Gender and the determinants of health: implications for health promotion policies

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The following paper brings together discussions of gender, health promotion and the determinants of health. It refers broadly to gender as a determinant of health using examples and statistics from Canada. Despite the importance of attending to the social determinants of health, it is argued there are dangers, if not only shortcomings, to a certain broad determinants approach which ignores the differences of the everyday context and lived realities of people’s lives. Since gender relations have produced inequalities in health, health promotion policies need to employ strategies both at the state level and at the local level to address these inequalities. The health promotion strategies of enabling and empowerment can enhance equity building local practices.

This study generates from the research conducted at the McMaster Research Centre for the Promotion of Women’s Health [MRCPOWH] at McMaster University in Hamilton, Canada. Funded by the Canadian federal research agencies for health (NHRDP) and the social sciences and humanities (SSHRC), the Centre’s mandate has been to research community based strategies for health promotion with women in the community. Using participatory action research, the researchers have worked primarily on the determinants of healthy work places, social supports, and enhancing coping skills.1

1. The research will appear in 1999 as Women’s Voices in Health Promotion (Toronto: Canadian Scholars Press).
THE DETERMINANTS OF HEALTH MODEL

It has become apparent that medical health services can contribute to a population's health only to a certain extent; medical help is only one among many determinants that affect the health of a population. Building on the principles accepted at the 1977 World Health Assembly at Alma Ata, the World Health Organization committed itself to action on the broader determinants of health. Certain fundamental conditions are prerequisites for health: peace and freedom from the fear of war; equal opportunity for all and social justice; satisfaction of basic needs; political commitment and public support (World Health Organization, 1985). Large epidemiological studies, particularly beginning with the Black Report or Whitehall study in England (Marmot, 1986; Marmot, Kogevinas, and Elston, 1987) have pointed to determinants of health other than medical health services. The Whitehall research indicated a relation between the social gradient and health status of government workers (from clerks to management). These and other studies have pointed to various correlations with health status, notably that of social support (House, Landis & Umberson, 1988); a supportive early childhood (Werner & Smith, 1982; Werner, 1989; Martin, Ramey & Ramey, 1990; Grantham-McGregor, Powell, Walker & Himes, 1991; Suomi, 1991); a good working environment (Karasek & Theorell, 1990; Johnson & Johansson, 1991); personal health practices and coping skills; physical environment; biology and genetics; as well as health services.

In Canada, the determinants of health model has been promoted with the leadership of the Institute for Advanced Research (CIAR), under the term “population health” (Evans, Barer & Marmor, 1994). A broad definition of population health is “an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population” (Hayes & Dunn, 1998). Evans and Stoddart proposed a framework that includes prosperity as one of the contributing boxes (1994). Some proponents of population health have recommended a transfer of investment from the health care sector to the economic sector in
order to increase the prosperity of the nation, which in theory would increase the population’s health status; others, like Wilkinson in England, have argued that the evidence shows that population health depends on the equality of income distribution, rather than the average income in which some might have a great deal and many a little (Wilkinson, 1996; Poland, Coburn, Robertson & Eakin, 1998).

Population Health, as a framework for understanding health, has been adopted by the Canadian federal and provincial governments, even to the extent of reorganizing and renaming government departments from “health promotion” to “population health”. The Federal/Provincial/Territorial Ministers of Health approved the document *Strategies for Population Health* (Minister of Supply and Services Canada, 1994) which identified nine health determinants. They indicated a commitment to act on these determinants. Yet, it would seem that at first the governments were more interested in adopting the framework for its “proof” that health services was not the key determinant of health and therefore did not warrant the kind of expenditures it was receiving. In other words the research model fit neatly into their agendas of debt reduction. At the same time other governmental cost-cutting measures ensued: in some provinces, welfare payments were reduced and women’s programs were eliminated; and a national housing program was disbanded. Policy action on the determinants entailed a cut to health care and a neo-conservative emphasis on the GNP as a solution to social and health problems.

The study of the social determinants of health fits with health promotion and feminist work on the structural context of health. However, the population health project, particularly with its emphasis on national economic growth and prosperity as a solution to health inequities, has been criticized for fitting too easily into a neo-conservative fiscal agenda of cutting government funding and weakening the welfare state. Critics have pointed out that within population health analyses there has been no analysis of the relation between specific fiscal policies or economic systems (e.g. capitalism) and health. (Labonte, 1995; Poland et al., 1998).
Feminist critiques have focused particularly on the lack of attention to gender in population health models, notably the role and place of women in the formal health care system and the gendered implications of moving health care into the community (Kaufert, 1996; Love, Jackson, Edwards & Pederson, 1997). Love et al. and others point out that the reduction of health care spending affects primarily the large female-dominated work force in the health care sector within and outside of hospitals. They suggest that the high population health status of countries such as Japan and Sweden may depend not so much on the average income of the country as on the hidden labour of women or the state welfare system that provides such services as day care and parental leave (Lock, 1993; Love et al. 1997). Kaufert (1996) complains that little attention is paid to extreme conditions, such as the impact on health of homelessness, long term unemployment or malnourishment; the relationship between health, poverty and race/ethnicity; and the relationship between health and gender. She re-examines three of the determinants of health listed by CIAR – satisfying employment, a secure and supportive social environment, and the equitable distribution of income – from a gender perspective: “all the indications are that the determinants of health are broadly similar for women and men, but this conclusion has little practical meaning unless related to the position of women within the occupational and general social structure … women are over-represented at the bottom and under-represented in the upper reaches along most of the gradients considered important to CIAR” (Kaufert, 1996, p. 6). Population health has relied heavily on epidemiological research and as such has been criticized for losing the contextual details of differently lived lives (Hayes, 1996; Labonte, 1995). It can also lack a theory of agency (Poland et al., 1998).²

² Some work has been done to enlarge our understanding of gender and cultural differences (Corin 1994; King & Williams, 1995; Walsh, Sorensen & Leonard, 1995). Some are working on a hermeneutics or semiotics of health, thus enlarging our understanding of the social determinants of health (Corin, 1995). Others are working on a model of gender as a modifiable health determinant (Davidson, Holderby, Stewart, van Roosmalen, Poirier, Bentley & Kirkland, 1997).
The evidence of structural sources of ill-health is mounting. Doyal has pointed to poverty, women's labour, violence, lack of social support and medical intervention as the causes of women's ill-health (Doyal, 1995), yet health promotion policies have traditionally focused on smoking, eating, drinking, exercise, etc. (Daykin & Naidoo, 1995; Nettleton, 1996). This discrepancy points to the bias that has gone into the conceptualizing of health promotion for women. Denton and Walters (1997) in their analysis of the 1994 Canadian National Population Health Survey found that: “the structures of social inequality are the most important determinants of health acting both independently and through their influence on the behavioural determinants of health.”

**WHAT IS THE HEALTH STATUS OF WOMEN IN CANADA?**

In Canada, women born in 1995 have a life expectancy of 81.3 years as compared to 75.4 years for men born that same year (Statistics Canada, 1996). Although women live longer than men in Canada, they experience more illnesses and spend a larger proportion of their lives in poor health. The major causes of women's death in Canada are: cancer, ischemic heart disease and stroke (Stein, 1997), with a sharp rise in women's death rate from lung cancer since 1979 (Nault, 1997; National Cancer Institute of Canada, 1997). Between 1979 and 1995 the life expectancy of men has increased at a greater rate than that of women (Nault, 1997). Women are also greater consumers of health care services than are men. They report more stress and mental health problems than men. They are also the main health care providers; they comprise the majority of workers in the health care system, and they are usually responsible for care within the family and community.

**MENTAL HEALTH**

Health promotion has focused less on mental health than physical diseases. Women are more likely than men to suffer from symptoms
of stress, anxiety and depression. The Canadian National Population Health Survey shows that the prevalence of depression in women is double that in men. In a Canadian study of women's perceptions and priorities of their health, stress and other mental health problems were persistent themes in interviews with women (Walters, 1992). Stress was identified as the most frequently mentioned health problem followed by anxiety and depression. Furthermore, poor women seeking help for mental health concerns are more likely to receive intrusive physical treatments (Canadian Mental Health Association, 1989). Recent immigrants to Canada with diverse ethno-cultural backgrounds experience mental health problems that have been overlooked in health promotion (Canadian Task Force on Mental Health Issues, 1988).

VIOLENCE

Violence has a major impact on health in our society and women are the primary victims of violence at home. A recent report by the Federal Department of the Secretary of State indicates that one million Canadian women are abused by their husbands or live-in partners annually. As well, one in four Canadian women can expect to be sexually assaulted at some time in their lives. 80% of women with a disability will experience sexual assault in their lifetime (Stimpson and Best, 1991). Women who face multiple barriers in our society, such as Aboriginal women, immigrant and visible minority women, lesbian women, young and third-age women, are at a higher risk of experiencing violence than other Canadian women (Kinnon and Hanvey, 1996). Assault has been estimated to be the cause of trauma injuries in 6% of women who visit emergency rooms. In addition to the physical injuries caused by violence against women, women often suffer psychological complications (Canadian Panel on Violence Against Women, 1993).

POVERTY

In 1993, 60% of female lone-parents lived in low-income situations, 28% of visible minority women and 33% of Aboriginal women
In the same year 56% of unattached senior women (65+) had low incomes. Women working full-time earned on average 70% of what their male counterparts earned. In 1994, 69% of all part-time workers in Canada were women. 34% of these workers indicated they would prefer full-time work (Status of Women Canada, 1998). Canada has the world’s second highest rate of child poverty among industrialized countries, second only to the United States. In 1995, one in five children under 18 years – 1.4 million – lived in poverty. 40% of today’s welfare recipients are children. Canada has no national child care system with set standards for fees and quality of services; it has abolished its national housing program (Canadian Council on Social Development, 1996).

ABORIGINAL WOMEN

In 1986, the life expectancy at birth for Aboriginal women was 71 years, compared to 81 for non-Aboriginal women. The infant mortality rate, although decreased from 1979 to 1993, was still 1.7 times the national average in 1993. (First Nations and Inuit Health Programs, 1993). The suicide rate for Aboriginal adolescent girls is eight times the national average. The top four causes of death for First Nations people have remained the same since 1979: injury and poisoning, diseases of the circulatory system, neoplasms (cancers), and diseases of the respiratory system (First Nations and Inuit Health Programs, 1993). The diabetes rate among Aboriginal peoples is 10 times the Canadian rate and is generally higher for females. Rates of cardiovascular and respiratory diseases, eye and ear infections and dental and gastrointestinal problems are all much higher among Aboriginal women than in the female population in general. Aboriginal women suffer higher rates of cervical cancer, sexually transmitted disease and cirrhosis of the liver than their non-Aboriginal counterparts. (National Forum on Health, 1997). In many Aboriginal communities, economic changes, cultural losses and male domination of political life have compromised the traditional social structure. Historical abuse in church, schools and high
levels of alcohol abuse exacerbate the problem. Among Aboriginal women, the rate of abuse may be as high as 80% and in some communities all women have a history of abuse (Ontario Native Women’s Association, 1989; National Forum on Health, 1997).

Given the shocking discrepancy between Aboriginal health and non-Aboriginal health we need to introduce a notion of race, the historical context of this ill-health, and the fact that women with multiple barriers are at significant risk. Any generalized population health intervention will obviously be inadequate to deal with the special conditions of, for instance, Aboriginal women or women with disabilities. More generally, if we turn to the question of why for instance women are on average poorer than men we have to postulate a key determinant prior to such determinants as level of education or having a satisfying job, or level of income. Why are women poorer, why do they not get jobs with high control? – because they are socialized in specific ways and the conditions of their lives do not permit them to advance, because the current ideology of what a woman should be and what she should do, circulating both generally in the population and internalized in women, determines whether women are able to advance towards, successfully obtain and retain high control jobs, in other words because of gender.

**Gender**

We understand gender to be the social construction of what it means to be a woman or man in a given society. e.g. women should be passive, men active; women should be care-givers, men bread-winners; women should be dependent, men independent; women should not be scientists or engineers, etc. In all these cases, we have cultural constructions of what a woman or man should be and institutional structures and practices that establish and maintain these ideologies. The family and the workforce reflect these constructions.

So when we turn to working on a determinant of health, for instance, low income, we must analyze the particular ideological
scaffolding and the institutional structures on which such a “determinant” depends, such as:

- psychological shaping of masculine and feminine;
- family, teacher and society career expectations for boys and girls;
- media representations of boys and girls, men and women;
- abuse, violence and harassment towards girls and women;
- employment equity standards and practices (equal pay; equal opportunity to work);
- reproductive rights: over their bodies, sexual education and contraception, power to say no and to be listened to;
- the presence or absence of adequate and subsidized child care, elder care and care for the sick;
- adequate old age benefits or pension funds for widows or single women.

It is not just some abstract notion of poverty that determines a woman’s ill-health. Women’s poverty and their health are experienced in the context of their everyday lives. On axes of place or time or social relations or labour/activity, women’s gendered lives are played out or determined by the structures that precede them and by the strategies they create to manage and endure. Gender (and race and class) is active in social relations; the division of labour; status; violence; ownership of the means of production; power over discourses, over political change, reproduction, resources; access to food, to health services, employment, and education. It is the knowledge of this experience that offers us clues to those structures – how the body, the quotidian is “the very site of material inscription of the ideological” (de Lauretis, 1987).

Nevertheless, to speak only of the determining forces that affect women’s everyday life is to tell only part of the story. At the same time, there exists a rich diversity of creative ways of inventing and making health as there are strategic ways of resisting controlling and detrimental structures. The everyday is a location of possible change and resistance; so Scholle can speak of both “the liberating and dominating relations that organize various aspects of everyday life” finding “possibilities for an emancipatory … politics … already pre-
sent in … the subjugated knowledges, local narratives, resistances and traditions of specific and diverse struggles over everyday life." (Scholle, 1992: 281, 283). The local and the everyday are the sites of both inequalities and potential policy change. The local is a place of ill health and oppression on the one hand and a place for social action on the other.

**Health promotion policy implications**

The originality and enduring significance of the Ottawa Charter is not only that it directed our attention to the relation between larger determinants and health but also that it pointed to the priority of enabling people to take control of their health. Feminists have argued that community development with empowerment is the approach that most closely meets women’s needs (Aird, 1986; Daykin & Naidoo, 1995; Roberts, Smith & Lloyd, 1992; Rodmell & Watt, 1986). Many are writing about a “new health promotion movement” in which empowering political strategies, such as community participation and coalition building, are used to address the social inequities of health” (Ward-Griffin & Ploeg, 1997, p. 282; Labonte, 1992; Raeburn & Rootman, 1998; Robertson & Minkler, 1994).

Nevertheless, that call for empowerment has been translated in many instances into a call for individuals to take responsibility for their health without any consideration about their power (or lack of power) to take control. In other words, the language of individualism, even consumerism, has privatized health at the very point where the Charter was asking for a collective response to health needs (Nettleton, 1996).

The implications for health promotion policy of the determinants approach would be to work both at the larger state level of intervention – on employment or food security measures, for instance – and at the local level. It is this local level that risks being lost in a determinants approach. The local is a place of knowledge – diverse and productive. The local is a place of agency, action and change. What are we to do with locally identified issues that do
not appear in a broader determinants model? If longitudinal studies offer broad categories that influence the health of populations, it is still at the local level that health or ill-health is experienced and understood. Health promotion should facilitate or enhance local practices that work for the community.

As health promotion researchers, we too must program our own involvement into the equation. How does our research mediate/promote/displace “health care”? How do our recommendations fit with a government program for managing and encouraging the health of a country; how on the other hand do I, as a feminist researcher committed to the diversity of women’s everyday practices and knowledge, support these with the policy I endorse or the health promotion I practise? The institutional funding structures for health traditionally support medical health services with support from public health. The determinants of health paradigm has demanded large epidemiological studies. At the local level, academic community research has facilitated some policy related and academic knowledge production, but:

- it is rarely a large investment (in comparison to, for instance, large biomedical research); and
- it still means that the communities involved must respond to researchers’ needs and specifications. There is no easy funding mechanism for community groups.

The policy implications of a new health promotion that attends to a gender determinants model are that interventions must be made on many levels. If gender relations have produced inequalities in power and access to the general good, all of which determine health status, then health promotion policy must attend to these inequalities and the structures that perpetuate them. To enable women to take control of their health entails programming on a continuum from broad state policy to community provision of programs applicable to individuals; it entails providing the physical and social environment in which women’s capacities may flourish.
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