

Conversations with the Experts

Gender and Health: Constrained Choices and Social Policies



**Chloe E. Bird &
Patricia P. Rieker**

Bio: Chloe E. Bird, PhD, is a Senior Sociologist with the RAND Corporation in Santa Monica, California, and Professor of Sociology at the Frederick S. Pardee RAND Graduate School. She is co-editor of the 5th and 6th editions of the *Handbook of Medical Sociology*. Her research focuses on assessing the determinants of gender, racial/ethnic, and socioeconomic differences in the physical and mental health of individuals and in the health care they receive. She is particularly interested in determining how social and physical characteristics of neighborhoods contribute to individual and population health and health disparities.

Bio: Patricia P. Rieker, PhD, is an Adjunct Professor of Sociology at Boston University, Associate Professor of Psychiatry at Harvard Medical School, and Emerita Professor at Simmons College. She is co-editor of three books, including: *The Gender Gap in Psychotherapy*, *Social Realities*, and *Psychological Processes and Mental Health: Racism and Sexism* (which was named an Outstanding Book by the Myers Center for the Study of Human Rights in North America), and also an evaluation research consultant to the Centers for Disease Control and Prevention. Her current research interests include cross-national comparisons of gender and health, the determinants of health care outcomes, and evaluation research capacity building.
Photo by Silvano Gilardoni, Bellagio (Como), Italy

An Interview with Chloe E. Bird and Patricia P. Rieker

By Karen Corday

Corday: Your book is on gender differences in illness and longevity. How did the book evolve?

Bird: Pat and I had already been studying and talking about gender and health for a long time, and we discussed what was missing from the field and how we could contribute.

Rieker: We had been part of a seminar series that met at the Harvard School of Public Health run by Sol Levine and Diana Chapman Walsh. It consisted of medical sociologists from the Boston area as well as some MD PhDs and public health faculty. Chloe and I were invited to join, and we met there.

Bird: The purpose of the seminar was to figure out how to further our understanding of social patterns of health and illness and what is actionable. It was a really exciting group, and it was a fascinating dialogue. At that time, a lot of attention was paid to the health gradient, which considers income and how and why people have differences in opportunities. Pat and I, and others who were focusing on gender, were saying that that's not all there is, that there are real differences in men's and women's health, and the differences are more complicated. It's not just that one sex has all the advantages and the other doesn't, be they biological or social and economic advantages.

Rieker: The group was conceptualizing the next possible steps and a new agenda for medical sociology. We broke out into a smaller gender-focused group.

Bird: We had people who were looking at intentional and unintentional injury, accidents, pediatric and neonatal health, and adolescent health. We all wanted to understand different kinds of areas as more actionable than in the past. How can we intervene into situations and problems that used to be seen as simply random and unavoidable?

Rieker: Chloe and I began by writing articles and publishing them, and we decided to write the book. We started applying for grants; the first few, we did not get. In some cases, people didn't think gender was the important issue; we were told by a large foundation that they were "not doing gender right now." We tried to explain that we were not just looking at women, but men and women, but they didn't think it was an important factor within medical sociology.

Bird: Another response that we received quite a bit was that it was "very ambitious," that we had laid out a career research plan, and we should go about our business and write the book later. However, we were coming from this group that was all about throwing down the gauntlet and saying what had to happen in order to effect positive change. We really wanted to shift the paradigm.

Rieker: We were eventually fortunate enough to be funded by the National Library of Medicine.

Bird: We spent a huge amount of time doing literature and database searches, and we realized that the work that had been done was so fragmented, so we had to use a social science model to put it all together and then work biology into that model.

Rieker: Another problem was that gender had disappeared from the research agenda; feminists were still addressing it, but most of the time, they were writing about how women were disadvantaged in a variety of ways.

Bird: There had been this "women are disadvantaged" model, which was used to explain women's higher rates of depression, and this depression was seen as women having overall poorer mental health than men. Then the first National Epidemiologic Survey came out, and women's higher rates of depression and anxiety were shown to NOT be emblematic of worse mental health than men. Mental health problems are different between the sexes—men have more substance abuse and antisocial behavior; women have more turning-in behaviors, especially depression and anxiety. Although mental health problems manifest differently in men and women, the overall rates of mental health problems are about equal. At that point, people who had been pursuing this line of research got pulled into other areas, and there was a real void that developed around gender research.

Rieker: We wondered why this void developed; what were the factors contributing to it? In addition to the lack of funding, gender differences is a difficult topic. It doesn't lend itself to the same models as other lines of research. It's so complex and complicated; a lot of our colleagues would hear about our plans and just respond with "Well...good luck!"

Corday: What are some of the patterns found concerning gender and health?

Rieker: The major pattern is that women still live longer than men all over the world, with the exception of the very poorest of countries, in which men don't live that long either. We don't think this can be entirely explained biologically, but we don't think it's entirely social, either.

In the book, we looked at four of the most prevalent conditions in which there are large gender gaps—cardiovascular disease, immune function and disorders, depressive disorders, and substance abuse disorders. We found that while women do live longer, they have more illness in the course of their lives.

Bird: Men have higher rates of early life-threatening diseases, such as cardiovascular disease, while women have more diseases that are lived with and manifest themselves with chronic problems and disabilities.

Rieker: Women's depression rates are double that of men's, while men's rates of substance abuse are double that of women's. The overall rates of mental illness are similar, but if you look at it by disease, you see large gender differences.

Bird: This wasn't understood before the National Comorbidity Study, because mental health research had been overly focused on depression and anxiety, as well as people who actually sought care. Women seek care more often than men, and those who suffer from depression and anxiety are more likely to seek care than those who abuse substances.

Now, there's a World Mental Health Study that surveys over 65 countries and continues to study how much and how little cross-national variation there is on this topic.

Rieker: For 50 years, women's health advantages and problems were explained by biomedical science as

hormone development and deficiency. Hormone replacement therapy was supposed to protect women from dying younger of heart disease, for instance. Of course, the hormone replacement therapy trials did not produce the expected findings.

Bird: The trials had a hard time getting funded, in fact, because people thought it was a no-brainer. The trials were considered by some to be a political favor to women. Amazingly, the first studies on estrogen and heart disease were done on men.

Rieker: In terms of absolute numbers, more women die of heart disease than men.

Bird: That's been true for over 100 years. They live longer than men do and have much heavier onset of heart disease after menopause, but they do die at a greater rate from heart disease. The comorbidities that are more common in women are often associated with a higher increase in the risk of cardiovascular disease and death. Developing diabetes far overshadows any protective rates seen in premenopausal women. Most women don't know that. We're often not taught about issues of obesity, diet, and exercise.

Corday: Please discuss the availability of health information and its effect on people's health choices.

Rieker: Very few people understand risk. Research studies come out saying various things are "risk factors," and it's very confusing. People get a voluminous amount of health advice, and no one knows which piece of advice to follow or which piece is most useful to their own personal risk compared to population risk. Then the media gets involved, hyping different factors at different times. The information is there, but it's not synthesized in a way that people can easily use it.

Corday: What is "constrained choice"? How does it function as a framework for examining gender differences?

Bird: The concept of constrained choice in terms of gender and health asks two questions: (1) What keeps men and women from making health an everyday priority? and (2) What factors contribute to the differences between men's and women's choices?

Rieker: There are four consistent patterns of risk; everyone knows about them, but not everyone follows them. Don't drink alcohol to excess, don't follow a diet high in fat, exercise on a regular basis, and don't smoke. That information is pretty clear; why don't people follow it? Everybody wants to live longer, but many do not take advantage of the pathways to do so. We went on to discuss how nonhealth policies and decisions at other levels, such as national policy, state policy, union policy, workplace policy, and decisions made in families might eliminate some options and opportunities that people have to engage in healthy behaviors.

Bird: When you begin to examine who is following these healthy behaviors, it turns out that it's only 4–5% of the population that adhere to them all. Most people do some, but not others. It's not that people are choosing or not choosing a healthy life; we wanted to back up and see what gets in the way of healthy behaviors. For some groups, it's financial. For some groups, it's time. This led us to examine what socially patterns men's and women's lives that would affect the health choices that they make. Gender becomes a way to illustrate all of this; it's not the only way to illustrate it, of course, but we wanted to show that men and women make decisions based on a constellation of roles and responsibilities. Where do they then prioritize themselves? Where is the sense of urgency in addressing one's own health? One of the only groups we see that does pursue their health is people who already have some diagnosis. It's no longer an option not to pay attention when this happens to you; you can't worry about your health once a month anymore. A diagnosis is a huge constraint!

Not all constraints are barriers to good health, of course. There are constraints that encourage better health, such as smoking bans.

Rieker: Smoke-free workplaces and seat belt laws are good examples. Many public health procedures and regulations were designed as preventive measures. Constrained choice is really a preventive orientation: It's not focused on health care; it's focused on recognizing barriers to healthy choices as a way of preventing health problems that will need care. Another example is the regulations on food packaging that require the display of ingredients and nutritional information so people can make healthy decisions.

Smoking is such a large contributing factor to illness and the gender gap. Eliminating smoking reduces some gender gaps. The smoking rate has been going down in the United States, but it's going up in other countries, especially Eastern European countries. The differences between men and women are enormous; many more

men than women smoke.

Corday: What is the impact of social policies on gender and health?

Rieker: As we mentioned before, there are constraints at the national policy level. We decided to look across countries and see if countries with lots of social welfare policies made it easier to make healthy choices. We examined the Nordic countries and countries such as France where they have free day care, free higher education, pensions that allow people to stay home with their children and still get income. Lo and behold, people in these countries do live longer. It's pretty clear that those non-health policies make it easier for people to make healthy choices. Of course, the smoking rates are higher in those countries than they are in the United States, and that undermines some of the other efforts.

Bird: You do see that investing broadly in education makes a difference in people's ability to make choices about their orientations and expectations.

Rieker: Many of the racial and socioeconomic disparities you see in the United States come from a lack of education. Education affects the opportunities and resources you can access as well as the kind of job that you will get.

Bird: Investing in universal preschool and early childhood education leads to a lower high school dropout rate, which means more people can go on and get better jobs. Usually, when we look at economic models and examine return on investment in universal preschool, the models show immediate impacts on women's employment and school dropout rates. Very few people have taken this information and said, "So, what happens from there in terms of people's health and longevity?" Well, it turns out that social policies increase the chance of people living longer and healthier lives. If we add this into the economic models of return on investment, we capture the effect of these policies on very expensive, long-term issues. These are not health care policies, but they might be the best levers for addressing population health and health disparities.

Rieker: One of the other intriguing findings was that we did not find one policy in any country that was devoted entirely to men's health. Most of the policies were intended for women balancing work lives with raising children, but there was not one policy specifically for men. A lot of feminists would argue that there's no need for men's policies because women are still highly disadvantaged in comparison, but it depends on what you're looking at. When you look at life expectancy, it's a harder argument to make.

Bird: When gender is used divisively, it costs both men and women. For instance, instead of saying "lots of mercury in the workplace is dangerous to people," it was "large amounts of mercury lead to birth defects, so we won't allow women to work here unless they are sterilized." The company with this requirement had a division closed after six women went through sterilization in order to work there. Instead of making the workplace safe for everyone, there was specialized advice that moved the issue off the table. It should be a public health issue, and it is treated as such in many countries, but not in the United States.

Corday: What types of research can better inform the understanding of this issue?

Rieker: We want to see dialogue and research in which biomedical researchers join with the people who understand social factors, patterns, and the organization of men and women's lives. We want integrated models; these fields work very separately at this time. For instance, in the case of smoking, we know that when men and women smoke small amounts of cigarettes—say, 10 or fewer per day—men get more lung cancer than women. There is something physiological going on there, but there are few studies integrating sociology and physiology.

Corday: Do you have any recommendations for workplace practitioners interested in this subject?

Bird: Workplaces can present positive choices to their employees. In the way that some cities have farmers' markets, some workplaces facilitate delivery of fruits and vegetables from a farmers' market. This makes healthy eating easier for employees. Some workplaces present opportunities for exercise within the course of the day; at the Pentagon, where there are very wide hallways, they have brisk walking breaks. My office building has attractive, safe, wide staircases that were constructed with the purpose of being walkable.

Rieker: There aren't a lot of data from companies that have "gone green" yet; it will be interesting to see

whether employee health improves in these organizations.

Lots of companies have worksite day care. Day-care concerns affect men and women and how they balance family and work. That attempt to balance is one of the greatest sources of stress in American life.

Bird: Onsite day care also provides a greater possibility for women to breastfeed. This is another example of how biology is relevant to this discussion. Both men and women benefit from onsite child care, but breastfeeding is proven to lessen women's chances of breast cancer, so this policy benefits women physically as well as mentally and emotionally. There are also the public health benefits to consider as well; breast-fed babies are sick less often than formula-fed babies.

Corday: What types of public policy would help improve men's and women's lives?

Rieker: I'm intrigued by the debate about health care reform. I'm in favor of it, but I'd like to hear some dialogue about, for example, the long-term health benefits of financial aid for low-income families. If these families have financial assistance, they will be able to make healthier choices and will not need the health care system as much. Maybe if we had universal day care and higher education, there would be less strain on the health care system in the future. Parents wouldn't have to take on second jobs to finance their children's college educations, leaving less time for healthy eating and exercise. Women tend to give up lots of healthy behaviors because they are busy putting their children first; that doesn't mean men don't love their children, but they think in different ways about their responsibilities to their families. They tend to work longer hours to make more money for their families, which can also lead to sacrificing one's own health.

Bird: What if, when people were making their career choices in college, they were taught about the stresses of particular jobs and career paths and learned about the need to balance these stresses in order to have a healthy life? What if you got information on the flexibility available in different arenas?

Corday: Anything else?

Rieker: Constrained choice is a platform for prevention. The United States needs such a platform, communities need one, and families need one. Other countries are oriented this way, and their social policies are intended as prevention.

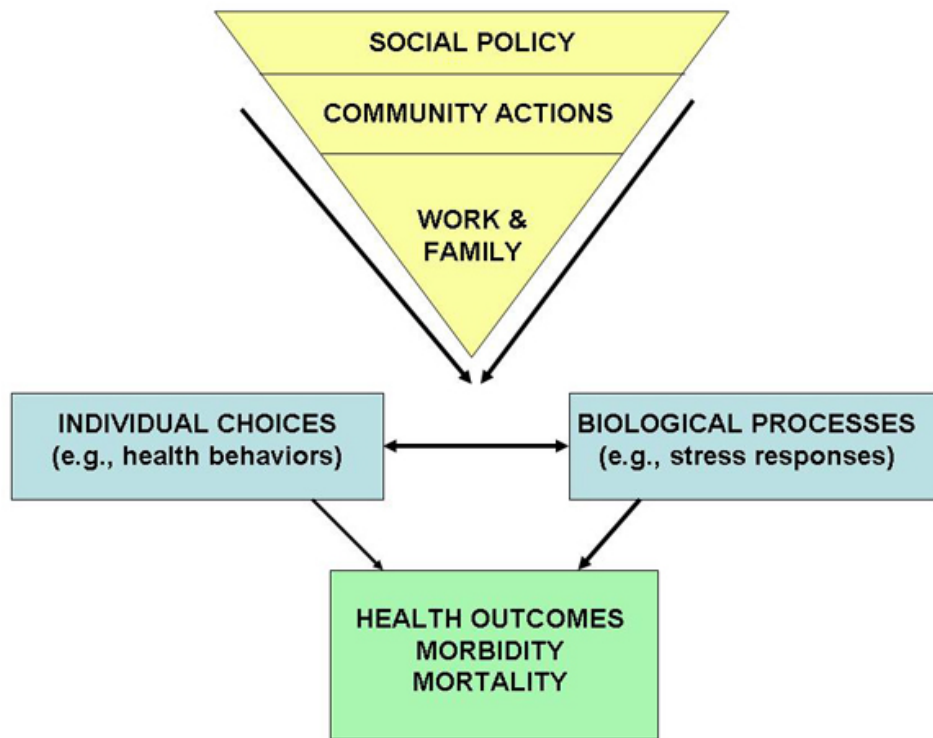
Bird: It's ironic that everyone knows that you need to plan for retirement, for instance—many workplaces have retirement plans for their employees—but there's nothing that lets people plan for their health over the course of their lives. We get academic and career advice in college, but not health advice. We know what we need to do; it's not rocket science. There's no study that's going to bring about the miracle cure that replaces healthy diet and exercise. We need to shift the norms in the workplace, in the family, and even in medical care!

Rieker: The way that medical care is now organized diminishes that possibility. Doctors see more patients in less time and are not focused on prevention. Men still go to the doctor less than women do. The medical field needs to step up to the plate with the media and make sure that important health information is being disseminated properly. They need to advocate for proper interpretation of their findings.

[Gender and Health: The Effects of Constrained Choices and Social Policies](#) is available from amazon.com.

[Click here](#) to read a review from *The New England Journal of Medicine*.

Conceptualization of Constrained Choice



Source: Bird, C. E., & Rieker, P. P. (2008). *Gender and health: The effects of constrained choices and social policies*. New York: Cambridge University Press.

Additional Resources Related to Work, Gender, and Health

International Women’s Health Coalition: “IWHC works to generate health and population policies, programs, and funding that promote and protect the rights and health of girls and women worldwide.”

- <http://www.iwhc.org/index.cfm>

Men’s Health Network: “Men’s Health Network (MHN) is a national non-profit organization whose mission is to reach men and their families where they live, work, play, and pray with health prevention messages and tools, screening programs, educational materials, advocacy opportunities, and patient navigation.”

- <http://www.menshealthnetwork.org/>

Pan American Health Organization: Gender, Ethnicity, and Health Unit: “The Pan American Health Organization’s Gender, Ethnicity, and Health Unit has prioritized making available to the governmental agencies, nongovernmental organizations, academy, cooperation agencies and society in general, resources related to statistical information in the area of gender, health, and development.”

- <http://www.paho.org/English/AD/GE/GenderStatistics.htm>

World Health Organization: Gender, Women and Health: “GWH advocates gender equality in health for women and men around the world. GWH brings attention to the ways in which biological and socio-cultural factors affect the health of women and men, boys and girls. GWH aims to increase knowledge and strengthen the health sector response by gathering evidence, strengthening capacity and engaging in advocacy on how gender and gender inequality affect health.”

- <http://www.who.int/gender/en/>

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