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The intersections of gender and class in health status and health care

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Abstract
It is increasingly recognized that different axes of social power relations, such as gender and class, are interrelated, not as additive but as intersecting processes. This paper has reviewed existing research on the intersections between gender and class, and their impacts on health status and access to health care. The review suggests that intersecting stratification processes can significantly alter the impacts of any one dimension of inequality taken by itself. Studies confirm that socio-economic status measures cannot fully account for gender inequalities in health. A number of studies show that both gender and class affect the way in which risk factors are translated into health outcomes, but their intersections can be complex. Other studies indicate that responses to unaffordable health care often vary by the gender and class location of sick individuals and their households. They strongly suggest that economic class should not be analysed by itself, and that apparent class differences can be misinterpreted without gender analysis. Insufficient attention to intersectionality in much of the health literature has significant human costs, because those affected most negatively tend to be those who are poorest and most oppressed by gender and other forms of social inequality. The programme and policy costs are also likely to be high in terms of poorly functioning programmes, and ineffective poverty alleviation and social and health policies.

Keywords: *Intersectionality, gender, class, health status, health care*

Introduction

Gender and class, as well as race, ethnicity, and caste, structure women's and men's exposure and vulnerability to ill health, their access to health protective resources, and the consequences to them of disease, disability, and violence

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(Lynch and Kaplan 2000, Östlin 2002). It is increasingly recognized that these axes of social power relations are interrelated, not as additive but as intersecting processes, each constructing and being constructed by the other (Glenn 1999, Whittle and Inhorn 2001). However, empirical evidence on their interrelationships and impact on health is, as yet, relatively limited.

Annandale and Hunt (2000) hypothesize that these intersections could be such that the impact on health of one type of inequality can be confounded by others, leading to unpredictable outcomes. In other words, similar inequalities along one given dimension can render men and women equally vulnerable to ill health, or produce differential effects, depending on the presence of, and interaction with, other dimensions. The intersections can also result in wide differences among women and among men. It is important, therefore, to study different dimensions of inequality simultaneously, e.g. class differences among men and women, and gender differences by class (Macintyre and Hunt 1997). It is equally important to analyse differences along the entire social gradient, not just at the two extremes (Sen et al. 2002a).

Empirical work on the intersections between gender and class has begun, in recent years, to yield new insights about the social determinants of health. Unfortunately, this has not permeated the health equity field generally. Many who work on health equity view the sources of inequity as primarily linked to economic class differentials, but this often leaves a number of crucial questions unanswered. For example, the standard work on gradients, gaps, and medical poverty traps tells us easily enough that the poor are worse off in terms of both health care access and health outcomes than those who are economically better off. However, it does not tell us whether the burden of this inequity is borne equally by different caste or racial groups among the poor. Nor does it tell us how the burden of health inequity is shared among different members of poor households. Are women and men (girls and boys), income earners and non-earners, equally vulnerable to ill health in poor households? Are they equally at risk in rich households? Are women and men, widows and income-earning youths, equally trapped by medical poverty? Are they treated alike in the event of catastrophic illness or injury? When health costs go up significantly, as they have in many countries in recent years, do households tighten their belts equally for women and men? Are these patterns similar across different income quintiles?

If the answers to such questions are in the negative, it poses a challenge for policies to ensure not only equity across but also, simultaneously, within households. Consequently, both theoretical and empirical work on the intersections is necessary for the advancement of social theory, for effective feminist politics, for better empirical science, and for appropriate social and health policies (Macintyre and Hunt 1997, Annandale and Hunt 2000, Sen et al. 2002a, McCann and Kim 2003). According to Weber and Parra-Medina (2003: 222), '... intersectional approaches complicate the traditional models of health and illness by incorporating more dimensions, situationally specific interpretations, group dynamics and an explicit emphasis on social change. On the other hand,

they provide a powerful alternative way of addressing questions about health disparities that traditional approaches have been unsuccessful in answering'. Our objective in this paper is to highlight, from existing empirical studies, what insights can be gained if gender and class are treated as intersecting, not separable, processes[1].

Methods

The review is based on a search for the relevant literature on gender and class in the context of health and health care in high- and low-income countries. Electronic journals and databases, including Medline, PubMed, JStor, Science Direct, and Ingenta Connect, were accessed, as well as listservs such as PAHO–Equidad. The searches were limited to English. Library searches were conducted at Karolinska Institutet (Stockholm, Sweden), University of Liverpool (Liverpool, UK), Indian Institute of Management Bangalore and Institute for Social and Economic Change (Bangalore, India), Centre for Development Studies and the Achutha Menon Centre for Health Sciences (Trivandrum, India).

Results

Example 1: gender and class inequalities in health status

We first summarize, and then critically question, the findings of studies that analyse gender and class as separable sources of inequality. We then discuss the findings and implications of studies that analyse the intersections and their impacts on health. With regard to gender inequalities in health, studies have long since established that women live longer but report more ailments than men, although this pattern applies to certain types of illnesses and at certain life stages (Macintyre et al. 1996, Annandale 1998, Östlin et al. 2001). Such studies do not tell us, however, whether gender differentials are similar in different economic groups. Analysis of UK survey data reveals that the gender gap in the prevalence of self-reported morbidity varies by class, being wider among the professional and managerial class than among the manual workers (Drever et al. 2004). The studies do not examine whether there are class differences among women or among men in the ways in which they recognize and respond to illness symptoms and, therefore, presume greater within-sex similarity than may be warranted. A Canadian study showed, on the contrary, that women tended to experience mental health problems differently depending on their socio-economic status, ethnicity, family structure, quality of family relationships, and nature of participation in the labour market (Walters 1993).

Studies analysing class inequalities, without reference to gender, are equally limited. Investigations in the nineteenth century in Paris, Upper Silesia, and England (Lynch and Kaplan 2000), and studies carried out in the 1970s and 1980s in the UK (Townsend et al. 1992) and the USA (Feinstein 1993, Navarro 2002), have consistently revealed that mortality rates are higher among the poor

compared to the rich. Morbidity rates were higher among persons in lower socio-economic groups, in a comparative study of 11 countries in Western Europe (Machenbach et al. 2002).

These studies do not ask whether the impact of socio-economic position on health varies by gender. However, empirical evidence from high-income countries suggests that class effects do vary by gender. Studies in the USA and Canada suggest that the strength of the association between social class and ill-health is stronger among women than among men (Mei Tang and Krewski 2003, Thurston et al. 2005, Loucks et al. 2007). Other studies, in Europe, reveal an opposite trend: the class gradients of mortality and morbidity are stronger among men than women (Stronks et al. 1995). Studies in the UK also point to the fact that the magnitude of class inequalities is not the same for men and for women (Emslie et al. 1999, Matthews et al. 1999, Drever et al. 2004). Moreover, a study in Sweden reveals how the lived experience of social class, in the form of stress associated with insecure incomes, adverse material conditions in the home, and excessive workloads, gets filtered through the gender system (Ahnquist et al. 2007).

Studies that attempt to analyse gender and class as intersecting, not separable axes, can be useful for the additional insights they yield. A number of studies confirm that risk factors determine health outcomes for individuals differently depending on their social position and show, additionally, that as both gender and class exert an influence, the pathways leading to social inequalities in health can be complex, and cannot be predicted along a single dimension of social inequality. For instance, studies in Canada show that the relative importance of health determinants vary by gender and class (Denton and Walters 1999, Denton et al. 2004).

Artazcoz and colleagues (2001) found that the prevalence of limiting long-standing illness, chronic conditions, and poor mental health was significantly higher among women, in both manual and non-manual worker categories, in a study in Catalonia. However, the magnitude of gender differences in mental health was much higher among manual workers than among non-manual workers. The relationship between family demands and health was influenced by both gender and social class. Among non-manual workers (both men and women), none of the indicators of family demands were associated with any health indicator. Among manual workers, there were differences in the family demands that exerted an impact on the health of men and women. Among male manual workers, living with children less than 15 years of age was positively associated with limiting longstanding illness. Among women manual workers, household size affected their workloads and, thus, had a significant adverse effect on self-perceived health status, limiting longstanding illness and chronic conditions.

A later study (Artazcoz et al. 2004) found that while unemployment resulted in poor mental health for Catalonian men and women, its impact was greater on men than on women. This gender difference was related to family responsibilities

and social class. Unemployed men, who were manual workers in their last job, were at higher risk of poor mental health than men who were non-manual workers; moreover, marriage only increased that risk, especially if they were not receiving unemployment benefits. For women, being unemployed and not receiving benefits was associated with poor mental health only if they were married, had no children, and were non-manual workers.

A more in-depth study of different aspects of mental health, by Griffin and colleagues (2002), found that among UK civil servants, both men and women with low control, either at work or at home, had an increased risk of developing depression and anxiety, but women were more at risk for depression, while men were more prone to anxiety. Women in the lowest or middle employment grades, who also reported low control at work or home, were at most risk for depression and anxiety. Men in the middle grade, with low work control, were at risk for depression, while those in the lowest grade were at risk for anxiety. Men in the middle and highest grades were at greatest risk for both outcomes if they reported low control at home.

The studies indicate that the relative importance of risk factors for health outcomes may differ for men and women, and from one context to another. For example, low control at home, resulting from lack of material and psychological resources to cope with excessive household and family demands, predicted coronary heart disease (CHD) among women, but not among men; and explained part of the association between social position and CHD among women (Chandola et al. 2004). Borrell and colleagues (2004) found that, among men, the association between social class position and self-reported health status was explained by work organization exposures, including physical and psychosocial working conditions and job insecurity. Among women, the association between poor health and working class position is accounted for by not only hazardous forms of work organization, but also by material well-being at home, and excessive amounts of uncompensated household labour.

Example 2: inequalities in access to health care

Women generally need more health services than men, due to their role in reproduction but also due to excess female health problems not caused by reproductive morbidity. In high-income countries, women take more medication and visit physicians more often than men, largely due to their use of preventive services for contraceptives, cervical screening, and other diagnostic tests (Gijsbers van Wijk et al. 1996). In low-income countries, although reproductive problems and other chronic diseases play a large role in explaining gender differences in health status, women often have less access to health care services than men (Vlassoff 1994), due to barriers located at the individual, familial, community, and health system levels.

In this section, we discuss gender and class inequalities in access to health care, with specific reference to countries that are without nationalized health systems, or that are undergoing structural reforms towards greater privatization and

liberalization. In such countries, access to health care depends crucially on the ability of households to pay, and is revealed in lack of treatment and inappropriate, or sub-optimal, treatment among the poor and among women (Gao et al. 2001, Sen et al. 2002b). A significant body of research has also highlighted the phenomenon of household impoverishment due to catastrophic medical expenditures in transitional economies in Asia and Africa (Krishna 2003, Liu et al. 2003, Sen 2003, Xu et al. 2003, Krishna et al. 2004). We now know that health expenditures can impoverish non-poor households, and/or intensify the vulnerability of those that are already poor (Whitehead et al. 2001, Wagstaff and van Doorslaer 2007). However, evidence on whether and how these impacts are mediated by gender and class intersections is limited.

Class inequality in access to health care, in market-driven health systems, stems from, but is not limited to, differences in the ability to pay. Although the poor suffer greater ill health, their ability to access care is less than that of the rich. Thus, good medical care varies inversely with the need for it in several parts of India (Nandraj and Duggal 1997) and Africa (Russell and Abdella 2002). Differences between rich and poor have been reported in terms of the proportion of persons who are able to meet their needs, the types of health providers and services they are able to access, and the frequency of contact with a health provider in transitional economies in Asia (Segall et al. 2000, Sen et al. 2002b, Huong et al. 2007, Luong et al. 2007), in Africa (Makinen et al. 2000), and in Central and Eastern Europe (Walters and Suhrcke 2005). The poor fare less well than the rich, even in high-income countries such as Canada and the UK that have national health systems (Blendon et al. 2002), although the gradients may be less steep.

In India, though the poor may spend less on treatment in absolute terms than the rich, they spend twice as much of the proportion of income, or the household budget, as the rich (George 1997, Bhatia and Cleland 2001). Evidence from Sri Lanka, Peru, and Vietnam suggests that poor individuals and households cope with financial constraints by switching to less expensive providers, taking fewer tablets, making fewer visits to the provider, delaying treatment, taking high interest loans from informal credit markets, distress sales of productive assets, changed labour patterns and cutbacks on education, and food-related expenses (Oths 1994, Segall et al. 2000, Russell 2001, Perera et al. 2007). Studies in Cambodia and in several African countries show that such strategies leave households vulnerable and destitute (Wilkes et al. 1997, Goudge and Govender 2000, Russell 2001, Russell and Abdella 2002, Kenjiro 2005, McIntyre et al. 2006).

These class-related barriers are differentiated by gender. Women tend to have poorer access to, and control over, resources within households, in communities, and in credit markets, and are tied to gendered divisions of labour that leave them with little time or opportunity for health seeking. In low income settings, not only is non-treatment higher among women than among men, but women are more likely to self-treat, or to receive treatment from informal health providers, or

receive treatment for shorter periods of time than men (Russell and Abdella 2002, Sen et al. 2007). They incur lower expenditures than men do in India (Sen et al. 2002b), or spend amounts that entail lower financial and social burdens for the household (Iyer 2007). In Bangladesh, women tend to have poor access to preventive and curative care, as they are economically dependent on their husbands, or on male heads of household, who may be unwilling to spend money on them (Schuler et al. 2002). Lower value placed on the well-being of girls and women also results in their receiving lower support when ill and unable to carry out daily chores, as shown in a study in a poor district in north India (Sama—Resource Group for Women and Health 2005). Moreover, when health care has to be purchased out-of-pocket, or through private insurance, women are particularly hard hit (Doyal 2003, Falkingham 2004, Östlin 2005, Ravindran and Maceira 2005). They are forced to alter normal health seeking behaviour, to seek less treatment, or to delay treatment, with adverse health consequences ranging from recurring or prolonged morbidity to untimely death.

The above studies indicate that responses to unaffordable health care vary by gender and class location of sick individuals and their households, but they raise a further set of questions. Are economic burdens shared more equally between men and women (boys and girls) in rich households or in poor households? What happens to gender relations as households accrue class privilege? Do gender inequalities in access to care reduce or disappear if there are no financial barriers? These questions are multi-dimensional and suggest more complex intersections.

A 16-month longitudinal study, in rural northern Bangladesh (Rousham 1996), revealed no apparent gender bias in child growth and nutritional status for those in farming and trading/employee households (which were non-poor). However, in landless households, girls had significantly poorer height-for-age and weight-for-age than boys. During a natural disaster, being a girl in a landless household was more detrimental to nutritional status than being a girl per se, or simply belonging to a landless household. Interestingly, while differences by gender were statistically significant in landless households during the disaster, they became insignificant when local conditions improved.

Another study (Iyer et al. 2007) probed how economic class, caste, and gender affect treatment seeking for long-term ailments in a poor rural area in south India, where health services are sparse and of doubtful quality, and health care costs are high and rising. The study found, on the basis of a large sample, that health care was affordable for only one out of three households, wherein affordability was defined as expenditures incurred without associated indebtedness or sale of assets and social burdens (Iyer 2007). Individuals and households responded to longstanding health needs by rationing treatment seeking (through lack of any care or discontinuing care) according to both class and gender. Gender differences were observed in all economic classes of households, but were larger in poorer households due to the effect of rationing. There were also significant class-based differences in the likelihood of non-treatment, but these differences

were limited to women. Thus, apparent class differences can only be understood through a gender analysis.

The interplay between gender and class can be important in relation to access to health care, even in high-income countries with universal health insurance. For example, a recent study in Sweden revealed significant effects of discrimination and socio-economic disadvantage on non-seeking of medical treatment by women, but not by men (Wamala et al. 2007). The authors associated these findings with 'vulnerable exposures of gendered discrimination in relation to social divisions premised on power and authority', and concluded that adverse discrimination based on race/ethnicity, gender, and age are relevant, even in more egalitarian societies such as Sweden.

The studies discussed above highlight the importance of considering class and gender as intersecting axes of power, as important processes are revealed from which theoretical and policy relevant insights can be drawn. The study from rural south India (Iyer et al. 2007) shows that class is a gendered phenomenon that hits women first before affecting men. This finding is important for predictions of the likely results of rising health care costs: they are likely to be much more severe for women (and girls). Indeed, the ability of men (and boys) to hold on to health care in hard times may even be at the expense of the women in their households. This finding has significant implications for policies.

Conclusion

This paper has reviewed existing research on the intersections between gender and class, and their impacts on health status and access to health care. Evidence on intersectionality and its implications for health is limited, since the problem itself has only recently begun to be examined in depth. The issues, however, are crucial from a policy perspective, since intersecting stratification processes can significantly alter the impacts of any one dimension of inequality taken by itself. Studies confirm that socio-economic status measures cannot fully account for gender inequalities in health.

A number of studies show that both gender and class affect the way in which risk factors are translated into health outcomes. However, the intersections can be complex, and health outcomes cannot be predicted satisfactorily by considering only a single dimension, such as economic class. The relative importance of risk factors for health outcomes often differs for men and women in different economic classes and contexts.

Other studies indicate that responses to unaffordable health care often vary by the gender and class location of sick individuals and their households. They strongly suggest that economic class should not be analysed by itself, and that apparent class differences can be misinterpreted without gender analysis. The burden of economic pressures on the household, and responses to disasters, can be disproportionately borne by girls and women. They are the ones more likely to be trapped by medical poverty.

Insufficient attention to intersectionality, in much of the health literature, has had, we believe, significant human costs, because those affected most negatively tend to be those who are poorest and most oppressed by gender and other forms of social inequality. The programme and policy costs are also likely to be high, in terms of poorly functioning programmes, and ineffective poverty alleviation and social and health policies that often target along a single dimension, such as income. In particular, anti-poverty programmes, intended to counter rising health care costs, must, specifically, support women's access. This can be done through a combination of universal systems (of provisioning or health insurance), coupled with forms of targeting or other mechanisms to ensure that they actually reach women and girls within households.

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Note

[1] For reasons of space, we do not address race, ethnicity, or caste in this paper.

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