ELSEVIER

Social Science & Medicine 64 (2007) 1892–1903

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Does increased gender equality lead to a convergence of health outcomes for men and women? A study of Swedish municipalities

Mona C. Backhans*, Michael Lundberg, Anna Månsdotter

Swedish National Institute of Public Health, Department of Public Health Sciences, Karolinska Institute, Stockholm, Sweden

Available online 6 March 2007

Abstract

This study examines associations between indicators of gender equality and public health. We compare Swedish municipalities on nine indicators in both the private and public sphere, and an additive index, and study the correlations with indicators of morbidity and mortality. The hypothesis that a higher level of gender equality is associated with a convergence of health outcomes (life expectancy, sickness absence) between men and women was supported for equality of part-time employment, managerial positions and economic resources for morbidity, and for temporary parental leave for mortality. Our main finding is that gender equality was generally correlated with poorer health for both men and women. Our conclusions are tentative due to the methodological uncertainties. However, the results suggest an unfortunate trade-off between gender equality as we know it and public health. Sweden may have reached a critical point where further one-sided expansion by women into traditionally male roles, spheres and activities will not lead to positive health effects unless men also significantly alter their behaviour. Negative effects of this unfinished equality might be found both for women, who have become more burdened, and men, who as a group have lost many of their old privileges. We propose that this contention be confronted and discussed by policymakers, researchers and others. Further studies are also needed to corroborate or dispute these findings.

Keywords: Gender equality; Aggregate data; Public health; Sweden; Convergence

Introduction

It has been proposed that the gender order, loosely defined as the structure of gender relations in a particular society (Connell, 1987; Harding, 1986), is an important determinant of gender differences in health (Chapman Walsh, Sorensen, & Leonard, 1995; Courtenay, 2000a; MacIntyre, Hunt, & Sweeting, 1996), and also that increasing gender equality may contribute to improvements in overall levels of public health (Kawachi, Kennedy, Gupta, & Prothrow-Stith, 1999). Indices of women's status in political participation, economic autonomy, employment and earnings, and reproductive rights, have been used in two US studies to examine the effect of relative gender equality on public health (Chen, Subramanian, Acevedo-Garcia, & Kawachi, 2005; Kawachi et al., 1999),

*Corresponding author. Tel.: +46 8 7373813; fax: +46 8 56613505.

E-mail addresses: mona.backhans@ki.se (M.C. Backhans), Michael.Lundberg@socialstyrelsen.se (M. Lundberg), anna.mansdotter@ki.se (A. Månsdotter).

0277-9536/$ - see front matter © 2007 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2007.01.016

and a country comparative study found that the strength of patriarchy was associated with male mortality (Stanistreet, Bambra, & Scott-Samuel, 2005). Moreover, a WHO study of school-aged children found that countries with a low gender development index score (UNDP, 1995) had a larger gender difference in health complaints (Torsheim et al., 2006). In this study, gender equality is defined as more or less similarity between women and men in every sphere of human life, including the private sphere (Moller Okin, 1989). Given this definition, few earlier studies have examined the relationship between gender equality and public health.

Sweden is ranked second according to the United Nation's Development Programme (UNDP) Gender Empowerment Measure (GEM), which consists of three dimensions: political participation and decision-making, economic participation and decision-making power, and power over economic resources (UNDP, 2003). Since the 1960s, Sweden has developed into what has variously been described as a weak breadwinner (Lewis, 1992), or individual earner-carer model (Sainsbury, 1999), characterised by the individualisation of benefits, equal access to paid work, and a general shift of the burden of domestic work from families to the state. Sweden is, however, also noted for its large occupational sex segregation characterised by a new public/private split with women being predominantly employed in the public sector and men in the private sector (Melkas & Anker, 1997). This makes women potentially doubly vulnerable to welfare state retrenchment both as claimants/service users and employees.

The present study takes as its starting point the argument that the current gender order, which is characterised by dichotomy (sexual segregation) and asymmetry (masculine domination) (Harding, 1986), has effects both on absolute levels of health, and on gender differences in health. The aim is to examine associations between dimensions of gender equality and public health. We have compared Swedish municipalities on a number of indicators in both the private and public sphere, and an additive index, and studied correlations with morbidity (indicated by compensated days from social insurance for sickness absence and disability pension) and mortality (indicated by life expectancy at birth). Women have higher levels of sickness and disability, while men are disadvantaged in terms of life expectancy. In what way does the gender order contribute to these differences, and how might greater gender equality change this pattern?

Inequality of welfare resources

The gender order fundamentally fixes the social determinants of health along gender lines. Resources by which an individual can choose and direct his/her own life, such as participation in political and economic decision-making, work opportunities and income, as well as time constraints, are unequally distributed between men and women (European Communities, 2004a, 2004b; Korpi, 2000; UNDP, 1995). Overall, women have fewer valued resources, and from this perspective gender equality has the potential to benefit women's health more than men's. A Swedish time-series analysis between 1945 and 1992 showed that economic growth had benefited women's mortality decline more than men's, and associations between the male/female wage ratio and men's excess mortality showed that a relative decline in male resources benefited women relative to men (Hemström, 1999). This finding is consistent with the theory of perception of relative social status having an impact on health through psychosocial pathways (Wilkinson, 1999). Thus, men who experience a loss of social status vis-à-vis women may feel threatened, inadequate, and humiliated—feelings that may be seen as chronic stressors, and that could also indirectly lead to ill-health through increased violence, accidents and alcohol-related deaths. However, previously presented studies show that both men and women may benefit from increased gender equality (Chen et al., 2005; Kawachi et al., 1999).

Role expansion and stress

One way in which greater gender equality may affect health is through women's role expansion, from the traditionally female private sphere into the male-dominated public sphere. A number of studies have investigated the health-effects of 'multiple roles' based on two opposing hypotheses. The first is the stress hypothesis, which refers to the idea that individuals with many activities and responsibilities experience increased pressure, conflict and ill-health (Goode, 1960). The second, the expansion hypothesis, refers to the opposite, namely, that individuals with several life roles have health advantages compared to those with fewer roles, as they may