Contents

Notes on contributors v
Preface vii
Acknowledgements x

1 Gender inequalities in health: research at the crossroads
   Ellen Annandale and Kate Hunt 1

2 Reinforcing the pillars: rethinking gender, social divisions
   and health
   Mick Carpenter 36

3 ‘Narrative’ in research on gender inequalities in health
   Jennie Popay and Keleigh Groves 64

4 Socio-economic change and inequalities in men and
   women’s health in the UK
   Hilary Graham 90

5 Gender and inequalities in health across the lifecourse
   Sara Arber and Helen Cooper 123

6 Trends in gender differences in mortality: relationships
   to changing gender differences in behaviour and other
   causal factors
   Ingrid Waldron 150
iv Contents

7 Gender and socio-economic inequalities in mortality in central and eastern Europe 182
Laurent Chenet

Index 211
Ellen Annandale is Senior Lecturer in Sociology at Leicester University. She is particularly interested in the relationship between the sociology of gender, feminist theory and research on gender, health and illness, and is currently writing *Feminist Theory and the Sociology of Health and Illness* (forthcoming). She is the author of *The Sociology of Health and Medicine* (1998).

Sara Arber is Professor and Head of the Department of Sociology at the University of Surrey. She is currently conducting research with Helen Cooper on older people and health inequalities, and on social support and health for the Health Education Authority. She is co-author with Jay Ginn of *Connecting Gender and Ageing* (Open University Press 1995).

Mick Carpenter is Reader in the Department of Social Policy and Social Work, and Co-Director of the Centre for Research in Health, Medicine and Society, at Warwick University. He has broad research interests in health policy, with inequalities as a central theme. He has acted as a policy adviser to a number of organizations, including the British public service union Unison. Recent publications include *Normality is Hard Work: Trade Unions and the Politics of Community Care* (1994).

Laurent Chenet is a population scientist at the London School of Hygiene and Tropical Medicine who specializes in developed countries’ demography. His areas of research interest include the demography of countries in transition, socio-economic and sex differentials in mortality,
and the impact of health policy. He is currently conducting research on Russia, the Ukraine and Lithuania.

Helen Cooper is a postgraduate student in the Department of Sociology at the University of Surrey, where she is investigating gender and ethnic differences in health using the Health Survey for England. Her work examines health inequalities across the lifecourse. With Sara Arber she has focused on the health of older adults and children.

Hilary Graham is Professor of Social Policy at Lancaster University. Her research and publications have focused on women’s experiences of caring in poverty and how health related behaviours, including diet and smoking, are shaped by these experiences. The implications of increasing poverty and income inequalities in the UK for public health strategies has also been a theme of her work.

Keleigh Groves is currently undertaking a PhD on benefit fraud at the University of Leeds. Her research seeks to relate the meanings that people offer for their fraudulent action to a theoretical framework that acknowledges both social structure and creative human agency. This research is funded by a three-year Economic and Social Research Council (ESRC) research studentship.

Kate Hunt is a Senior Research Scientist at the Medical Research Council’s Social and Public Health Sciences Unit at Glasgow University. She is a social scientist whose main interests are in gender and health, and the social construction of gender. Other current research includes inequalities in health (by social class and ethnicity as well as gender), and lay perceptions of inheritance and their influence on health related behaviours.

Jennie Popay is Professor of Sociology and Community Health and Director of the Public Health Research and Resource Centre at the University of Salford. She is also Associate Director of Research and Development for the Department of Health funded National Primary Care Research and Development Centre, and a non-executive board member of the Mancunian Community Health NHS Trust. She is a social scientist whose work has focused on the social patterning of health and illness, particularly gender inequalities; lay knowledge about health, illness and health care, family and child health; and health and social service policy analysis.

Ingrid Waldron is Professor of Biology and Donna and Larry Shelley Term Professor of Women’s Studies at the University of Pennsylvania. She studies gender differences in health related behaviour and mortality, with a particular interest in recent trends in the USA. She also studies the effects of employment, marriage and parental status on women’s health.
An influential body of research on gender inequalities in health has developed since the late 1960s. However, the combination of rapid social change in the lives of men and women in the last decades of the twentieth century, and an increased questioning of an oversimplified established wisdom about gender and health, makes a critical retrospective especially timely. The rationale for this collection lies both in recent developments in social theory which raise new questions about gender inequalities, and in the restructuring of gender related experiences which are likely to have widespread implications for the mental and physical health of men and women at the start of the twenty-first century. Each chapter questions some of the assumptions underlying the oversimplified orthodoxy and begins to identify ways to inject new energy into the debate.

All the chapters engage, to a greater or lesser degree, with current theoretical debates, some utilize published empirical data, while others involve new analyses of empirical data. Chapters 2 and 3 are orientated towards theoretical critiques of current research on gender and health (as is much of Chapter 1). The later chapters make more extensive use of empirical data, each focusing on different aspects of social change. Thus Hilary Graham (Chapter 4) is concerned with gender in the context of increasing socio-economic inequalities in Britain, Sara Arber and Helen Cooper (Chapter 5), also using data from Britain, focus on gender differences in health at three very different stages of the lifecourse, Ingrid Waldron (Chapter 6) draws on North American data for a detailed review of potential mechanisms underlying the changing pattern of
mortality in the USA in the latter half of the twentieth century, and Laurent Chenet (Chapter 7) examines the impact on gender differences in health of the dramatic social changes following the collapse of former communist structures in eastern Europe during the late 1980s and 1990s. Like much research to date, the collection concentrates on gender and health in industrialized countries, with a particular focus on Britain, the USA and eastern Europe, and it focuses upon health status rather than wider questions such as the experience of health care.

In Chapter 1, Ellen Annandale and Kate Hunt outline general trends in research on gender and health since the 1970s when second wave feminism inspired an interest in the subject, highlighting methodological and theoretical concerns. They describe widespread social change, concentrating on changes in employment, educational qualifications, and the household and family, using Britain as a case study. They draw out three frameworks, the ‘traditional’, the ‘transitional’ and the emerging ‘new’, to summarize shifts in the theoretical and methodological approach to research on gender and health since the 1970s. The chapter argues in particular that research needs to be clearer than it has been to date about the nature of the social relations of gender as they impact upon the health of men and women.

In Chapter 2, Mick Carpenter also stresses the need for a critical reassessment of the theoretical foundations of this research and reviews issues arising out of the New Left and second wave feminism in the 1970s. He argues that problems with the ‘second wave paradigm’ need to be resolved, drawing on recent social and political theory, including postmodern analyses, work on masculinity, the sociology of the body and emotions, and puts forward eight ‘realist’ propositions for research on gender inequalities in health.

In Chapter 3, Jennie Popay and Keleigh Groves continue the critique of the ‘grand narrative’ of gender and health research on three counts: that research is affluence centred, ahistoric, and has neglected recent developments in social theory. They take up the criticisms of social role theory outlined in Chapter 1 by Annandale and Hunt. While Chapter 1 pointed to lack of clarity in terms of what ‘gender’ now means in the face of changes in society and theoretical critiques of gender from various forms of feminism and wider social theory, Popay and Groves also emphasize the need for greater attention to theory in the measurement of ill health in this area of research. There is, they suggest, much to be gained from more focused measures of health. They argue that qualitative research, and in particular narrative accounts, offers a means of exploring the relationship between structure and agency, illuminating the way in which men’s and women’s lives and health are differentially moulded and experienced.

In Chapter 4, Hilary Graham’s focus is upon the consequences of rapid economic and social change for inequalities in health among men
and women. Using UK data, she describes socio-economic inequalities in health, the factors which contribute to these health differences, and the ways in which they cluster together and accumulate through the lifecourse. She goes on to describe changing patterns of inequalities in wealth. She argues that little is known about the ways in which gender (and other axes of inequality such as ethnicity) mediate exposure to the influences underlying inequalities in health. Yet, she argues, social class ‘expresses itself in a gendered form’ and is ‘written on the body’.

In Chapter 5, Sara Arber and Helen Cooper continue the theme of socio-economic inequalities in health. Using British data, they illustrate their contention that different factors should be considered at different stages in the lifecourse by analysing gradients in health among men and women at three distinct stages: childhood, the working ages and older adulthood. A lifecourse perspective, they argue, ‘takes social change seriously and sees lives as dynamic and responsive to changed circumstances and opportunities’. Stages of the lifecourse are not merely distinguished by age but by the historical experiences that each generation has shared.

 Chapters 6 and 7 move from a concern with morbidity to mortality. In Chapter 6, Ingrid Waldron takes a historical view of trends in mortality in the USA from 1950 to 1990. She examines trends in mortality sex ratios, analysing different causes of death and time periods separately, against several causal hypotheses to explain important recent changes in the patterns of gender and mortality. In Chapter 7, Laurent Chenet presents a series of analyses of trends in male and female mortality in a situation of extreme social change, namely the social turmoil following the collapse of communism in eastern Europe, focusing in detail on changes in mortality in Russia. He shows the very wide gender differences in mortality that are apparent in these countries, as men’s mortality has worsened dramatically over a very short period of time. However, socio-economic differentials among women in Moscow are much greater than they are for men, in contrast to the patterns seen in much of the western world.

As it becomes increasingly widely accepted that the established wisdom ‘women get sicker but men die quicker’, which was based on research on gender and health from the 1970s, is an oversimplification, researchers in the field are increasingly striving to be more sensitive to the complexities of individuals’ lives and more reflexive about the methodological premises that frame their research. While there are other issues that need to be addressed in this respect, such as the significance of ethnicity for gender differences in health, which are hinted at but not explored in detail here, we hope that the chapters in this book will feed into this debate and contribute to the resolution of the problems and challenges that this complexity presents for future for research.
Acknowledgements

The enthusiasm and motivation for initiating this book derives from discussions over a number of years with colleagues who share an interest in gender and health issues. We would like to thank all of these people, both colleagues in our own institutions and elsewhere, including of course all of the contributors to this collection. We would particularly like to acknowledge our debt to Judith Clark, Carol Emslie and Sally Macintyre with whom we have worked closely on some of the issues raised here. As ever the strictures of meeting deadlines have ramifications for others’ lives, so thanks and love to Marc, Chloe and Lottie van Grieken, and to Nick James.
Gender inequalities in health: research at the crossroads

Ellen Annandale and Kate Hunt

Introduction

Gender inequalities in health have been a major area of sociological research interest since the early 1970s. Rising to prominence on a wave of interest in the social relations of gender which challenged the empirical, theoretical and methodological core of sociology during the 1970s and early 1980s, the search for an explanation for differences in male and female morbidity and mortality, alongside interest in the relationship between variations in women’s social circumstances and their health, has been a vital part of feminists’ attempts to challenge the detrimental effects of patriarchy on women’s health.

By the late 1970s a research orthodoxy had emerged, under the twin influences of liberal feminism’s assimilationist agenda, which emphasized the health enhancing effects of access to social roles and statuses hitherto defined as male, and the radical feminist stress upon the primacy of gender over other statuses in the production of inequality (Annandale 1998a). This orthodoxy became a blueprint for research on gender differences in health which stressed entrenched inequalities in the experiences of women and men in the related spheres of paid and domestic work, and the consequences of these differences, for example for status and income. A distinction between sex (biology) and gender (the social) was essential to this tradition of research since it made clear that gender inequalities in health were in the most part socially produced, rather than biologically given. As such they could be ameliorated, even
Ellen Annandale and Kate Hunt

eradicated, through changes in the gender order. This orthodoxy, which generated an exciting and substantial body of research, prevailed largely unchallenged until the mid-1990s (although see e.g. Clarke 1983) when researchers began to express disquiet about its theoretical and conceptual foundations. Kandrack et al. (1994: 588), for example, wrote of a conceptual impasse and intellectual inertia in the field. They argued that ‘our methods and theories seem incapable of taking us beyond rudimentary statistical findings’ and called for a major conceptual leap forward.

The source of the conceptual impasse that Kandrack et al. (1994) and others have identified can be found in the very frameworks that laid the foundation for the field. Liberal feminism (with its emphasis upon the occupancy of social roles) and radical feminism (with its emphasis on gender as ‘difference’) have both been seriously questioned, in response to accelerated changes in society as an object of study, and in social theory as a basis of explanation. These developments have brought with them not only serious conceptual and methodological challenges, but also opportunities. Thus a new vibrancy is being injected into debates on gender inequalities in health as an emerging ‘new agenda’ challenges received wisdom.

However, the questions that are posed and the research agenda that they call forth are still in flux. We are led to ask, for example, to what extent should the ongoing social change in men and women’s lives in the worlds of work, household and the family, leisure and consumption in western societies be understood in terms of greater equality or greater inequality? How are we to understand the new social relations of gender in this context – has patriarchy been superseded, or has it taken on new forms that no longer rely upon a binary division of gender? So far, these questions remain largely unaddressed in research on gender inequalities in health, despite receiving attention within wider sociology and feminism. Yet it is crucial that these questions are taken seriously within the field of health and illness, since a clear sense of what gender actually means as we reach the beginning of the twenty-first century is essential to research on inequalities in health status.

The aim of this chapter is to review the current status of research on gender inequalities in health with particular reference to theoretical and methodological concerns, drawing upon empirical data where appropriate. Some of these concerns are taken up in more detail in the chapters which follow. We begin by addressing the broad issue of social change in the lives of men and women in Britain, concentrating on changes in employment, educational achievement, and in the household and family since it has been argued that these are the most important areas in the ‘transformation of gender’ (Walby 1997) which has taken place since the 1970s. This section draws, among other sources, on Sylvia Walby’s
Gender inequalities in health: research at the crossroads

important book, in which she argues that ‘fundamental transformations of gender relations in the contemporary Western World are affecting the economy and all forms of social relations’ (Walby 1997: 1). This review of key aspects of social change is followed by a discussion of how these changes can be explained within a new social relations of gender. We then draw out three frameworks, which we label the ‘traditional’, the ‘transitional’ and the ‘new’, to summarize shifts in theoretical and empirical approaches to research on gender and health since the 1970s. Finally, we reflect on some of the complex epistemological and methodological issues which need to be addressed in order that research can ultimately move forward. The chapter concludes by highlighting, in summary form, the emerging ‘new agenda’ for research on gender inequalities in health ‘at the crossroads’.

Social change in the lives of men and women

Gender related social change as reflected in patterns of employment, education, family and household structure, leisure and consumption at the societal level, and in the everyday experience of individual men and women, has been high on the policy agenda and a topic of widespread academic interest among social scientists since the mid-1980s. While many of these changes are massive in scope, they are complex and subject to diverse explanation. Walby’s (1997: 1) argument about women’s circumstances applies equally to men – contemporary lives are changing in complex ways, not simply for better or worse. In this section we outline social change related to employment, the household and the family, education, and the relationship between home and work. For each of these domains, we reflect critically upon existing linked research on gender and health status.

Changes in work and employment

The problematic history of the conceptualization of women within the sociology of work and employment is especially important to research on gender and health status which has had the link between employment and health at its core since its inception. Early research of the 1950s, 1960s and into the 1970s, operated on the premise that ‘workers were men’ (Crompton 1997). Other feminists pointed to the ‘invisible woman’ and raised concerns about taken-for-granted assumptions about the nature of men’s and women’s work (for example, that it was the physical conditions of work that counted for men, while for women it was friendship and social support that mattered). Alongside this, there
was a propensity within research to see women’s domestic roles and responsibilities as ‘natural’ and to interpret their labour market position as secondary to ‘domestic commitments’. As Acker (1991: 170) has pointed out, the very concept of a ‘job’ is inextricably linked to gender as ‘it assumes a particular organisation of domestic life and social production’.

In the field of health research, early work tended to draw upon male-only samples, or to assume that it was possible to extrapolate from men to women in a universalizing manner (Messing et al. 1993). Indeed, despite significant increases in women’s labour force participation after the Second World War in the west, it was not until the 1970s that the health implications of their work became a centre of attention (Doyal 1994). By the mid- to late 1980s, the pendulum had swung resulting in a focus on women-only samples and work related differences in health among women (Sorensen and Verbrugge 1987). In addition, almost irrespective of the nature of the sample, assumptions continued to be made about which aspects of work were important to men and which to women (Hunt and Annandale 1993). There was then little truly comparative research. This again reflects the gendered assumptions that were woven into research on inequalities in health, stemming from the dominant ideologies of the time and pervasive gender differentiation in the labour market. Thus, even though gender related patterns of employment began to change during the 1970s, there was a lag before this was reflected in changed research paradigms. However, although research which explicitly concerns gender and work is still marked by a focus on female-only samples (and research on men’s work and their health still tends not to have a gender focus), a new research vista has been opened up by rapid social change in the sphere of employment since the late 1980s. Here we briefly map some parameters of this change.

Crompton (1997) contends that an understanding of women and work needs to be placed in the context of the increasing economic polarization and material inequality that accompanies the marketization of society. With reference to contemporary Britain (although her observations are broadly relevant to other western societies), she extends Hutton’s characterization of the ‘30:30:40’ society to take account of the household and gender. In the ‘30:30:40’ society, ‘only around 40 per cent of the workforce enjoy tenured full-time employment or secure self-employment . . . , another 30 per cent are insecurely self-employed, involuntarily part-time, or casual workers; while the bottom 30 per cent, the marginalized, are idle or working for poverty wages’ (Hutton 1995, quoted in Crompton 1997: 131). When gender is incorporated into this model, the picture as shown in Figure 1.1 emerges.
The model in Figure 1.1 encapsulates gender differences in forms of employment, where women predominate in part-time work as they are disproportionately affected by the casualization and flexibilization of the workforce. Thus, in 1997, fully 92 per cent of British men who were in paid work were employed full time, compared with just 57 per cent of women. Working patterns still vary much more according to parental status (particularly when there are pre-school age children in the household) among women than they do among men. Overall, more than eight in ten part-time employees were women in 1997 (Office for National Statistics (ONS) 1998) and nearly as many women now work part time as they do full time. Despite this gender difference, there has also been a major shift in male employment from permanent full-time work to part-time or temporary work (ONS 1998); indeed 11 per cent of men now work part time (Walby 1997). This has been contemporaneous with a decline in the total number of men in employment (which has disproportionately affected those lower down the social hierarchy), alongside a rise in the total number of women in employment.

The exact figure that is put on women’s increased participation in employment depends on how work and employment are defined. Thus statistics which utilize a more inclusive definition tend to show figures for women that are closer to men. Labour Force Survey data from Britain show that 91 per cent of men of working age were economically active in 1971, compared to only 57 per cent of women. Women’s economic activity rates increased to 72 per cent by 1997, while men’s rates declined to 85 per cent over the same period (ONS 1998). But as Walby (1997: 29–30) notes, at the household level, the decline in male employment should not be taken as precipitating female employment. This has been reflected in the growth of 'no-earner' households (see Graham, Chapter 4 in this volume). Indeed, income support systems within Britain may even inhibit women’s paid employment. For example, when after six months’ unemployment a woman’s husband moves from an individually based insurance benefit to income support, which

---

**Figure 1.1** Employment and households in the 30:30:40 society

<table>
<thead>
<tr>
<th></th>
<th>30</th>
<th>30</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td>Unemployed</td>
<td>Insecure full time</td>
<td>Full time</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>Unemployed</td>
<td>Insecure part time</td>
<td>Full time/part time</td>
</tr>
</tbody>
</table>

*Source: Crompton 1997: 131*
Ellen Annandale and Kate Hunt

is means-tested at the household level, it is typically not worthwhile in financial terms for her to work. Ethnic variations are also important, with differences in labour force participation generally being larger among women than among men. While the highest economic activity levels are among ‘white’ men and women (86 per cent and 72 per cent, respectively), Pakistani/Bangladeshi women have particularly low economic activity rates (25 per cent) (Walby 1997: 61, see also ONS 1998: 28). Part-time work especially is lower among minority ethnic women than it is among the majority ‘white’ population.

Walby summarizes the shift in gender related employment patterns as follows:

During the post-war period and especially in the last decade there have been very significant changes in the position of women in employment. Women are almost as likely as men to be employed; but almost all of this increase is in part-time work. There has been a significant narrowing of the wages gap between women and men who work full-time, but this does not extend to women who work part-time. There has been a major increase in the proportion of women in top jobs, but significant sex segregation in employment still remains.

(Walby 1997: 36–7)

Gender segregation within the labour market is pervasive, although the actual jobs that are characterized as ‘male’ or ‘female’ may change over time (see Alvesson and Billing 1997, for example). Thus, at present the main employment sectors for women in Britain are ‘public administration, education and health’ and ‘distribution, hotels and restaurants’, and it is in these same sectors where most part-time female employees are found. Indeed, part-time work exceeds full-time work in the ‘distribution, hotels, and restaurant sector’ (ONS 1998). Although the manufacturing sector has significantly declined since the 1970s – from a 32 per cent share of employment in 1973 to 19 per cent in 1993, representing a decline from 7.8 to 4.6 million people (Office of Population Censuses and Surveys (OPCS) 1995) – it is still the sector in which most male employees work. Part-time work is relatively rare in manufacturing, especially for male employees (ONS 1998). While manufacturing continues to decline, the female dominated service sector is predicted to rise to 74 per cent (17.0 million people) by the year 2000 (OPCS 1995).

There is some evidence of reduction in gender differences within more specific occupational areas. Thus, using British census data from 1981 and 1991, Walby considers 15 ‘occupational orders’ to demonstrate that while one gender still tends to predominate in most occupations, ‘women have increased their participation in the upper occupational
Gender inequalities in health: research at the crossroads

orders and reduced them in lower ones – the higher the order the more likely an increase in both the absolute and relative numbers of women’ (Walby 1997: 35). There has been a 155 per cent increase in women in the ‘highest’ occupational order (‘professional and related supporting management; senior national and local government managers’) over the period, compared to a 33 per cent increase among men. Female ‘gains’ can also be seen among specific occupations. For example, the proportion of female solicitors holding practising certificates rose from 20 per cent in 1988 to 33 per cent in 1997 in England and Wales and the proportion of female barristers rose from 14 per cent in 1987 to 24 per cent in 1997 (ONS 1998). However, vertical segregation remains (Arber and Gilbert 1992): even where women have entered ‘male’ jobs, they tend to remain at the bottom of the ladder; and within ‘female’ jobs, men are over-represented at the more senior levels (Williams 1992). Some have suggested that the breakthrough of women into higher status occupations is little more than cosmetic (Savage 1992), and that even within the same job title, men and women may actually undertake quite different work, in different conditions and with a male power structure still essentially intact. It has also been argued that women have had the greatest success in ‘infiltrating’ those male jobs which are least attractive (in terms of working conditions, power and economic rewards) to men (see e.g. Legge’s (1987) discussion of personnel management).

While the trends towards greater equality of men and women in the labour market are important in and of themselves, they are only markers for broader changes in labour market experience. An important theme in this regard is the emergence of new forms of work environment. For example, although definitional problems make it difficult to give accurate figures for ‘homeworking’, the 1991 British census indicated that 1.2 million people conduct paid work ‘mainly from home’ (Crompton 1997), undertaking work as wide ranging as clothing assembly, packing products, electrical assembling and craft knitting, and women typically predominate in lower level work (see e.g. Phizacklea and Wolkowitz 1995). Teleworking, itself a very diverse category, is becoming increasingly significant, and the electronic cottage is seen by many as the workplace of the future (Crompton 1997). When compared to the traditional workplace, homeworking disperses the workforce across both place and time. Of equal interest in terms of new work environments is the emergence of Call Centres which, in contrast, aggregate large numbers of people into one place in a manner reminiscent of the heyday of factory manufacturing. It has been estimated that two-thirds of all Call Centre workers are women and that Call Centres will account for one in every fifty jobs by the year 2000 (Stanford 1999). As research on gender and health has a longstanding concern with ‘combining’
domestic and paid work and, more recently, with the similarities in conditions and the experience of work in each sphere for men and women, the advent of widespread homeworking is likely to be extremely interesting in relation to health given the collapse, or blurring, of distinctions between the ‘home’ and ‘work’ environments. Women or men who undertake homeworking will thus be subject to the conditions of their ‘home’ environment through both their unpaid ‘domestic’ work (see Bartley et al. 1992) and paid work. For those living in the least affluent conditions, this may present a double jeopardy to their health and, if more women undertake the least attractive ‘homeworking’ jobs, a yet more complex interaction between gender and socio-economic status may unfold.

Whether we examine the gender balance in more traditional or newly emerging employment sectors, it is crucial that we look beyond tabulations of gender similarities and differences in the terms, conditions and experiences of work. Since the late 1980s, research on gender, work and employment has turned its attention increasingly towards the ways in which different kinds of gender identities are actively constructed in the workplace (see e.g. Pringle 1988; Crompton 1997), and the supposed gender neutrality of conventional organizational theory has been subject to a fierce critique (see e.g. Acker 1991; Mills and Tancred 1992; Witz and Savage 1992; Halford et al. 1997). ‘Appropriate’ performances of gender may be achieved through diverse means, from male and female codes of dress, sexual harassment, or the predominance of a masculine culture of sexuality (see e.g. Collinson and Collinson 1990), and restriction of knowledge and opportunities by the exclusion of one gender. Gender relations therefore emerge and are subject to ongoing negotiation within the workplace (be this the factory or office, the Call Centre, the homework environment or the domestic workplace). There has been little research on the health implications of this process within research on gender inequalities in health, which has tended to utilize rather static notions of social roles and experiences in relation to work and health. In Chapter 3, Popay and Groves are also critical of this tendency within existing research and point to the ways in which the narrative method can move research forward.

Although paid work has been a major interest within research on gender inequalities in health in and of itself, it has also been of central concern because occupation has often been the basis of assigning a position in a socio-economic hierarchy. The theoretical power of socio-economic status as a concept derives from its holistic character as it draws together several facets of an individual’s life under one umbrella term. Measures of socio-economic status such as education and occupation thus ‘stand for’ a complex conceptualization of a person’s economic
power and social standing. The difficulties that this poses are intensified by conceptual confusion over what social class/socio-economic status actually stands for theoretically, notably as it intersects with gender (Crompton and Mann 1994).

Occupation and, to a lesser extent, education are the most often used indicators of socio-economic status in research on health, although the use of occupational social class has been highly contested. The strands of this debate are both empirical and theoretical. Empirically, the British Registrar General’s classification of occupations is based on a male occupational structure and, because of the entrenched gender segregation discussed above, fails to adequately discriminate between women’s jobs (which cluster in social class III non-manual – secretaries, sales assistants, clerical workers, for example). As a consequence, socio-economic gradients in health tend to be shallower among women than among men (Pugh and Moser 1990; Pugh et al. 1991; Koskinen and Martelin 1994), although gradients are less too by some other measures (Macintyre and Hunt 1997). Second, women’s occupations often do not ‘match’ their educational achievements due to movement out of the labour force, and discrimination within employment inhibiting the promotion of women. As the structure of employment changes, many of these problems may also concern men. One ‘solution’ to these problems of ‘women’s social class’ has been to move from an individually to a household based measure of social class, typically relying on the male ‘head of household’ (Goldthorpe 1983). Objections to this have long been raised on the grounds that women are subsumed under men and that such household based measures are assumed to stand equally for all household members, when in fact access to household assets (while formally communal) may be highly gendered (Payne 1991). The conclusion is obvious, but crucially important for the study of gender inequalities in health – one is simply not comparing like with like (Payne 1991; Hunt and Macintyre in press).

These technical debates on the operationalization of socio-economic status have pervaded discussion of gender inequalities in health status, although in empirical research they have been more commonly raised in the context of differences among women than in comparative research including men. In a time of rapid and complex social change in the lives of men and women which is generating new lines of economic inequality (see Graham, Chapter 4), it is crucially important to capture gender differences in socio-economic status in a way that permits valid gender comparative research. Certainly the evidence that does exist to date suggests that systematically comparing inequalities among men and among women, and trying to account for similarities and differences (looking at different health outcomes, different age groups, and
so on), could provide major clues to the aetiology of ill health, and inequalities, in both men and women (Macintyre and Hunt 1997; Hunt and Macintyre in press).

To summarize this section of the chapter which has been concerned with changes in work and employment: since around the late 1970s there has been a complex restructuring of employment which is likely to have differential impacts upon different ‘groups’ of women and men, generating new forms of equality and inequality. While some female ‘gains’ are apparent, ‘there can be no sweeping statement about women catching up with men’, nor does the pattern of gender related change fit neatly into a conceptualization of ‘gender as opposition’ (Walby 1997: 47). One of the most notable new divisions that is apparent is between different age groups. As Walby notes,

to a significant extent women are polarising between those, typically younger, educated and employed, who engage in new patterns of gender relations somewhat convergent with those of men, and those, particularly disadvantaged women, typically older and less educated, who built their life trajectories around patterns of private patriarchy [i.e. subordination within the domestic realm]. These new patterns are intertwined with diversities and inequalities generated by social divisions including class, ethnicity and region.

(Walby 1997: 2)

There is a need for research on health status to take these more recent patterns of inequality between women into account. But equally, there is a need to consider new forms of equality and inequality between men and women. There is a tendency even today within wider commentaries on gender and social change to foreground women’s experience, leaving men’s experience as a largely unarticulated backdrop. As noted earlier, this continues a long legacy of research on work and health in which the empirical spotlight is upon either women or men. However, in common with the wider field of gender and health inequalities, research which considers the relationship between employment and health is addressing an increasingly sophisticated agenda, in response to the increasing diversity and complexity of men’s and women’s lives. Some of the most important of these are summarized in Figure 1.2.

Figure 1.2 highlights moves towards a more inclusive research agenda around paid work, gender and health. However, at the moment, this movement is both rather piecemeal and inhibited by the quality of existing large scale statistical data sets which often contain limited or crude measures of paid work circumstances and health status, which make sensitive operationalization very difficult. Quantitative research on employment and health which seeks to use gender comparative samples
is also constrained by the continuing extent of gender segregation. Except at the higher levels of aggregation (e.g., occupational orders), it remains difficult to find sufficiently large numbers of men and women doing the same jobs to undertake more sophisticated analyses that can take more sensitive account of other domains of men’s and women’s lives (see Emslie et al. 1999).

It is now widely recognized that paid employment in and of itself generally has a beneficial effect on health (with those in paid work tending to be in better health than those who are not) (Waldron et al. 1998). However, this finding is tempered by the specific terms and
conditions of employment, and the relationship between paid work and other aspects of men’s and women’s lives. For this reason, we will suspend a more detailed consideration of empirical research until we have looked at recent changes in the domains of education, and the family and household.

**Changes in education**

Walby (1997) argues that, alongside women’s movement into paid employment, education is at the leading edge of the shift from a domestic to a public gender regime. Education is also crucial in marking out new patterns of increased inequality between women. For example, it differentiates between those younger women who are formally educated to levels that meet, or even exceed, those of similar aged men, and older women who have until the 1990s been excluded from the labour market and had few educational opportunities earlier in life.

There is evidence that women have made more rapid gains than men in educational terms in the 1990s. In Britain, entry into further education has increased significantly for both men and women (ONS 1998), but the number of women undergraduates increased by over 115 per cent between 1975–6 and 1992–3, while that of men increased by only 35 per cent. Improvement in the advanced (A level) school examinations was also greater for women than for men between 1975 and 1985 (ONS 1998), and young women made up 53 per cent of those with two or more A level passes in 1993–4. The proportion of young women aged 17 who gained three or more A levels rose from 9 per cent in 1985–6 (compared to 10 per cent of men) to 16 per cent in 1993–4 (compared to 14 per cent for men). In 1995–6, at the lower level of national school examinations (grades A to C GCSE or SCE level), 51 per cent of women compared with only 41 per cent of men aged 16 in the UK achieved five or more passes (Walby 1997).

In the context of gender inequalities in health status, Arber (1997) has argued:

> it is timely to reassess the value of educational qualifications in the British context, especially among women, where it is acknowledged that occupational class is a less than ideal measure because of downgrading following childbirth. Educational qualifications are a major factor in obtaining many jobs and promotion within occupations.

*Arber 1997: 775*

Thus Arber argues that educational qualifications are a more robust measure of socio-economic status than occupational social class since they are strongly related to occupational achievement, but also a stable
Gender inequalities in health: research at the crossroads

measure for those who fail to reach or sustain a level of occupational achievement that is consistent with their qualifications (through illness or exit from the labour force to rear children, for example). Moreover, educational qualifications offer the potential for greater discrimination between both women and (with labour market exclusions increasing) men. In this respect, it should be noted that occupational social class has had more prominence in British studies of health inequalities than elsewhere.

Since the ‘success’ of women in education only dates from around the mid-1980s, there is still a marked female educational disadvantage among older age groups. Using the British National Vocational Qualifications (NVQ) classificatory scheme, there was very little difference between the qualification levels of men and women aged 16–24 in 1997–8. However, by age 25–34, men’s qualifications exceeded those of women. In older age groups, differences are even more marked, with the number of women holding no qualifications at all far exceeding men (ONS 1998). This pattern of gender difference by educational achievement, whereby younger women are converging with men (i.e. a pattern of emerging equality), but where there are profound inequalities by age within women (and persistent, but less marked, inequalities by age within men), highlights the complex nature of gender inequalities at the beginning of the twenty-first century.

Of course, possession of qualifications does not translate simply into success in the public sphere of work, as noted earlier. Discrimination in recruitment and promotion, and work related experiences such as sexual harassment, persist because of direct and indirect male exclusionary practices (see e.g. Witz 1990; Crompton 1997). A greater openness to the actual constitution of gender relations in the workplace, as described above, should help us to look at not only the complex ways in which educational qualifications are, or are not, ‘translated’ into success in the workplace, and the role of gender as part of this, but also the impact of the positioning of men and women in various ways upon psychosocial health – perhaps, for example, through the experience of status incongruity between potential and current achievement.

Changes in the family and the household

There is an explicit association between the changes in employment and other aspects of people’s lives. As Crompton notes (1997: 3), the rise in women’s employment ‘has been accompanied by a falling birth rate, a rise in single-parent households, and an increase in the divorce rate’ while ‘much of the expansion of women’s employment has been in the area of “non-standard” jobs, and . . . women’s continuing family
Ellen Annandale and Kate Hunt

Responsibilities loom large as a reason for taking up and continuing this kind of paid work. The trends in patterns of marriage, parenting and fertility and in women’s greater inroads into paid employment are not merely coincidental. Equal employment opportunities and control over fertility through wider access to contraception and termination of pregnancy were two key foci of second wave feminism.

Following the ‘baby boom’ of the 1960s (when there were around 80 live births per 1000 women), fertility rates for women aged 15–44 declined until the late 1970s (at which point there was a slight increase). During the 1980s and 1990s, rates remained fairly stable at around 60 live births per 1000 women. These rates conceal considerable age variations including a marked shift towards later childbearing. In England and Wales, the mean age of mothers at childbirth rose from 24.4 years in 1977 to 26.8 years in 1997. Fertility rates for women in their 20s have been falling, while those for women in their 30s have been rising. In addition, there has been a rapid increase in the number of women who remain childless at the age of 45 (from 9 per cent of women born in 1946 in England and Wales to 15 per cent for those born just five years later in 1951). It is projected that as many as one in five women born in 1961 will remain childless (ONS 1998).

Alongside these changes in fertility patterns, there have been major changes in patterns of marriage and divorce. Most notably, the number of first marriages has declined rapidly since the early 1970s in the UK, while the number of divorces and remarriages has risen. Divorce rates vary markedly by age, with higher numbers concentrated in younger age groups (those under age 25 have experienced the biggest growth). Data for 1996–7 indicate that, overall, men are more likely to be married than women (62 per cent compared to 58 per cent) and also more likely to be single (28 per cent compared to 22 per cent). This reflects the greater propensity for women to be either widowed or divorced (12 per cent and 7 per cent, respectively) than men (4 per cent and 6 per cent). Changes in marriage patterns have been associated with a rise in cohabitation; more than one in five non-married adults in Britain were cohabiting during 1996–7. While most adults still live in a couple household, there are important gender differences. Women are more likely than men to live in a household without another adult, either as lone parents or as an elderly person. Lone parenthood is often associated with material deprivation (see Graham, Chapter 4) and with relatively poor health for men and women (see e.g. Popay and Jones 1990; Macran et al. 1996). (This summary is drawn from ONS 1998.)

These trends have potentially wide-ranging ramifications for the study of gender and health, especially when considered alongside changing patterns of work. As we stress throughout this chapter, such changes in
the lives of research subjects require us to rethink the ways in which we conceptualize the research agenda. The use of marital status categories is one pertinent example of the problem of trying to take account of diversity of experience while using the normative understandings which are embedded in official statistics and social surveys. As Arber (1997) notes, research of the 1970s and 1980s tended to show that previously married people have the worst health (a finding that holds particularly for women); that married people have better health than single people; but that the marital advantage is more evident for men than for women. However, ‘it may be that more recent changes in marriage patterns, particularly the increase in divorce, and growth in cohabitation has meant that [these] earlier relationships . . . no longer hold’ (Arber 1997: 776). Furthermore, Graham (1993: 14) recounts the problems of relying on data which present people’s lives through categories which give them ‘clear, stable and singular identities’. Thus, one cannot be simultaneously married and single so ‘it is women’s [and men’s] legal status that drives the classification, not the meanings [they] give to their personal relationships’ (Graham 1993: 32). (Another illustration given by Graham is that, since cohabitation is usually defined in heterosexual terms, gay men and women are typically construed as outside marriage/cohabitation, which may be at variance with their experience, and a violation of their sense of self.) Yet far from being static, marriage and other relationship statuses are currently subject to significant change as ‘more women [and also men] are experiencing periods of living alone, living with a partner, marrying, divorcing and becoming lone mothers [and fathers]’. Thus ‘individual biographies remind us that the labels ascribed to women [and men] do not describe a permanent status’ (Graham 1993: 40).

These conceptual points notwithstanding, one issue that has been central to research on gender, health and the household, has been the domestic division of labour. Interest in whether either ‘housewives’ or women in paid work are in better health has continued since the 1970s. Early work tended to concentrate on the simple occupancy of the ‘housewife’ or ‘paid worker’ role, with little attention to the nature and quality of each ‘role’. This of course mirrors the way in which the paid work–health relationship was approached (see Figure 1.2). Women-only samples have been the norm and it is only since the late 1980s that researchers have begun to develop more sophisticated models in which paid work and domestic work in their complexity are addressed in an adequate manner with comparative attention to both women and men. This incipient shift in research attention makes it important that we look more generally at whether the domestic gender division of labour is changing alongside, or perhaps as a result of, changing patterns in men’s and women’s paid work.
Although this is a contentious area, there is some evidence that the amount of work that women undertake in the home has declined as they have entered paid employment in larger numbers. Looking at trends over the period 1975–87, Gershuny et al. (1994) reported that husbands of full-time employed women had increased their proportion of housework the most. However, decreases in gender differences in time spent in housework are equally likely to be a result of working women (especially those who work full time) reducing their hours, rather than men increasing theirs (Crompton 1997; Walby 1997). Consequently, while recent data suggest that both men and women who are in paid work spend less time on domestic chores than those who are not in paid work in Britain, there is still evidence that ‘gender differences in time use appear to persist despite a variety of lifestyles in different families’ (ONS 1998: 64). Thus if we consider the crude division of domestic tasks, among eight out of ten married and cohabiting heterosexual couples in 1994, it was still the woman who ‘always or usually’ did the washing and ironing, while for three-quarters it was still the man who ‘always or usually’ did repairs around the house. A larger percentage of couples reported that other ‘tasks’ were more equally shared (about 45 per cent described looking after sick family members, as ‘about equal or both together’ and the corresponding figure was 52 per cent for shopping for groceries), although the remaining couples reported that these tasks were more likely to be ‘usually or always’ undertaken by the woman (ONS 1998). However, data from the 1991 British Social Attitudes Survey point towards an interesting gap between these reported actions and prevailing attitudes. Thus, while 62 per cent of couples felt that household cleaning should be shared equally, only 27 per cent of couples actually reported that they did share (and it has been noted that reports of time spent on, or sharing, household activities are themselves quite subjective). At the very least, as Crompton (1997: 87) concludes from a review of existing research, ‘although men do take on more domestic work as a consequence of their female partner’s paid employment, . . . this increase does not equalise the amount of work carried out by men and women.’

Informal caring work has also typically been perceived as gendered. Data from the 1991 British Household Panel Survey show that 17 per cent of women and 12 per cent of men looked after or gave special help to people who were sick or disabled either within or outside the household (Walby 1997). Research from the 1990 General Household Survey (GHS) shows that there were 3.4 million adults in Britain who were sole carers for relatives, friends and neighbours who were sick, handicapped or elderly. Although gender differences in the sample are again relatively small – 17 per cent of women and 14 per cent of men are carers –
Gender inequalities in health: research at the crossroads 17

women are more likely to be sole carers than men (57 per cent versus 42 per cent) and to be involved in caring for more hours per week (Evandrou 1996).

On the optimistic side, perhaps as Gershuny et al. (1994) suggest, we are witnessing a process of ‘lagged adaptation’ as changes in the household begin to ‘catch up’ with the changing realities of men’s and women’s paid employment. Moreover, the incipient move towards a somewhat more equal division of labour in some households in western societies is occurring alongside a rise in the availability of domestic goods. By 1994, 89 per cent of British households had a washing machine, 85 per cent of households had central heating and 67 per cent had a microwave oven (equivalent figures for 1979 were 75, 55 and 30 per cent respectively: Walby 1997). While it is important to appreciate, as Graham argues in Chapter 4 (see also Graham 1993), that both absolute and relative deprivation has been widening within Britain over this period, and this is disproportionately affecting lone female parents, it is a salutary reminder that patterns of domestic inequality are significantly more marked in third world countries where domestic work is especially open ended. Doyal (1995: 31) points out that the ‘rigours of domestic work are at their most severe’ in the third world where women ‘weave their patchwork of survival through the direct production of their own and their family’s needs’.

The picture that we have presented here of the domain of the household and of the family is no more than a snapshot. The concerns that we have concentrated upon (marital status, fertility and lone parenthood, and the domestic division of labour) are those which have predominated in discussions of gender and health status. In many self-evident ways, this manner of conceptualizing life in the family and household is woefully inadequate. We have little sense, for example, of how the various ‘roles’ that we have highlighted, such as that of lone parent, part-time paid worker with low status and low wages, in a new relationship, actually combine to influence health. We have even less sense of individuals’ actual experience of this and other real life situations and how they might compare to those of other men and women. Furthermore, we often take an ‘atomized’, rather than an integrated, view of these domains of life; looking separately at men’s and women’s positions within the occupational structure and at their ‘family’ circumstances, for example, may obscure some very gendered patterns. ‘Achieving’ a certain place within the labour market may bring more hard choices for women than for men. Certainly, there is evidence that when and whether women have children (or a partner) varies more by occupational position for women than it does for men (see e.g. Emslie et al. 1999).
Without these more complex understandings, there is little or no opportunity to explore any similarities by gender that might be embedded in different complex social circumstances (see also Popay and Groves, Chapter 3 in this collection). Additionally, there are whole swathes of ‘domestic life’ which remain largely untouched by existing mainstream research on gender and health. One example of this is domestic violence which is a public issue on a global scale (Doyal 1995). The World Development Report of 1993 indicates that ‘rape and domestic violence together account for about five per cent of the total disease burden of women aged fifteen to 44 in developing countries and nineteen per cent in developed countries’ (cited in Doyal 1995: 53). Marriage, cohabitation and other forms of intimate relationship then seem to offer a veritable cornucopia of unexplored benefits and losses for health much in the same way that we have described for paid work. Finally, in spite of the established finding of the ‘marriage advantage’ (referred to above), the balance sheet for men is even more obscure at the present time as gender related social changes pose new challenges to traditional patriarchal forms. A crucial question, which we take up in broader terms later in the chapter, is the significance of the changing world of employment for men (notably rising unemployment in lower social strata) and the emergence of what some social theorists have called ‘new ways of living’ in the personal sphere (Beck and Beck-Gernsheim 1995). Giddens (1992), for example, positions women as the prime movers in what he calls the developing ‘democratisation of the personal sphere’, by which he means the emergence of free and equal relations between people. Yet Pahl (1995) contends that men are ill equipped for the ‘new world’ of work today (i.e. for the loss of the ‘provider role’) and that their emotional reticence makes it difficult for them to adapt to changes in domestic circumstances.

Research on paid work, domestic work and health status

Lorber (1997) reminds us that

jobs and families are complex variables with good and bad effects on the physical and mental health of women and men. Both are areas for social support, which is beneficial to health; both are sometimes hazardous environments with detrimental physical effects; both produce stress.

(Lorber 1997: 27)

In research terms, it is now appreciated that since neither ‘women’ nor ‘work’ are homogenous categories, large scale comparisons of women in the home and women in work are of little real use (Doyal 1994).
Rather, ‘the key question is not whether paid work in general is good for all women, but rather what the conditions are under which specific types of work will be harmful or beneficial for particular women in particular circumstances’ (Doyal 1994: 67; see also Waldron 1991). The same points pertain to men.

Understanding of the relationship between paid work, domestic work and health status has taken a series of important conceptual steps forward over a relatively short time period. The following six developments are key.

First, as noted above, research began with large scale comparisons between women who were in paid work and full-time ‘housewives’. This research culminated in the general conclusion that women in paid work tend to be in better health than those who are not (Nathanson 1975).

Second, questions were then raised about possible health selection effects (that is, perhaps it is not so much that being full time in the home has a negative impact upon health, but that unhealthy people are being excluded from the workforce). However, subsequent analyses have generally confirmed that the better health of employed women does not simply reflect a ‘healthy worker effect’ (Arber 1997).

Third, research then began to build a range of additional work and family related factors into analyses (Nathanson 1980). For example, researchers considered if the protective effect of paid work upon health for women was mediated by whether it was full or part time, with many (though not all) researchers concluding that it is often part-time work that is associated with better health. They also looked at marital status (Kane 1994); the presence of children (of various ages) in the household (Arber et al. 1985; Verbrugge 1989); and socio-economic status (variously measured, see above). The conceptual framework that was employed was very much that of ‘role relationships’ with the emphasis squarely upon the basic occupancy of a role (see Figure 1.2).

Fourth, an influential set of basic hypotheses emerged which raised the question of whether the occupancy of ‘multiple roles’ was positive (‘role accumulation’, ‘role enhancement’) or negative (‘role strain’) for women’s health. The general finding was that multiple role occupancy was good for health. Thus in the early 1980s, Verbrugge (1983: 26) concluded that ‘there is no evidence that multiple roles harm women’s health, or for that matter men’s’. In a later article with Sorensen, she expressed her view that benefits can be additive, or they may be synergistic:

when troubles arise in one role, the others may offer supports and buffers such as overt advice and empathy, a place to renew energy and self-esteem, and a means of locating people and resources to solve the problem. Multiple roles offer excuses; obligations in one
arena can be dropped by citing responsibilities in another. Being very busy with roles can make someone’s feelings of worth and excitement bound upward.

(Sorenson and Verbrugge 1987: 244)

The multiple role framework continues to be influential today as researchers develop increasingly complex hypotheses about the beneficial and harmful health effects of various specific roles and role combinations. Thus, drawing upon longitudinal data (for 1968 and 1988) from the USA to explore three ‘roles’ (marriage, employment and parenthood), Waldron et al. (1998) have concluded that ‘role substitution’ is the most successful of a series of hypotheses in explaining women’s physical health status. ‘Role substitution’ means that when two roles perform similar functions they substitute for each other. For example, the authors suggest that ‘employment and marriage may substitute for each other as sources of income, health insurance, and social support’ (Waldron et al. 1998: 218).

Fifth, although the underlying premise of this body of research has been that if women were in the same role positions as men, then there would be little or no difference in their health status, until the late 1980s there has been very little gender comparative research (as stressed throughout this chapter). In part this neglect has been theoretical: traditionally, ‘gender’ has been seen as something that concerns only women. But it has been also due to the lack of large scale data sets which contain questions on work and health for both men and women. Since the mid-1980s we have seen growing calls for the inclusion of men in analysis (see e.g. van Wijk et al. 1995). Analyses have begun to emerge, some of the most interesting of which look at changes over time in men’s and women’s ‘roles’ and their relative significance for health (see e.g. Hibbard and Pope 1983). However, as indicated earlier, the more specific that gender comparative research seeks to be (within a more quantitative tradition at least), the more it is constrained, not only by theoretical and methodological limitations, but by the fact that at the beginning of the twenty-first century being male or female remains such a key organizational feature of all aspects of our lives, systematically structuring opportunities and experiences. As Emslie and colleagues remarked about their attempt to conduct an explicitly gender comparative piece of research:

attempting to obtain a more homogenous sample of men and women is at best problematic because of the very gendered world we live in; controlling for participation in one social role . . . highlights the very different experiences of men and women in other spheres of life.

(Emslie et al. 1999: 44)
Sixth, as one part of a move towards greater inclusivity during the 1990s, the call for gender comparative analysis has also led researchers to stress the need to develop measures of work related experience which fully capture the complexity of the workplace (Lennon 1987; Matthews et al. 1998) and working life, with a particular emphasis upon the quality and meaning of men’s and women’s experience (see Saltonstall 1993; Simon 1995). For example, van Wijk et al. (1995: 600, our emphasis) argue that ‘ultimately, the experienced quality of each single role and combination of roles seems a far better predictor of health than the sole occupancy of roles’ (see also e.g. Dennerstein 1995). It has also been argued that, in order to capture gender related social change, it is important in principle to explore each facet of the paid and domestic work environment (and their combination) for both women and men (Hunt and Annandale 1993).

Although this mapping of research on the paid work–domestic work combination inevitably over-schematizes what actually have often been contiguous developments, it appropriately depicts the movement of research in the field towards a more inclusive agenda. However, given that it is ultimately the changing social relations of gender which underpin this development, there are in-built limits to how much further research can move forward without reflecting critically upon ways in which gender itself should be conceptualized in research. We turn now to this issue.

**Health inequalities and the social relations of gender**

In the preceding discussion, we reviewed some dimensions of social change from the perspective of social roles and statuses. However, as raised in the introduction to this chapter, although it is important to appreciate the research advances that have been made from within this framework, it tends to lack an explicit overarching theory of the social relations of gender that underpin women’s and men’s lives. The relatively more fluid movement of men and women between what were once either male or female dominated social spheres is important, but it does not necessarily ‘make all things equal’ (Hunt and Annandale 1999). The social relations of gender, then, consist of ‘more than’ movement in and out of social roles; and changes in the occupancy of certain roles and statuses may not mean the diminution of patriarchal privilege, but rather its continuation in new forms. The purpose of this section of the chapter is to step back from the specifics of research findings on gender inequalities in health and to raise a series of broad theoretical concerns. We begin with a brief critical review of the social roles framework.
Next, we consider the gender related social changes outlined earlier from a wider structural perspective that considers changes in the social relations of gender, drawing particularly upon the work of Walby (1990, 1997). We then highlight the issue of social complexity through debates between modernist and postmodernist approaches to socio-economic diversity in women’s and men’s lives at the beginning of the twenty-first century in the west. Finally, we conclude with a summary model of three conceptual approaches to gender inequalities in health as a foundation to a consideration of methodological issues.

Social roles

Criticisms of the use of the social role framework within the sociology of gender are now well rehearsed. In particular, it exaggerates the extent to which social life is scripted or prescribed (see e.g. Connell 1995) and abstracts lived experience from the everyday context in which it is embedded (see Popay and Groves, Chapter 3 in this collection). For instance, there is often an assumption that roles have the same meaning for men and women, whereas, in fact, they may have different meanings for men and women in different social contexts (Clarke 1983). While it is certainly possible to ‘correct’ for this tendency by building more sophisticated and nuanced measures of women’s and men’s own interpretations of their circumstances into analyses, they will still be limited if they neglect the wider social relations of gender. Thus looking factor by factor at men’s and women’s circumstances, as has been the tendency of much research, ‘makes it very difficult to pull together a coherent story’ to account for relationships between gender and health status (Stein 1997: 117). This ability to develop a ‘story’ is also exacerbated by the conceptual incoherence that marks the field (Kandrack et al. 1994). Thus as Bartley et al. (1992) note, we frequently find that variables like marital status, parental status, household structure and occupational social class have been used variously as measures of social role, social position or social conditions. But the most important overall point is that the problems of both factor-by-factor analyses and conceptual confusion result inevitably from theoretical indeterminancy. In brief, it is essential that we move away from treating roles and statuses as properties of individuals and locate them instead in the structural context of men’s and women’s lives (Arber 1990; Graham 1993; Stein 1997). As Carrigan et al. (1987: 167, our emphasis) put it in their critique of the role framework in the study of masculinity (though not referring to health): ‘the result of using the sex role framework is an abstract view of the differences between the sexes and their situations, not a concrete one of the relations between them’. In the context of our interest in this
Gender inequalities in health: research at the crossroads

chapter in gender related social change and health, it means seeing social change as located in power dynamics, rather than as something that ‘happens to roles’ (Segal 1992; Carpenter, Chapter 2 in this collection).

Changes in the social relations of gender

Dynamic in form, social relations of gender are both responsive to and constitutive of social changes in society that concern men and women. As was stressed earlier in this chapter, the contemporary social relations of gender belie easily summary in terms of ‘gains and losses’ on the part of either women or men. At the level of subgroups of women and men, new lines of similarity and dissimilarity are emerging, many of which can be conceived of as new axes of inequality. It has been possible to identify several key areas of social life within which traditional gender patterns are changing – employment, the family and the household, and education. However, their identification tells us little about the overall form that patriarchy takes (as it affects not only women, but also men). Recognizing this, Walby (1990: 174) makes a conceptual distinction between degrees and forms of patriarchy. Degrees of patriarchy refer to ‘the intensity of oppression within a specified dimension’ of social life (e.g. the family), while forms of patriarchy refer to ‘the overall type of patriarchy’ in a society. Taking a broad historical sweep, she argues that British society has shifted in form from ‘private’ (or domestic) to ‘public’ patriarchy. This has been associated with the declining significance of domestic activities for women’s employment (especially for older women) and the rise in educational opportunities for women. But importantly, while work and education are the spearhead of the shift from a ‘domestic/private’ to a ‘public’ gender order, they are also the leading edge of increased inequalities between women. So while we may be witnessing emerging patterns of equality between some men and some women, this is accompanied by intensified forms of inequality between women (and presumably also between men). This is because segregation is at the heart of public patriarchy, as women are drawn into the public domain but segregated within it. Crucial to this process are the ‘spiral of changes’ which intersect with age and generation, not simply because they represent ‘different stages of the life cycle, but because people of different ages embody different systems of patriarchy’ (Walby 1997: 12). This appropriately highlights the fact that relationships between family and household circumstances and health, particularly as they intersect with paid work, are likely to vary considerably for different age cohorts, a topic which has to date been sorely neglected within sociology (see McMullin 1995; Arber and Cooper, Chapter 5 in this collection).
The significance of these points is that, as we build towards more complex models of social change in the lives of men and women in western societies, we need to appreciate that change is unlikely to impact on different subgroups of men and women equally. Age, socio-economic status and ethnicity are among the most important parameters of difference.

Social complexity

The complex and shifting nature of the gender order, as it concerns men as well as women, poses significant problems in the conceptualization of research on health inequalities. Diversity has become the ‘buzz word’ as we seek to understand newly emerging patterns of inequality which open up new divisions within men and within women, and foster new commonalities of experience between (some) men and (some) women. This new theoretical sensitivity is now central to research on health inequalities, with commentators stressing, for example, the need to embrace the complexity of debate (La helma and Rahkonen 1998); to recognize that ‘similarity is crosscut by diversity’ (Graham 1993: 5); and to appreciate that health varies in response to a ‘maze of interlocking variables’ (Payne 1991: 115).

However, there is the widely recognized risk that the search for the ‘causes’ of gender inequalities in health will collapse if the increased recognition of ‘sheer complexity’ dissipates into relativism. It was only at the end of the 1990s that feminist health researchers began to engage critically with these debates, and to do so quite forcibly. They have been almost wholly neglected within the sociology of men and masculinity as it concerns health status. Thus Oakley (1998: 143), for example, contends that the social world ‘remains obdurately structured by a dualistic, power-driven gender system’. This perspective raises very serious concerns about the terms on which gender can be investigated when looking at health status. For example, while it seems able to accommodate diversity among women – since a public patriarchy may structure women ‘differently’ in ways that generate new inequalities – the extent to which we can incorporate a concern with similarities between men and women, and dimensions of male oppression under patriarchy is more questionable. The distinction between sex and gender, as it has recently been open to debate between modernist and postmodern approaches, is central here. Oakley (1998: 135) argues that feminism must continue to use the ‘wedge of sex and gender as an oppositional nature/culture dualism to identify an agenda of preventable differences between the sexes, and thus effectively to force open the door of oppression and discrimination’. In similar terms, Doyal (1998), in a discussion
of discrimination in women’s access to treatment for various health problems, and Scambler (1998) in her discussion of mental health care, highlight the need to retain gender (as well as sex) as a dichotomy in order to recognize the manner in which women are oppressed as ‘others’ under patriarchy, and the implications that this has for health care. This contrasts to those more sympathetic to postmodern approaches to gender/sex (see Butler 1990; Hood-Williams 1996) who view biological sex as a construction of discourses of gender (i.e. what counts as male and female biological sex is influenced by social and political judgements) and highlight the relative fluidity of gender as it is enacted in everyday life. The postmodern approach to sex/gender is significant insofar as it seems to undermine the structural accounts of gender which are predicated to a significant degree upon dichotomies of sex, gender and (to a lesser extent) masculinity and femininity and the power that attaches to male-sex, male-gender and masculinity. Thus the loss of gender-as-difference in favour of gender-as-diversity becomes problematic for authors such as Oakley, Doyal and Scambler. But nonetheless, they strongly appreciate that the social relations of gender are increasingly complex. Scambler (1998), for instance, echoes many other commentators when she argues that we can understand diversity within patriarchy without rejecting causality and reference to structures. Thus she writes, ‘a strong modernism, reinforced by the insights of discourse analysis, offers both an appreciation of difference and a structural theory of a patriarchy which is pervasive but chameleon-like in its effects’ (Scambler 1998: 107).

In sum, there is here at once a will to be sensitive to the interaction of gender with other factors, that is, to appreciate social complexity while also holding onto gender-as-difference. However, a tension remains in that, the closer we move towards embracing complexity, inevitably the closer we simultaneously move towards undermining the primacy of gender-as-difference (that is, male/female as a binary division of power). Perhaps the solution to this, as Scambler (1998) seems to imply but does not take up in detail, is to conceptualize complexity itself as a product of a new form of gender order – i.e. a causal structure itself – which, rather then being predicated upon the male/female binary, is productive of a more complex and fluid social relations of gender (Annandale and Clark forthcoming). Deploying Walby’s (1990, 1997) vocabulary, from such a perspective the new degrees of gender equality and inequality which seem to more radically divide women within specific dimensions of social life, and to draw (some) men and (some) women into circumstances that are more similar than in the recent past in the west, are not the indiscriminate effects of a radical postmodernism, but both the outcome of competing and potentially contradictory forms
of patriarchy which concern both men and women. Such an approach would also permit a more inclusive treatment of gender.

As the female-only focus moved progressively to the fore in research on gender inequalities in health during the 1970s and 1980s, men became the new ‘shadowy characters’ in analyses of the social relations of gender. As Sabo and Gordon (1995: 4) put it: ‘while women were in the gender-spotlight, men resided backstage’. However, a cascade of factors has meant that the social production of health and illness among men is now receiving an explicit gender focus which seems likely to culminate in a shift in the methodological approach that is taken to health inequalities. First, at the theoretical level, there has been a questioning of patriarchy as privilege within the sociology of masculinity (Connell 1995). This opened the door to the possibility that, far from being health protective, patriarchy may undermine (some) men’s health (Annandale 1998b). Thus, in the context of paid work, although patriarchy may operate differently for men and women, its negative health impacts may be the same. For example, Jackson (1994) among others has written of the ways in which work constructs masculinity, undermining health in the process:

as I piled more and more pressure on myself at work [as a school teacher], my body started to give me warnings that it couldn’t stand that alienating rhythm any more. These were mostly in the form of stress-related symptoms like insomnia, an incessant scratching of my scalp when I was anxious, a dry tightening of my throat, tension headaches.

( Jackson 1994: 57)

Second, at the empirical level, the social changes that we outlined in the first part of the chapter, and the new social relations of gender accompanying them, are undermining any straightforward association between women and femininity and men and masculinity. In these terms, many women will recognize Jackson’s (1994) description of masculinity, work and its consequences for health as far from male specific. Perhaps the more interesting question, however, is how far many men would recognize the equivalent descriptions of the health stresses of domestic and caring work in the home generated by women? Third, arguably the only way in which a gender comparative approach can be addressed is by change at the methodological level (see below) which involves including men in analyses alongside women.

To draw together most of the points that have been made so far in the chapter, we conclude this section by outlining in Figure 1.3 three approaches to research on gender and health status, which we have labelled the ‘traditional’, the ‘transitional’ and the ‘emerging new’ frameworks.
These represent broad shifts in the conceptual and empirical research focus over time, from the 1970s to the present day. In Figure 1.3, a hard line has been drawn between the ‘traditional’ and the ‘transitional’ frameworks in order to highlight the degree of discontinuity between them. In distinction, the dotted line between the ‘transitional’ and the ‘new’ frameworks, highlights the emergence of the ‘new’ from the ‘transitional’ framework, that is the continuity between them.

Methodological issues

The bottom (shaded) right-hand box on Figure 1.3 summarizes some of the most important methodological issues which must be addressed if empirical research is to be taken forward within the emerging ‘new’ research agenda. In the final part of the chapter we take each of these issues up in a little more detail.

As indicated first of all on Figure 1.3, we would argue that a gender comparative approach is essential to the emerging ‘new’ approach to gender inequalities in health. To argue this point is not in any way to suggest that ‘all things are equal’, but rather that in times of significant change, it is crucial that we consider the operation of the social relations of gender as they impact on the health of men and women. Although poorly articulated within the ‘traditional’ framework, it is often automatically assumed that the social relations of gender support ‘good health for men’ and ‘poor health for women’. Thus there is a search for ‘what makes women sick’ (Annandale and Clark 1996). The emerging ‘new’ framework moves away from this, to recognize that the social relations of gender operate in much more complex ways. Thus similar circumstances may render both men and women vulnerable to ill health or good health. Equally, similar social circumstances may produce different effects (positive for one, negative for the other) upon the health of men and women – perhaps, for example, because of the interaction of other factors. Thus, it is also important to build an explicit consideration of differences within men and within women into research. To highlight these points is not to suggest that research on gender and health must always and in every case be comparative, since there may be occasions where it is appropriate to concentrate upon differences within women or men, but simply to highlight the complex ways in which the social relations of gender may impact upon men’s and women’s health.

This leads us to the second bullet point in the shaded box in Figure 1.3 – the need to explicitly incorporate a concern for the gender order in empirical analysis. In this chapter we have emphasized that this is one of the most pressing concerns in research on gender inequalities in health. Unfortunately, it is also one of the most difficult to take
**Figure 1.3** A summary of theoretical and methodological approaches to research in the field

<table>
<thead>
<tr>
<th>Framework</th>
<th>Theoretical approach</th>
<th>Methodological approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional</td>
<td>• Only implicit&lt;br&gt;• ‘Gender’ equals difference between women and men&lt;br&gt;• Distinction between sex/gender&lt;br&gt;• Focus on women’s exclusion from/inclusion in social roles and circumstances</td>
<td>• Social roles and statuses as properties of individuals which affect health&lt;br&gt;• Women-only samples&lt;br&gt;• Static&lt;br&gt;• Work and health as predominant focus</td>
</tr>
<tr>
<td>Transitional</td>
<td>Growing recognition of&lt;br&gt;• Cross-cutting patterns of gender inequality&lt;br&gt;• Similarities across men and women, and differences within women and within men increasingly emphasized</td>
<td>• Increasingly gender inclusive approach emphasizing diverse axes of inequality&lt;br&gt;• Stress upon the meanings that people attach to roles and statuses</td>
</tr>
<tr>
<td>Emerging new</td>
<td>• Explicit attention to the gender order seen as essential&lt;br&gt;• Questioning of the hard division between sex and gender</td>
<td>• Gender comparative&lt;br&gt;• Incorporation of the gender order in analysis&lt;br&gt;• Combination of quantitative and qualitative methods&lt;br&gt;• Emphasis on social change over time in the gender order (in both degree and form) at individual and structural level</td>
</tr>
</tbody>
</table>

forward. The ‘traditional’ framework, as discussed already, approaches the gender order from the vantage point of roles and statuses, which means that there is little or no sense of gender beyond the level of the isolated individual. In moving beyond this, there are two related ways in which the gender order can be considered more explicitly. The first of these is theoretical; that is, making sure that we have a clear idea of what the gender order consists of and how it may impact upon health in ways that can be specified in empirical research. In qualitative research,
which is deductive in nature, this may emerge from data analysis, while in quantitative research which is inductive in form, key concepts and their operationalization will need to be made clear in advance of data collection. Direct incorporation of concepts which tap the nature of the gender order as it may impact upon the health status of women and men has been extremely limited to date. Although in this chapter we have stressed that this is a result of theoretical indeterminacy, the problem is equally methodological and technical. In the words of Herbert Blalock (1964), ‘the basic problem faced in all sciences is that of how much to oversimplify reality’ (quoted in Stein 1997: 199). Drawing upon the work of Walsh et al. (1995), which stresses the need to capture the underlying processes which allocate resources and power in relation to gender, Kawachi et al. (1998) have included composite measures of gender inequality at the geographical state level (women’s political participation, economic autonomy, employment and earnings, and reproductive rights) in an analysis of mortality and morbidity. They conclude that in the USA, ‘women experience higher mortality and morbidity in states where they have lower levels of political participation and economic autonomy. Living in such states has detrimental consequences for the health of men as well’ (Kawachi et al. 1998: 21). This analysis attends to structure but, as the authors recognize, since their data are aggregate in form (that is, they use age-standardized mortality rates for each state) rather than representing individuals, it risks the ecological fallacy (that is, assuming that the associations that they report would also exist at the individual level). The ‘traditional’ framework, in contrast, risks the fallacy of composition, that is, assuming that the operation of the whole (the gender order) is equivalent to the sum of its parts (individual roles and statuses). In methodological terms, this brings us back to the theoretical issues that were raised earlier: can we at once take account of social complexity at the individual level while also being sensitive to the form of patriarchy as a social structure?

In Stein’s (1997) opinion, progress in this regard has been hindered by the limitations of the dominant positivist method in the field. Referring only to the health of women, but in the global context, she writes that ‘positivism can be viewed as a framework that is too constricting to support a broad investigation in women’s health and women’s lives’ (Stein 1997: 209). Health, she contends, has been perceived as having a single, dominant determinant or multiple determinants, when it might be more appropriately approached as ‘an intricate, non-linear, tangled web of factors, some of which are socio-political’ (1997: 89). Conceptually, Stein’s tangled web metaphor is useful since it allows for the social complexity of gender that we have stressed in the chapter. But, as she recognizes, we need to be mindful of its methodological implications:
how do we practically conduct analysis in these terms? Stein stresses that her approach is ‘not meant to lead to inactivity, paralysis, or hopelessness’, but to move the focus of research from an investigation of ‘relatively simple causality to a search for understanding that focuses on synergistic relationships and interactions that may be more fundamental and more reflective of reality’ (1997: 172). But, she continues, ‘as with many of the critiques of current modes of thought, it is easier to identify the problems and to envision alternatives than to figure out how to operationalise those alternatives’ (1997: 208). However difficult these issues are to grapple with, they are an essential foundation upon which the emerging ‘new’ framework for research on gender inequalities in health must be built, and therefore a central area for methodological development.

Greater use of qualitative methods than has hitherto been the case in research on gender inequalities in health is one important way in which to take account of the social relations of gender alongside the complexity of individual lives. In particular it may permit us to better take account of social agency – how people actively reflect upon their lives and their health and translate this into action (or inaction) (see also Popay and Groves, Chapter 3 in this collection). As Thomas (1999: 11) stresses in reference to the broader area of health inequalities, there has been a tendency to ‘shred up’ and reduce agency to ‘atomised and measurable dimensions of people’s knowledge and behaviour’ in research – in our terms, in ways that are resonant of the ‘traditional’ framework. Within the emerging ‘new’ framework it is important to consider ways in which quantitative and qualitative research can be combined so that we can look in depth at how men and women respond to and actively engage with the gender order in ways that influence their health.

The final methodological component of the ‘new’ framework is the importance of social change. The ‘traditional’ framework adopted a rather static or snapshot approach, fixing the lives of women (and sometimes men) in time both conceptually and empirically. But throughout the chapter, we have emphasized that gender structures are changing in ways that are likely to impact differentially upon different subgroups of people, even at the same time as some similarities may be emerging between women and men. It is therefore crucial that we not only try to capture dimensions of structural change in the ways described above, but also change in the life of individuals and subgroups of individuals. A focus upon the individual lifecourse is crucial in this regard (see Arber and Cooper, Chapter 5 in this collection) since it permits us to track the cumulative experiences of different generations (Kuh and Ben-Shlomo 1997; Acheson Report 1998; Bartley et al. 1998) as they vary by gender in the context of other factors, such as socio-economic status and ethnicity.
In conclusion, the purpose of this chapter has been to reflect critically upon the established agenda for research on gender inequalities in health and to outline an increasingly recognized need to establish a new way forward. In particular, we have stressed that social change in various domains of social life, calls for a more gender inclusive approach to research that is sensitive to social complexity, alongside an awareness of new forms of gender related equality and inequality that are emerging both between women and men, and between subgroups of men and subgroups of women. We have concluded by identifying, though not resolving, some of the very challenging methodological implications that follow if this emerging ‘new’ framework is to lead to greater insights into the aetiology of gender inequalities in health.

Note

1 The term ‘economically active’ refers to people who are employees, self-employed, participants in government employment and training programmes, and doing unpaid family work. It also includes those aged 16 or over who are looking for work and available to start work within the next two weeks, those who have been seeking a job in the last four weeks, or are waiting to start a job that has already been obtained (ONS 1998: 28). This is self-evidently a wide definition.

References


Gender inequalities in health: research at the crossroads


Ellen Annandale and Kate Hunt

Gender inequalities in health: research at the crossroads


Integrating gender into HIV/AIDS programmes in the health sector: tool to improve responsiveness to women’s needs. 1. HIV infections. 2. Gender identity. HIV TESTING AND COUNSELLING Objectives 2.1 Background 2.2 Addressing gender inequalities in some components of HIV testing and counselling services.