

# Gender and Health Inequality

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## Key Words

morbidity, mortality, health disparities

## Abstract

This review synthesizes gender differences in U.S. health and systematically examines the attention that gender has received in the sociological literature on health disparities over the past three decades. Its goal is to map where we have been in order to identify new directions for sociological research. We begin by summarizing major differences in U.S. men's and women's health and by reviewing explanations for observed differences. We then assess the basis for this knowledge, namely publications in major sociology journals and funding by major granting agencies, focusing on both the quantity and substantive content of this work. We couch the discussion in the broader framework of the analysis of gender in sociology and conclude with promising avenues for future work.

## INTRODUCTION

The early to mid-1980s marked a watershed era in research and policy on gender and health. Verbrugge (1985) published a seminal piece in the *Journal of Health and Social Behavior* that outlined the major patterns, hypotheses, and explanations for gender differences in U.S. health. Nathanson (1984) published an article in the *Annual Review of Sociology* that examined sex differences in mortality, and a Public Health Service task force of the U.S. Department of Health and Human Services (HSS) issued a widely discussed report urging more scientific data on women's health (Public Health Serv. 1985). At the same time, Stacey & Thorne (1985) published an influential piece in *Social Problems* arguing that sociology had been less successful than other disciplines in placing women's experiences at the center of analysis or, put differently, in treating gender as an organizing category of social life.

We take these publications as our point of departure to ask, "What is the quantity and quality of attention that gender has received in the sociological literature on health disparities since that time?" We take a two-pronged approach to answer this question. First, we look at changes in research activities and funding to determine the degree of support for research on gender and health—funding that supports publications on this topic. Second, we examine the coverage of gender and health in four major sociology journals (*American Journal of Sociology*, *American Sociological Review*, *Journal of Health and Social Behavior*, and *Social Forces*, hereafter AJS, ASR, JHSB, and SF) in addition to *Demography*, the flagship population studies journal and an important outlet for sociological research on morbidity and mortality. We tally the number of articles published in each journal since 1980 and discuss the substantive content of those articles. We distinguish the articles along three dimensions: (a) comparative (women relative to men) versus those focused on one gender (women or men), (b) quantitative versus qualitative, and (c) major thematic focus.

Together, these approaches allow us to assess the prominence of gender in the health

disparities literature and to estimate whether and how the treatment of gender has changed over the past three decades. Our primary goal is to map where we have been in order to identify new directions in which to go. To that end, we begin by summarizing the major patterns and explanations for gender differences in U.S. health. We then focus on the foundation of our knowledge to date: published research and funded grants. The final section looks toward future research studies and identifies two related areas that look particularly promising for pushing our knowledge regarding gendered patterns of health forward: specifically, contextual assessments of health and multimethod approaches.

For the purposes of this review, we made several difficult choices in order to work within space constraints and to keep the article focused on the relationship between gender and health. First, we limited our discussion to the U.S. context, owing to a lack of comparability in data and publishing/funding practices abroad. Second, we focused on two broad dimensions of U.S. adult health—mortality (death) and morbidity (physical illness)—and included any article that addressed these topics. We included articles on mental health when they related to physical health outcomes and/or mortality and acknowledge that gender differences in mental health could serve as the basis of an entirely separate review. Finally, we focused on general patterns rather than specific differences across population subgroups (e.g., younger versus older adults, whites versus blacks, etc.), although we recognize that these differences are important and have reviewed these trends elsewhere (Gorman & Read 2006; Read & Gorman 2006, 2010).

## PATTERNS AND EXPLANATIONS OF GENDERED HEALTH DISPARITIES

### Patterns

The historical and contemporary motivation for sociological interest in gendered health

disparities is rooted in the indisputable fact that men and women differ in their physical health profiles, regardless of how health is defined. In broadest terms, women have longer life expectancies than men but suffer from more illness. This finding is well documented in the health disparities literature, and several reviews provide detailed descriptions of the size and scope of gender differences in health (e.g., Bird & Rieker 2008, Read & Gorman 2010, Rieker & Bird 2000). Rather than replicate those reviews, we briefly summarize the major patterns and explanations for contemporary differences in men's and women's health in terms of mortality and morbidity and then move to an assessment of trends in research and funding on gender and health.

Gender differences in health are most obvious with respect to mortality: Women live longer than men in every developed country in the world. The most recent data for the United States show that life expectancy at birth for women is 80.4 years, compared with 75.2 years for men—meaning that, on average, women live 5.2 years longer than men (Natl. Cent. Health Stat. 2009). While large, the size of the gap has been steadily declining since the mid-1970s, when women, at the peak, held a 7.8-year advantage over men. The most frequently cited explanation for the diminishing mortality gap is changes in men's and women's smoking patterns, as men have been reducing their smoking at a more rapid pace than women (see review by Gorman & Read 2007). It is also important to note that men and women are susceptible to the same diseases, even though women outlive men; for example, the top two leading causes of death for both men and women are heart disease and cancer.

Gender differences in morbidity are not as straightforward as those for mortality, with the gap between men and women varying by specific disease outcome and stage of the life cycle (Crimmins et al. 2002, Gorman & Read 2006). At younger ages men tend to engage in more health-damaging behaviors than women (like heavy drinking, illegal drug use, and until recently smoking) that adversely affect their

well-being and increase their risk of death via accidental injuries and homicide. These behaviors also have a cumulative impact that negatively affects men's health at later stages of life by elevating their likelihood of premature death from life-threatening conditions (e.g., heart disease, cancer). In contrast, women are more likely to suffer from nonfatal, chronic conditions such as arthritis and disability that do not necessarily result in their death but do depress their quality of life. These health patterns are directly related to the differential life expectancy of men and women. Although women live more years than men without disease and disability, studies show that the elevated female morbidity rate is related to their longer length of life (Crimmins et al. 1996, 2002). As a result, diseases that show a weaker relationship with age (e.g., asthma, bronchitis/emphysema) vary less by gender than do those with stronger age gradients (e.g., heart disease, hypertension, arthritis).

## Explanations

Why do women live longer than men but spend more years in poor health? Research has advanced several explanations for this relationship, and they typically reference a combination of biological, social-structural, psychosocial, and behavioral characteristics and conditions that differentiate the lives of men and women (Verbrugge 1985, Read & Gorman 2010). These explanatory categories are not mutually exclusive and are often framed in terms of differential exposure (men and women have different levels of exposure to the conditions that foster good health) or differential vulnerability (men and women react differently to these health conditions), with both perspectives receiving empirical support (see reviews by Denton et al. 2004, Rieker & Bird 2000). Biologically, women are more robust than men. For example, estrogen helps to reduce women's risk of heart disease by lowering the circulation of harmful cholesterol, whereas testosterone puts men more at risk of life-threatening

conditions by causing immunosuppression (Owens 2002). However, because biological explanations fail to explain why the gender gap in health differs over time and by social group, they are rarely discussed prominently in sociological studies of gender disparities in health.

More commonly, sociological studies focus on social and contextual factors that shape men's and women's behaviors, social positions, and well-being. The most widely and frequently cited factor shaping contemporary differences in men's and women's health is socioeconomic status (SES). In general, persons of higher social standing have better health because they have greater access to resources needed to prevent and cure disease and typically can better cope with stressful events over their lifetimes (Marmot 2004). Yet women remain economically disadvantaged in U.S. society relative to men, despite advances in recent decades (Milgrom & Petersen 2006, Rose & Hartman 2004, Valian 1998). These and other studies show that women occupy fewer positions of power in most occupational categories, especially prestigious occupations, and are less likely to hold key leadership positions in their local, state, or federal governments. They are also more likely to work part-time, engage in domestic and unpaid labor, and receive less pay than men for similar work. For example, using 15 years of data from the Panel Study of Income Dynamics, Rose & Hartman (2004) show that even among adults with the strongest attachment to the labor force, only 9.6% of women earned more than \$50,000 annually, compared with 44.5% of men.

When compared with men, it is clear that the socioeconomic profile of women places greater limits on their access to health-related resources (Phelan et al. 2004, Ross & Bird 1994, Walters et al. 2002). In addition to this direct pathway, SES also has a large indirect influence on health through psychosocial characteristics (Denton et al. 2004, McDonough & Walters 2001). Studies show that poor SES increases stress and decreases feelings of personal control and self-esteem, and not surprisingly, women report more stressful life events and chronic

stressors than men, in addition to lower levels of self-esteem and personal control (Denton et al. 2004, Forthofer et al. 2001, Nazroo et al. 1998, Rieker & Bird 2000, Thoits 1995). Depression also increases as socioeconomic standing declines, and studies consistently report higher levels of depression among women (Kessler & Zhao 1999). This is harmful to physical health in that there are numerous longitudinal studies showing that depression is linked to a plethora of physical health problems, particularly heart disease (see review by Rugulies 2002). On the more positive side, women do have stronger support networks than do men, and these networks appear to enhance their well-being (Denton et al. 2004, Shye et al. 1995). Some studies indicate that women benefit more from social support than do men (Denton et al. 2004, Denton & Walters 1999, Forthofer et al. 2001, Umberson et al. 1996). However, the evidence on this point is not conclusive (see Elliott 2001, Neff & Karney 2005), as women are more involved in the health needs and behaviors of family, friends, and other social network members, and this higher involvement can result in additional strains and stresses that are harmful to health (Shye et al. 1995).

A large body of research also examines how men and women differentially participate in behaviors that are either beneficial or harmful to health. With few exceptions, men are exposed to more harmful behavior, which is why adjusting for behavioral measures tends to narrow the gap in mortality for men relative to women. Men receive fewer preventive health care visits than do women, and they drink more frequently and more heavily than women, especially during young adulthood (Johnson et al. 1998, Crimmins et al. 2002). Smoking rates are also higher among men, and men may be more vulnerable than women to the health effects of cigarettes and alcohol (Denton et al. 2004, Denton & Walters 1999). Furthermore, across a wide array of risky behaviors (including illegal drug use, drunk driving, and lack of seatbelt and helmet use), men participate at higher levels than women (e.g., Everett et al. 2001, Subst. Abus. Ment. Health Serv. Admin.

2006). As a result, they experience more unintentional injuries than women, contributing to their elevated rate of premature mortality (Cent. Dis. Control Prev. 2005).

That said, the gender pattern is more mixed for behaviors related to diet/exercise and violence. Men engage in slightly higher levels of regular exercise (Natl. Cent. Health Serv. 2009), and they appear to benefit more from exercise than do women (Denton et al. 2004). However, they eat a less healthy diet than women (Cent. Dis. Control Prev. 2007), and rates of overweight are higher for men—although obesity levels are slightly higher among women (Natl. Cent. Health Serv. 2009). In addition, although violence plays an important role in shaping the health profiles of men and women, they differ by the types of violence they are exposed to. Women experience much higher rates of sexual and intimate partner violence than men, with women comprising over three-quarters of victims of sexual assault and rape (Tjaden & Thoennes 2000). Intimate partner violence makes up 20% of all nonfatal violence against women but only 3% of nonfatal violence against men (Rennison 2003). In terms of fatal violence, however, rates of suicide and homicide are more than twice as high among men than women (Cent. Dis. Control Prev. 2005).

In sum, for women their biological advantage and generally more positive behavioral profile result in a longer life expectancy than men, but their disadvantaged economic status and elevated exposure to social stressors increase their likelihood of experiencing acute and chronic nonfatal illnesses that elevate their morbidity levels in relation to men.

## COVERAGE OF GENDER AND HEALTH: RESEARCH AND PUBLISHING

### Research

Thus far, our review shows that quite a bit is known about gender differences in health. This knowledge has been gained by an influx of funding that has invigorated research and

publishing on this topic, particularly since the mid-1980s. Indeed, the mid-1980s marked a time of important change regarding the place of women and gender issues more generally within the medical research community. As detailed by Epstein (2007), a long history of women's health activism coupled with the broader feminist movements of the 1970s and 1980s provided an important motivational backdrop for reformers who argued that health knowledge was incomplete and health practices unjust because of inadequate representation and attention to women and racial minorities in medical research. Those pushing for more attention to gender had statistical support on their side: Women make up more than half of the U.S. population and comprise 58% of seniors aged 65 and older (U.S. Census Bur. 2007), the implications of which are striking in terms of the dynamics of health care. As an example, hypertension afflicts two-thirds of adults aged 60 and over (Ostchega et al. 2007). Yet because of differential mortality and morbidity rates, after the age of 65 women spend about twice the amount of time living with hypertension than do men, which implies that the costs to treat this condition will be greater for women than for men (Crimmins et al. 2002). Beyond the financial burden, this is worrisome for women given that adverse drug reactions affect women at 1.5–1.7 times the rate of men (see review by Anderson 2005).

These factors, coupled with increasing internal and external pressure by critics and medical reformers, led HSS in the early 1980s to create the Public Health Service Task Force on Women's Health Issues. In 1985, the task force issued a report that highlighted the lack of scientific data on women's health and called for, among other things, increased attention to how gender shapes health conditions and diseases in biomedical and behavioral research. As discussed by Auerbach & Figert (1995), this report was used by women's health activists, professionals, politicians, and scientists to push for reform, and it laid the groundwork for change to come. Over the next decade, several policies, guidelines, and federal laws were enacted

that sought to include women in medical studies, thereby permitting the study of gender-based difference in medical research (see Epstein 2007 for review). These changes removed formal barriers to women's inclusion in medical research (e.g., repeal of a 1977 FDA rule excluding fertile women from a large portion of clinical drug trials) and sought to remove more informal preferences for male subjects because of concerns surrounding how fluctuating hormone levels in women might complicate medical studies. The changes reflected the view of critics and reformers alike that "[g]enuine equality between the sexes should be based not on a false assertion of sameness, but rather—at least sometimes—on a proper acknowledgment of difference" (Epstein 2007, p. 67).

Together, these transformations have helped contribute to a research environment that is more supportive of research on gender differences in health and mortality than ever before. Indeed, a 2001 review by the Institute of Medicine came to the overarching conclusion that sex "is an important basic variable that should be considered when designing and analyzing studies in all areas and at all levels of biomedical and health-related research" (Wizemann & Pardue 2001, p. 2). Direct assessments of funding do provide positive evidence regarding the inclusion of women and attention to gender-based disparities in medical research investigations (Epstein 2007). For example, part of the mission of the Office of Research on Women's Health at the National Institutes of Health (NIH) is to monitor adherence to NIH policies regarding the inclusion of women in funded clinical research studies. According to the most recent assessment (Pinn et al. 2008), NIH is compliant with its policy, importantly with regard to the larger-scale Phase 3 efficacy trials in which women represent more than half of research subjects.

But at the same time, barriers to the advancement of knowledge about gender differences in health and illness persist (Wizemann & Pardue 2001). For example, the continuing neglect of gender in health research is illustrated in the grants that are funded by NIH, the largest and

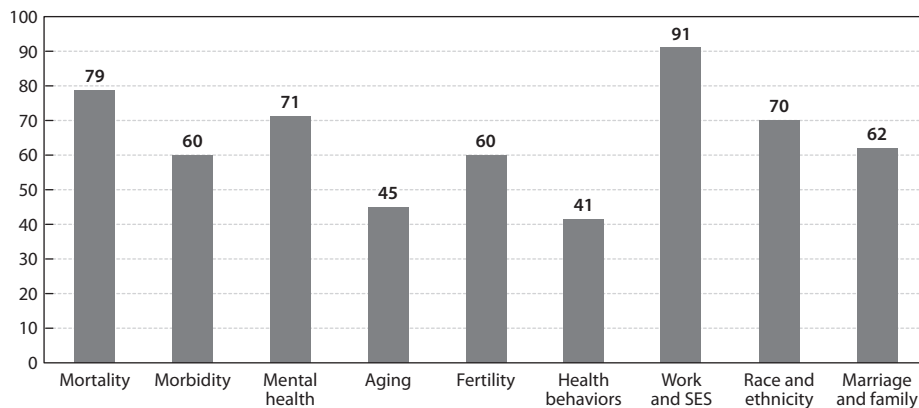
most important funding source for health research in the United States. Analyzing 2000–2003 NIH data, Simon et al. (2005) calculated the percentage of funded proposals for which at least one specific study aim was to examine male and female differences in health status. The authors found an average yearly percentage of just 3% of the total proposals awarded NIH-wide. Furthermore, even though the total number of grants awarded at NIH increased by nearly 20%, the number awarded to study sex/gender differences in health dropped by 16%. Overall, Simon et al. (2005, p. 8) concluded that "for the most part, the NIH institutes with the largest budgets, and hence the most impact on the conduct of biomedical research in the United States, have provided relatively little support for sex differences research in their areas."

Additionally, a recent analysis of clinical trials for heart disease found that since 1965 the overall enrollment rate of women has increased significantly, reaching 54% in 1998 (Harris & Douglas 2000). However, more than half of the women were enrolled in one of just two very large, all-women trials: the Women's Health Study (designed to explore the efficacy of aspirin use for women) and the Women's Health Initiative (a study of cardiovascular disease, cancer, and osteoporosis in women). If these types of single-sex studies are excluded, female participation drops to 38%, which is not a significant increase from the 1965 rate. That said, although gender-comparative research designs are crucially important, single-sex studies do make a meaningful contribution to the representation of women in health research, and these studies (when considered alongside the findings from gender-comparative research) are clearly increasing our understanding of how men and women are similar and different (Buring 2000). We next discuss perhaps the most important avenue for the dissemination of research on gender disparities in health status—publishing.

## Publications

An exhaustive review of five major journals from 1980 through 2008 produced 281 articles that





**Figure 1**

Number of articles by theme across all journals, 1980–2009. Morbidity includes functional ability, physical outcomes, and medical conditions; health behaviors include physical activity, drug/alcohol use, smoking, nutrition, obesity, and sexual behavior; work and SES include employment status, unpaid employment, and neighborhood; race and ethnicity include immigrant health; marriage and family include parenthood, marital status, and marital happiness.

dealt explicitly with gender and health. These journals include the top-tier, nonspecialized sociology journals mentioned above: *AJS*, *ASR*, *SF*, *JHSB*, and *Demography*. Our review strategy consisted of downloading all article titles and abstracts for each journal issue over the selected time period. The data were then imported into Excel, and key word searches allowed us to narrow the list to articles that examined the relationship between gender and health. Of the remaining articles, we reviewed the titles and abstracts for substantive content, coded them by specific key words, and then grouped the key words thematically (see **Figure 1** and **Table 1**).

We excluded internationally based journals and/or journals with a strong international and interdisciplinary focus, such as *Social Science & Medicine*, owing to lack of comparability in content and structure with U.S.-based journals. We also looked at two prominent outlets for gender-based sociological research, *Gender & Society* and *Sex Roles*, to assess how much attention health was receiving in the gender disparities literature since 1980 (a slight reversal of our primary research question) and found 14 articles in the former and 122 in the latter; a significant number of articles employed qualitative methods (86% and 10%, respectively)

and topically addressed body image, nutrition, and eating disorders.

**Figure 2** illustrates the dispersion of the 281 articles across time and by journal. As might be expected, *JHSB* published the most pieces on gender and health, with a total of 132 over the 29-year period, followed by *Demography* with 87 articles. Far fewer articles appeared in the *AJS* (10), *ASR* (18), and *SF* (34). Except for *JHSB*, articles on gender and health make up a very small fraction of all articles published in any given year, ranging from an average low of about 1% for *AJS* and *ASR* to 10% for *Demography* and 16% for *JHSB* (percentages vary slightly from year to year). That said, there has been a general trend upward in the number of articles published on gender and health since 1984. The last period (2005–2009) produced the highest number of articles (63), compared with a low of 30 articles between 1985 and 1989.

Yet these numbers only tell part of the story. Although **Figure 2** gives us a sense of the quantity of articles that have been published, it provides no information about the substantive and thematic focus of the articles. To provide more insight on these issues, we conducted a content analysis of the articles to distinguish quantitative from qualitative, comparative from

**Table 1** Key word searches<sup>a</sup>

Abortion	Marriage
Adolescents	Medical, medical conditions
Age, age at first birth	Men
Aging	Mental health
Alcohol, drinking	Mental illness
Blood pressure	Morbidity
Cancer	Mortality
Cardiovascular disease	Neighborhood
Children	Nutrition
Class, social class	Obesity, overweight
Comparative	Older adults
Death, dying	Parent, parenthood
Depression	Prenatal health
Drug use, abuse	Physical activity
Economic	Physical health
Employment, unemployment	Qualitative
Family structure	Quantitative
Female(s)	Race, ethnicity
Fertility	Religion
Functional ability, disability	Relationships
Gender	Review article
Gender inequality	Self-rated health
Genetics	Sex ratio
Health, health behaviors	Sexual behavior
HIV/AIDS	Sexual health
Homicide	Single country (non-U.S.)
Hypertension	Smoking
Infant mortality	Socioeconomic status
Immigrants	Suicide
Immunization	Treatment differences
International scope	Welfare
Male(s)	Well-being
Marital happiness	Women
Marital status	Work

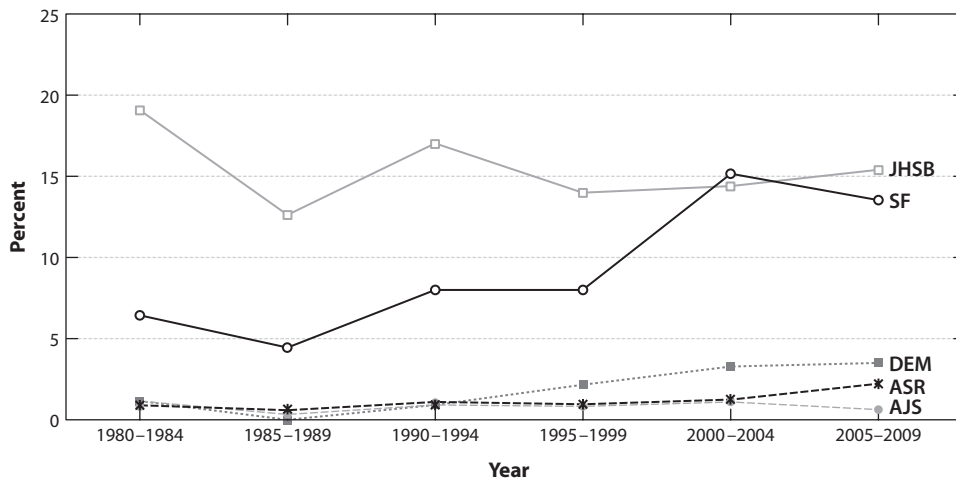
<sup>a</sup>Terms searched separately, in combination, and in derivatives (e.g., parent, parenting).

single-gender focus, and thematic content. Most articles were quantitative (98%), with *JHSB* the only journal to publish studies that were primarily qualitative. We also differentiated between comparative articles and those that only focused on men or women. Most (54%) compared the health profiles of women and men, 34% focused on the health of women only—typically reproductive health—and a

small proportion (12%) focused only on men. The trend since 1995 has been away from male-only studies toward a greater focus on comparative pieces and studies on women.

In terms of thematic focus, we identified 55 recurring key words, which we then collapsed into 9 major thematic categories that are common in the health disparities literature. For example, we combined smoking,





**Figure 2**

Articles on gender and health as a percentage of all published, by journal. The figures for 2005–2009 are constructed from an average of 2005–2008. Journals: JHSB, *Journal of Health and Social Behavior*; SF, *Social Forces*; DEM, *Demography*; ASR, *American Sociological Review*; and AJS, *American Journal of Sociology*.

alcohol consumption, nutrition, and exercise into “health behaviors” and specific disease outcomes, such as cancer, cardiovascular disease, and functional ability, into “morbidity.” **Table 1** provides details on our coding decisions. **Figure 1** illustrates the frequency of the themes across all journals and all years. Moving from left to right in the figure, we order the themes into three major groups: major health outcomes (mortality, morbidity, and mental health), health processes (aging, fertility, and health behaviors), and social and contextual factors that influence health (work and SES, race and ethnicity, and marriage and family). Importantly, most articles deal with a combination of themes (e.g., mortality and SES); thus, the themes should not be interpreted as representing individual articles. Rather, they provide insight into the most common and popular topics covered in research on gender and health. In terms of health outcomes, **Figure 1** shows a strong focus on mortality, followed by mental health and morbidity. For health processes, reproductive health has received the most attention, which is not surprising given its centrality in research on women’s health. Although not readily apparent

in the figure, there is a high degree of thematic overlap in many of the individual journal articles. For example, most of the articles dealing with morbidity and mortality also focus on health behaviors and socioeconomic position.

Overall, three findings are particularly noteworthy from this 29-year publishing review. First, research on gender and health remains firmly grounded in the purview of demographers and quantitative sociologists (**Figures 1 and 2**). Nathanson (1984) accurately noted that this was the case 20 years ago, especially with respect to studies of mortality, and we find this remains the case with most publications appearing in *Demography* and JHSB. For all other major sociological journals, attention to gender and health has remained relatively small and flat. Second, we have seen a slight increase in coverage of this topic in sheer number of articles published since 1985, although not in the proportion, except for *Demography*, where there has been an overall increase in both. And across the board, we have seen a movement away from single-gender studies to more comparative works, partly reflecting a shift toward more inclusive studies of both women and men.

Third, and importantly in terms of future directions, our analysis shows that quantitative research clearly dominates the field in terms of methodological approaches, and this is largely due to the type of data that is available and the type of funding that supports the collection of new data. More than two decades ago, Stacey & Thorne (1985) noted that when gender was incorporated into sociological studies, it was mostly as a variable in a quantitative analysis. In Williams's (2006) reassessment, although quantitative methods continue to dominate in journals such as *ASR* and *AJS*, qualitative work is more typical in gender-focused journals such as *Gender & Society*. Our examination supports these assessments, with the composition of health-related articles in the gender journals we reviewed (i.e., significantly more qualitative studies, with a strong focus on issues related to diet and body image) indicating a substantial disconnect with the nonspecialized, health, and demography journals included in our review. This methodological and topical split is unfortunate, as it represents a missed opportunity for qualitative and quantitative sociologists to work in a more collaborative fashion and to publish this work in outlets that are widely read by users of both methodological disciplines.

Beyond these general trends, our 29-year review also reveals important substantive shifts in research on gender and health that we believe lay the foundation for future research in this area. Notably, there has been a clear movement toward greater specificity in the conditions that shape men's and women's health. Research in the early and mid-1980s was dominated by language such as "sex differences," "minority groups," and "social structure." Today, the focus is more on "women's and men's positions," "health of (insert specific ethnic group) and (insert specific disease outcome)," and "education, occupation, and income." The common thread is an attempt to situate and contextualize individuals' lives without losing the ability to generalize to different population subgroups. For example, until recently, research on gender and racial differences in mortality and life expectancy focused almost exclusively on blacks

and whites (e.g., Manton & Stallard 1980, Keith & Smith 1988, Berkman et al. 1989, Guest et al. 1998). However, in recent years we have seen growing attention to how gender differences in mortality differ across a broader array of ethnic groups beyond blacks and whites, particularly Hispanics (e.g., Elo et al. 2004, Pampel & Rogers 2004). This is a significant trend that will continue in order to fit the ever-changing demographic makeup of the U.S. population.

In addition, a growing number of studies are exploring whether the gender-health pattern seen in developed contexts, such as the United States, applies in poorer contexts as well—and findings suggest that both similarities and differences exist. For example, Fuller and colleagues (1993) examined morbidity rates among Thai men and women, concluding that although gender patterns in morbidity and mortality mimic U.S. patterns, explanations for these patterns differ from U.S. studies, with problems relating to reproductive health and psychological distress accounting for most of the gender difference in morbidity. Other work has also examined how gender patterns in mortality, disability, health behaviors, and specific health conditions operate both within and across nations (e.g., McKinlay 1996; Pampel 1998, 2001; Timæus & Jasseh 2004; Yount & Agree 2005), suggesting that we still have much to learn about how social conditions shape the health experience of men and women in an increasingly global society.

## NEW DIRECTIONS

In the course of conducting this review, we made a conscious effort to pay close attention to the nature and content of research on gender and health over the past three decades, particularly with respect to how it has evolved and where it should be heading now and into the future. Two areas stood out in terms of their potential for moving forward theory and evidence on gender and health: contextual/multilevel approaches and mixed-methods research. These two areas are not mutually exclusive; rather, they have the potential to work in tandem to

improve our understanding of the mechanisms that differentially (and sometimes similarly) affect the health of men and women.

### Contextualizing Gender and Health

Research on the gender-health relationship has typically revolved around identifying individual-level factors that differentially shape health outcomes for men and women, particularly socioeconomic position (e.g., poverty status, educational level, health insurance status) and health-related behaviors (e.g., body mass index, smoking, alcohol consumption). This attention is appropriate, as research has repeatedly demonstrated strong connections between these factors and physical health status. The problem with such a focus is that individuals are situated within broader social, cultural, and political contexts that also condition their health status (Dodoo & Frost 2008). As discussed by Macintyre & Ellaway (2003), the neighborhoods that people occupy can have direct as well as indirect effects on health status (through cognitive and emotional processes), although there is no reason to assume that these effects are similar across health outcomes or population groups. In terms of gender differences, contextual influences may operate differently because men and women perceive their environment differently or because of different levels of exposure and/or vulnerability to aspects of the local environment (Stafford et al. 2005).

Findings to date are mixed with regard to the differential importance of neighborhood context for the health of men and women (see discussion by Stafford et al. 2005), although many studies do find that neighborhood conditions have a larger influence on the health of women. For example, in a study of obesity, Robert & Reither (2004) find that although no measures of community SES are related to body mass index among adult men, there is a strong, significant relationship among women. Similarly, Stafford et al. (2005) find that multiple aspects of neighborhood characteristics, including sociopolitical environment, amenities and

the physical environment, and economic indicators, are more strongly related to self-rated health status for adult women than for men and that overall self-rated health status varied more across neighborhoods for women. The authors attribute these differences to unequal exposure to neighborhood conditions; specifically, women as a group spend more time in their neighborhoods than do men because of lower employment rates. Other studies have also put forth an exposure argument to explain the stronger relationship between context and health seen among women, although heightened perceptions of fear and feeling unsafe in one's neighborhood may also contribute to this difference (Roman & Chalfin 2008, Wang & Beydoun 2007).

There are several promising directions for future research that emerge from this relatively new literature on contextual effects. First, we need more studies that examine gender differences in health using multilevel methods across a diverse set of outcomes, particularly because attention to gender in contextual health studies has been limited to date, and not all studies are consistent in finding bigger effects for women. Second, more attention should be directed toward investigating why these gender differences exist—is it greater exposure or vulnerability to contextual circumstances among women, or is it that men and women view their contexts differently, with discordant health outcomes as a result? As is, our understanding of this emerging pattern is incomplete. Third, we need more studies that examine contextual effects in a longitudinal framework not only to account for selection effects (i.e., how long have people lived in these neighborhoods), but also to consider how health unfolds across the life course and how this might complicate our understanding of contextual influences. For example, recent work by Hamil-Luker & O'Rand (2007) indicates that childhood SES has a stronger impact on adult women's health than on adult men's, and the same might be true for the long-term effects of neighborhood SES (and other contextual factors).

## Mixed-Methods Research

How can we do a better job contextualizing gender inequalities in health? One promising avenue is the use of mixed methods that get at contextually and individually based risk factors. As discussed in this review, research on gender and health (and health more generally) is largely quantitative, in part because of the nature of population studies that are interested in documenting broad-based inequalities as precisely as possible. There is a definite split between the types of questions addressed in quantitatively based research on gender and health (often focused on individual-level characteristics) and those addressed in qualitatively based studies (often focused on more contextual-level factors). This disconnect is further evidenced by the methodological break between gender journals (more qualitative) and mainstream/health sociology and demography journals (almost completely quantitative).

Our understanding of gender differences in health is hampered by this split. Numerous studies demonstrate that combining quantitative and qualitative approaches provides greater explanatory power than a single approach because it captures both objective, numerical patterns and subjective, qualitative experiences (Beatty et al. 2004, Rubin & Rubin 2005). Specifically, in-depth interviews that follow up on survey findings (*a*) allow participants to give narrative responses that elucidate the question-answer processes and provide meaning to the quantitative patterns (Beatty et al. 2004, Greene et al. 1989); (*b*) allow interviewers to probe specific responses, which helps increase the validity of the survey findings (Denzin & Lincoln 2000); (*c*) initiate new understandings of the survey data by explaining quantitative patterns that appear counterfactual or surprising (Greene et al. 1989); and (*d*) provide researchers the opportunity to capture subtle biases and subjective experiences that can be missed with quantitative data (Rubin & Rubin 2005; see Dufur & Feinberg 2009 for example).

The use of mixed-method approaches is particularly important in research on gender

inequality because it allows for a wider discussion of subtle biases sometimes missed in quantitative approaches alone. To date, the benefit of this approach has been demonstrated in several sociological research veins, perhaps most prominently in recent studies of race and racial attitudes, where survey data document a precipitous decline in overtly racist principles among Americans (Bobo 2001)—even though interview data find that while whites are less apt to report racism directly, racial bias is persistent, with minorities continuing to bear the brunt of these perspectives (Feagin & Sykes 1994, Bonilla-Silva 2006). With respect to gender and health, Popay & Groves (2000) note that the body of qualitative research available is very limited, although evidence is mounting that mixed-method projects offer a more accurate picture of how various social factors and relationships shape the health profile of men and women. One illustrative example they discuss involves gender differences in pain, with epidemiological survey data consistently finding that women report higher levels of chronic and intermittent pain than men. However, interview data from Bendelow (1993) show that both men and women express beliefs that pain is more “normal” for women because of the experience of childbirth and because socialization processes actively discourage men from expressing pain. Interview respondents felt that men take longer to admit to pain than women do, suggesting that the prevalence of pain documented in epidemiological studies overestimates the extent of gender difference that exists among adults. As this example demonstrates, the ability of qualitative research to explore the tangled relationship between identity, agency, and social structure for men and women makes it an important tool in research on gender inequalities in health, particularly when used in tandem with quantitative techniques.

The use of mixed-method approaches might also help bridge the publication divide between gender-specialized journals and more mainstream health journals, which in turn would allow research on gender and health to reach a wider audience. The use of mixed-method

approaches is certainly easier in theory than in practice, especially for junior scholars who often have the creativity and energy to tackle such tasks but who are also bound by the tenure clock and the need to publish from readily available data. Thus, it is incumbent on more established scholars, funding agencies, and policy makers to advocate for more data collection efforts that include both quantitative and qualitative techniques. Similar advocacy efforts in the 1980s had a clear and lasting impact on the field of gender and health inequalities, and we must continue to push for progress in this arena.

## CONCLUSION

The past three decades have witnessed numerous changes with respect to the treatment of gender in sociological research on health inequalities. Feminist activists, scholars, public health officials, and researchers have helped move policies and research in a more inclusive direction that focuses on the experiences of women as well as men. As a result, our knowledge and understanding of differences in men's and women's health have grown enormously, with studies demonstrating that although, on average, women live longer than men because of biological advantage and engagement in healthier behaviors, they suffer from elevated morbidity rates across a range of conditions because of their depressed SES and greater exposure to social stressors.

That said, progress in the field has been somewhat slow and localized in the realm of demographers and quantitatively based research. As Doodoo & Frost (2008) recently argued, this isolation results in the treatment of gender as

an individual attribute rather than as a system of inequality, a sentiment that echoes Stacey & Thorne's (1985) claim made some 25 years ago. How might future research move past this seeming impasse to integrate gender theory more fully into studies of gender and health? One promising avenue discussed in this review is the use of multilevel and mixed methods that would allow for a more comprehensive framework to deal with gender as an organizing principle of life that structures opportunities and resources at the individual and contextual levels.

Although progress on the methodological front is one promising possibility, additional research attention is also needed on the intersectionality that characterizes (and differentiates) the experiences of men and women. As discussed above, generalizations about women's health based on data from men no longer serve as the normative research model, and recent years have seen movement away from strictly broad-based comparisons between men and women toward more fine-tuned analyses of difference based on a variety of individual and structural characteristics (e.g., specific health outcome, life cycle stage, racial/ethnic group membership, neighborhood location) that differentiate the lives of men and women (e.g., Bird & Rieker 2008, Gorman & Read 2006, Stafford et al. 2005). We expect that such detailed comparisons will continue and that, when combined with more sophisticated multilevel and multilevel analytic techniques, the coming decades of sociological research on gender difference in health will advance our understanding of this relationship in substantial and perhaps unexpected ways.

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