Australia, for example, investment programs may support the males' health in relation to prostate cancer that is responsible for males' health issues (Smith & Robertson, 2008, p. 284-285). Health promotions focussed on addressing this problem show significant differences to those directed at women: they aim to ally health concerns with traditional conceptions of masculinity, perhaps to break down the associations traditionally made (Smith, 2007, p. 21). Australia Movember Foundation (2014) draws attention to men's health issues throughout the country. The concern with the gendering of health and disease can be seen as reflected in the need for a men's mode of health practice (Smith, 2007, p. 21). Pioneered in Victoria, an initiative was developed to engage men from rural communities in health issues (Hall, 2003, p. 406-407, Smith, 2007, p. 22). To an extent, it is problematic to associate behaviour with attitudes towards health (Smith et al., 2006, p. 81). An important feature of these approaches is the implicit acknowledgement that health issues are not just presented in how they are associated by men within society (Saunders & Peerson, 2009, p. 93-94, Smith et al., 2006, p. 81; Smith, 2007, p. 21). The focus on " male-specific health promotions" also indicates an acknowledgement of the impact of gendering within the medical and healthcare professions (Smith, 2007, p. 22-

23). Nevertheless, aspects such as different health promotions for men do not essentially challenge the social construction of masculinity but attempt to work within these understandings of health and illness (Smith, 2007, p. 23). This might suggest that breaking down the boundaries between masculine and feminine perceptions of health are still a long way off (Smith, 2007).

Conclusion

In conclusion, deconstructing the relationship between gender and health status has proved intractable. In the first place, gender can be seen as promoting significant approaches to health and different lifestyle choices. These can impact on other lifestyle choices, such as combatting depression with alcohol rather than seeking medical assistance. However, the gendering of health issues also pervades the health professions. It is also potentially not as acute as other factors, such as socio-economic circumstances. Nevertheless, there are significant differences in approaches to health that have been tackled using a “ gender-specific approach” and “ gender-specific health promotion” (Smith, 2007, p. 23; Saunders & Peerson, 2009, p. 93). This reflects the attention that the relationship between health promotion and masculinity has engendered in recent decades. However, these approaches frequently seek to work within existing cultural stereotypes rather than challenging them. This means that the influence of associated gender behaviour and health may continue to affect health status in Australia for the foreseeable future.