Keywords: Gender/Marxism/Feminism/Sociology

●This article has been double-blind peer reviewed

This part of a series on the socioeconomic influences on health and wellbeing discusses how sociology can help to explain health patterns associated with gender

PART 3 OF 5: SOCIOLOGY IN NURSING

How gender influences health inequalities

In this article...

- Sociological theory relating to gender-based health patterns
- How society affects the health of men and women
- A Marxist-feminist view of women's role in society

Author David Matthews is lecturer, health and social care, Coleg Llandrillo, Rhos on Sea.

Abstract Matthews D (2015) Sociology in nursing 3: how gender influences health inequalities. *Nursing Times;* 111: 43, 21-23. This third article in a five-part series on the relationship between sociology and nursing practice discusses the issue of gender as a social determinant. Health inequalities between men and women are the result of the interaction between biology and society in terms of how society structures and influences our lives. Men and women have different expectations and roles imposed on them by society and this has a significant impact on health.

While a range of socioeconomic factors influence health and wellbeing, gender is of particular significance. While women have lower mortality rates than men (Annandale, 2014), they also experience greater morbidity and are over-represented in health statistics (White, 2013). This gives rise to the notion that "men die quicker but women are sicker" (Bartley, 2004), although recent figures show that the gender gap is closing (Box 1).

In addition to overall mortality and morbidity, certain health and wellbeing issues are more commonly associated with one gender. For example, dementia, depression and arthritis are more common in women, while men are more prone to lung cancer, cardiovascular disease and suicide (Broom, 2012). The popular biomedical interpretation would argue that variations in health and lifespan can be accounted for by inherent biological differences between men and women. This has led to gender-specific medicine using scientific analysis to explain variations in the physiological differences between the sexes (Annandale, 2014). However, scientific analyses can be criticised for overemphasising differences associated with gender – in biological terms there is less difference between male and female than popular belief suggests.

Although it influences health, biology does not determine it (Annandale, 2014). Health inequalities between the sexes are the result of the interaction between biology and society in terms of how society structures and influences our lives. This article discusses the issue of gender as a social determinant and demonstrates that the way society shapes men's and women's lives has a significant impact on their health. It also examines the extent to which sociological theory can be used to explain health patterns associated with gender.

Society and gender

There have been a range of theories as to how and why society influences gender inequalities, although there are broad agreements about potential influences. One of these is the gender-specific roles prevalent in society and society's response to these roles.

Women are the main providers of informal care for children, disabled and older people and, some feminists argue, men. The effects of this role can include reduced sleep, less leisure time and increased risk of poverty for women who

5 key points

1. Women have lower mortality rates than men, longer life expectancy, greater morbidity and are over-represented in health statistics
2. Some health problems are more commonly associated with one gender than the other
3. Sociological factors are as important as biology for determining gender-related health inequalities
4. Women's natural reproductive function has increasingly been medicalised, leading to the increased need for healthcare
5. Expectations of how men and women should behave are based on social constructs and have an impact on health

Gender constructs are such that women tend to be seen as carers, while men are more likely to engage in dangerous activities and internalise problems, taking solace in alcohol

Alamy

are full-time carers. All of these can have serious negative consequences for both physical and mental health. Indeed, it has been suggested that the potential impact of the caring role on mental wellbeing may explain the higher rates of depression in women of childbearing age (Bebbington, 1996).

Women's role as carers has been justified as a result of their reproductive function. However, while this is determined by biology, the way it is understood is socially constructed and can affect their experience of health. Women's natural reproductive function has increasingly been medicalised. For example, mood changes around the time of menstruation are no longer viewed as a natural period of hormonal imbalance resulting in premenstrual tension (PMT), but is now a medical syndrome (premenstrual syndrome) (Morrall, 2009). This medicalisation means women consult doctors and attend hospital more often (White, 2013) than men.

Since their bodies have been constructed as a medical issue to a greater degree than men's, women are scrutinised and regulated more by medical professionals. This, along with their role as the main providers of care, are significant reasons for their over representation within health statistics.

Outside of childbearing age women tend to attend hospital at the same rate as men (Broom, 2012), and when men and women are exposed to the same stressful non-gender specific situations they have broadly the same rates of depression (Nazroo et al, 1997). When variables are no longer a factor, or are controlled, gender-related health inequalities reduce.

BOX 1. **LIFE EXPECTANCY**

- In England and Wales, between 2007-09 and 2011-13, life expectancy for men increased from 78.1 years to 79.3 years, and for women from 82.2 years to 83.0 years. As such, the gender gap reduced from 4.1 years to 3.7 years
- Healthy life expectancy in England was 63.4 years for men and 64.1 years for women in 2010-12; this gender gap is less than for life expectancy in general, meaning men will have more years of good health relative to overall life expectancy than women

Source: Office for National Statistics (2014a, 2014b)

Masculinity and femininity

Expectations of how men and women should behave are influenced by the concepts of femininity and masculinity, and have consequences for health and wellbeing. However, these concepts are social constructs; what it means to be a man or woman is culturally and historically specific. The emphasis on women as the main providers of care is a construction of femininity by society, while societal pressures on women in terms of appearance can be identified as contributing to the greater prevalence of eating disorders among young women, as well as the reduced levels of physical activity in adolescent girls.

Constructions of masculinity can have similarly negative consequences for men. Perhaps in an effort to "prove" themselves, young males have a tendency to be less risk averse than young women, making them more likely to take part in contact sports, excessive alcohol consumption and dangerous driving. As a result males have higher rates of accidental and non-accidental injuries (Broom, 2012).

Further, it is argued that women have more mental health problems but are more likely to express their feelings and seek support, while men are more likely to internalise anger, turning to substance and alcohol abuse for relief, potentially resulting in drug abuse or even suicide (White, 2013).

Ideas of masculinity and femininity influence choice of occupation, and the notable gender divisions within the labour force also have health consequences. For example, manual occupations – some of which are potentially dangerous – are predominantly performed by men, which exposes them to higher levels of risk. Indeed, of the 350,000 occupational deaths that occurr globally every year, 90 per cent are men (Mathers et al, 2009).

Social divisions and gender inequality

Although gender-specific roles have significant health consequences, gender does not operate alone, but interacts with other factors. This can be illustrated by looking at the impact on women of socioeconomic status and inequality.

While men have often been the subjects of studies on the impact of socioeconomic inequality on health, there is no reason to assume that such inequality matters less to women than it does for men. This has the potential to exacerbate health inequalities between men and women, but can lead to inequalities and different experiences of health between people of differing backgrounds within each gender.

Many women take career breaks to raise children or care for other family members, while others work part-time to fulfil their caring responsibilities – as a result, women tend to have a lower socioeconomic status than men. Although data regarding the links between their socioeconomic status and health is relatively limited (Annandale, 2014), it is possible to surmise that more women are located at the lower end of the socioeconomic scale than men, which would contribute to health inequalities between men and women. These effects are particularly acute for single women with children. Although some women who are married or in a stable relationship with a working partner may be of a lower socioeconomic status than their partner, they benefit from the material advantages provided by their partner's socioeconomic

BOX 2. **EFFECTS OF SOCIOECONOMIC STATUS**

Life expectancy in women varies depending on their socioeconomic status:

- Class 1 (highest classification): 83.9 years
- Class 3: 82.7 years
- Class 7 (lowest classification): 79.7 years

The difference between classes 1 and 7 is 4.2 years.

Source: Office for National Statistics (2011)

position. This explains why there are differences in the impact of economic inequality on health among women; there are also differences in life expectancy for women in different socioeconomic groups (Box 2).

Theoretical explanations: Marxism and feminism

Social theory can provide a context in which to interpret health patterns. Feminism is a broad theory, offering a variety of perspectives from which to understand women's position in society. In general, feminists argue that society disadvantages women by constraining them and limiting their opportunities. This is enforced through the domination of beliefs, theories and ideas that support and justify women's subordinate position relative to men. While there were significant advances towards equality during the 20th century in advanced capitalist societies, feminist theory argues that women are still exploited by society's structural organisation combined with embedded cultural attitudes and ideas that function together to exert social control over women (Turner, 2013; McDonnell et al, 2009; Rogers, 2009).

Although, like feminism, Marxism is characterised by considerable interpretation, all varieties of Marxism are critical of capitalism. The goal of capitalism is the increasing accumulation of profit, which Marxist theorists believe originates from the exploitation of the labour force – primarily by paying them less than the value of what they produce. Capitalist societies are characterised by significant economic inequality and oppression, with major inequality in wealth between the mass of the labour force and those in control of society's economic resources. Marxists argue that social institutions such as the government, family, media and health system are influenced by the needs of capitalism, and operate to support the continued accumulation of profit to maintain this unequal situation (Miliband, 2004; Callinicos, 1999). They believe that society's social organisation benefits capitalism at the expense of the majority.

Utilising both theories simultaneously, a Marxist-feminist perspective emphasises that women's position of subordination is largely the result of the interaction between patriarchy – the dominance of men – and the needs of capitalism.

Many feminist perspectives have drawn on the medicalisation of women's bodies as an illustration of social control by a patriarchal medical profession, arguing that most of those in a position of influence are male and use scientific knowledge formulated largely by men. Feminists believe that men also primarily control the reproductive process, including access to contraception, pregnancy and childbirth, and reproductive technology. Women must submit themselves to male authority and knowledge, reducing their ability to make their own informed decisions (Abbot et al, 2008); their submission to such medical intervention reinforces female characteristics of passivity and dependence (White, 2013) and can be seen as an illustration of patriarchal social control over women.

Scientific understanding of women's bodies with regard to reproduction has historically had consequences for their social role (Doyal, 1985). Science is often used as a tool to explain the natural world, and its increasing application to the reproductive process reinforces both the assumption that women's nurturing role is natural and the expectation that they take on the role of carer. Marxist feminists believe this has many advantages for the economy.

Since the advent of capitalism there has been a division of labour between work and home (Zaretsky, 1986). Labour performed at work is valued, while that performed in the home – domestic tasks still largely undertaken by women – has no economic reward or value. Marxist feminists believe that domestic labour performed by women, including childcare, provides the capitalist system with an army of unpaid labourers whose activities enable family members – particularly men – to work, which subsequently contributes to capitalist growth.

Conclusion

This article has illustrated how gender influences the distribution of health. Instead of reducing the health of men and women to a matter of pure biology, we need to consider society's impact in terms of the roles it confers on them, as well as its expectations of their behaviour, because such social constraints exacerbate the health divisions between men and women. However, while gender has a significant effect on health inequalities, these are not simply differences between men and women. Gender-related factors also lead to significant divisions within each gender, illustrating that the impact of gender varies as a result of other social factors. **NT**

References

Abbot P et al (2008) The medicalisation of reproduction. In: Earle S, Letherby G (eds) *The Sociology of Healthcare: A Reader for Health Professionals.* Basingstoke: Palgrave.

Annandale E (2014) *The Sociology of Health and Medicine: A Critical Introduction.* Cambridge: Polity Press.

Bartley M (2004) *Health Inequality: An Introduction to Theories, Concepts and Methods.* Cambridge: Polity Press.

Bebbington P (1996) The origins of sex differences in depressive disorder: bridging the gap. *International Review of Psychiatry;* 8: 4, 295-332.

Broom D (2012) Gender and health. In: Germov J (ed) *Second Opinion: An Introduction to Health Sociology.* Melbourne: Oxford University Press.

Callinicos A (1999) *The Revolutionary Ideas of Karl Marx.* London: Bookmarks.

Doyal L (1985) *The Political Economy of Health.* London: Pluto Press.

Mathers C et al (2009) *Global Health Risks: Mortality and Burden of Disease Attributable to Major Risks.* Bit.ly/WHOHealthRisks

McDonnell O et al (2009) *Social Theory, Health and Healthcare.* Basingstoke: Palgrave Macmillan.

Miliband R (2004) *Marxism and Politics.* London: The Merlin Press.

Morrall P (2009) *Sociology and Health: An Introduction.* Abingdon: Routledge.

Nazroo JY et al (1997) Gender differences in the onset of depression following a shared life event: a study of couples. *Psychological Medicine;* 27: 1, 9-19.

Office for National Statistics (2014b) *Life Expectancy at Birth and Age 65 by Local Areas in the United Kingdom, 2006-08 to 2010-12.* Bit.ly/ONSExpectancyByRegion06-12

Office for National Statistics (2014a) *Healthy Life Expectancy at Birth for Upper Tier Local Authorities: England 2009-11.* Bit.ly/ONSUpperTierExpectancy09-11

Office for National Statistics (2011) *Trends in Life Expectancy by the National Statistics Socio-Economic Classification 1982-2006.* Bit.ly/ONSLifeExpectancy82-06

Rogers MF (2009) Contemporary feminist theory. In: Ritzer G, Smart B (eds) *Handbook of Social Theory.* London: Sage.

Turner JH (2013) *Theoretical Sociology: 1830 to the Present.* London: Sage.

White K (2013) *An Introduction to the Sociology of Health and Illness.* London: Sage Publications.

Zaretsky E (1986) *Capitalism, the Family and Personal Life.* New York: Harper Collins.

For more on this topic go online...

- Ensuring cultural safety in nurse education
- **Bit.ly/NTCulturalSafety**