

Towards a structuralist understanding of gender differences in health

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Gender differences in health are increasingly examined from a structuralist perspective predicting that similar social conditions are likely to elicit similar health outcomes¹. In other words, determinants of women's and men's health, such as their living conditions and health-related behaviours, can be understood in terms of their social position as well as their social roles.

The origins of a structural understanding of the production of men's and women's health can be traced back to the Parsonian analysis of the sick role according to which women more easily than men adopt the sick role². Since it is socially and culturally more acceptable for women to be ill, they recognise and express more illhealth, and seek more professional help³. A consequence of this view of women as "expressive" and men as "instrumental" was a "normalisation" of gender differences in health, encapsulated in an universal generalisation: "women sicker, but men die quicker".

The early analyses were strongly influenced by the "American values" advocated by Parsons. Although functionalist and conservative in content, the Parsonian tradition was nevertheless the starting point for a serious sociological analysis of gender differences in health. From the 1960s on feminist ideas influenced the Parsonian analysis of gender and health.

A revival of interest in gender differences in health in the 1990s has increasingly questioned the taken-for-granted generalisation, and we can agree with Macintyre et al.⁴ who "were struck not by the consistency of female excess in reported illhealth, but by the lack of the predicted female excess and by the complexity and subtlety of the pattern of gender differences...". The structuralist perspective provides opportunities for a deeper understanding of the observed gender patterns in health by looking at men and women as occupying different social structural positions and roles⁵⁻⁸.

A stream of research in the USA has emphasised for women

their roles as determinants of health⁹. For men, in contrast, their structural and social class positions have been emphasised as major determinants of health. However, gender roles are changing and this is exemplified by women increasingly entering the labour market. As a consequence, women are gaining more economic independence and their roles as well as structural and class positions are changing in most countries. Therefore, an examination of the social determinants of women's and men's health must combine key aspects of the social position, including social class, employment status, material living conditions, and domestic and marital roles⁶.

A combined approach, that of "multiple roles" as determinants of particularly women's health^{9,10}, suggested that women combining roles as a parent, spouse, and employee were excessively burdened and therefore reported poor health. The potential structural advantages of multiple roles were overlooked, and a contrasting approach suggested that employment and marriage provide additional sources of material and social support as well as self-esteem, and therefore employed and partnered women would report better health than their non-employed counterparts.

By now, most studies are in accordance with multiple roles being associated with good rather than bad health. On the one hand, this can be accounted for by structural advantages of multiple role occupancy producing good health. On the other hand, recruitment to different social positions and roles is likely to be selective due to a "healthy worker effect" as well as a "healthy married" and "healthy mother" effect¹¹. In other words, women and men with good health are in an advantageous position at the labour market as well as at the "marriage market". Furthermore, women giving birth to a baby tend to be healthier than those not giving a birth. Although the health advantages of multiple roles seem obvious, countries are different in the extent to which they

support women (and men) combining being a parent and an employee¹². The less economic and other support for childcare and parenting, the less likely are the advantages of combining multiple roles.

Evidence from comparisons of women's and men's health in two different welfare states, i. e., Britain and Finland, is illustrative. In both countries employed women and men have better health than their non-employed counterparts. Finland provides an interesting case, since women, even when they are having small children, are full-time employed nearly as often as men. Women with dependent children and employed women in Britain and Finland have as good or better health than other women¹². Being without paid work is a health disadvantage, and this is seen particularly clearly in Britain. Housewives and unemployed women in Britain have much poorer health than employed women. Looking

furthermore at lone mothers' health we find that in different countries this group shows a particularly poor health^{12,13}. However, in Britain a greater part of the health disadvantage of lone mothers is because of their disadvantaged social structural position.

Gender differences in health emerge from complex interplay with different social structural determinants and their interaction. Therefore, universal generalisations are unlikely to be meaningful. Distinguishing between different structural positions of women and men provides a fruitful starting point for a detailed analysis of gender differences in health. Thus subgroups of women and men with particularly high risks, such as lone mothers or long-term unemployed men, can be identified. This is challenging for further analysis looking for causes of poor health among women and men as well as egalitarian health and welfare policies.

References

- 1 Umberson D, Chen MD, House JS, Hopkins K, Slaten E. The effect of social relationships on psychological well-being: are men and women really so different? *Am Sociol Review* 1996; 6: 837–57.
- 2 Parsons T. The social system. Glencoe, Ill.: The Free Press, 1951.
- 3 Nathanson CA. Illness and the feminine role: a theoretical review. *Soc Sci Med* 1975; 9: 57–62.
- 4 Macintyre S, Hunt K, Sweeting H. Gender differences in health: are things really as simple as they seem? *Soc Sci Med* 1996; 42: 617–24.
- 5 Lorber J. Gender and the social construction of illness. Newbury Park, CA: Sage, 1997.
- 6 Arber S, Lahelma E. Inequalities in women's and men's illhealth: Britain and Finland compared. *Soc Sci Med* 1993; 37: 1055–68.
- 7 Macintyre S, Hunt K. Socioeconomic position, gender and health: how do they interact? *J Health Psychol* 1997; 2: 315–34.
- 8 Lahelma E, Martikainen P, Rahkonen O, Silventoinen K. Gender differences in illhealth in Finland: patterns, magnitude and change. *Soc Sci Med* 1999; 48: 7–19.
- 9 Gove WR. Gender differences in mental and physical illness: the effects of fixed roles and nurturant roles. *Soc Sci Med* 1984; 19: 77–84.
- 10 Nathanson CA. Social roles and health status among women: the significance of employment. *Soc Sci Med* 1980; 14a: 463–71.
- 11 Khat M, Sermet C, Le Pape A. Women's health in relation with their family and work roles: France in the early 1990s. *Soc Sci Med* 2000; 48: 1807–25.
- 12 Lahelma E, Arber S, Kivelä K, Roos R. Multiple roles and health among British and Finnish women: the influence of socioeconomic circumstances. *Soc Sci Med* 2001 (in press).
- 13 Whitehead M, Burström B, Diderichsen F. Social policies and the pathways to inequalities in health: a comparative analysis of lone mothers in Britain and Sweden. *Soc Sci Med* 2000; 50: 255–70.