

Gender inequalities in US adult health: The interplay of race and ethnicity

Jen'nan Ghazal Read^{a,*}, Bridget K. Gorman^b

^a*Department of Sociology, University of California-Irvine, 4201 Social Science Plaza B, Irvine, California 92697, USA*

^b*Department of Sociology, Rice University, 6100 Main Street, Houston, Texas 77005, USA*

Available online 24 August 2005

Abstract

Gender differences in adult health are well documented, but only recently has research begun to investigate how race and ethnicity condition gendered health disparities. This paper contributes to this line of inquiry by assessing gender differences in morbidity across five major US racial and ethnic populations. Using data from the 1997–2001 waves of the National Health Interview Survey, the analysis examines differences in men and women's self-rated health, functional limitations, and life-threatening medical conditions for whites, blacks, Mexicans, Puerto Ricans, and Cubans. For each health outcome, we investigate the utility of socioeconomic factors in accounting for observed disparities. Contrary to finding universal excess in female morbidity, the results show that the magnitude of gender difference varies considerably by racial/ethnic group, health outcome, and comparison category. The most striking findings are the consistently higher levels of functional limitations for all women compared to men in their same racial/ethnic group and the poorer health of black women relative to both white and black men for all health measures, after adjustment for socioeconomic and background factors. The gender gap for all other health measures is more variable, and for Mexican women a difference is only evident for functional limitations and only when compared to Mexican men. Our results underscore the need for more research on the role of race and ethnicity in shaping gendered health inequalities and the mechanisms that lead to such variable patterns of difference across and within US racial and ethnic populations.

© 2005 Elsevier Ltd. All rights reserved.

Keywords: USA; Gender; Morbidity; Racial/ethnic disparities; Socioeconomic status

Introduction

Racial and ethnic health disparities are well-documented (Hayward & Heron, 1999; Rogers, Hummer, & Nam, 2000; Williams, 2001), as are gender differences in health (Annandale & Hunt, 2000; Macintyre, Hunt, & Sweeting, 1996; Verbrugge, 1985), yet few studies pull together these strands of research to assess whether and

how racial and ethnic group membership shapes differences in men and women's well-being. In an exception to this general pattern, Cooper (2002) finds that minority ethnic men and women in the United Kingdom experience much higher rates of morbidity compared to white men. Socioeconomic disadvantage accounts for much of this disparity, but fails to explain gender differences within ethnic groups.

The implications of minority group membership for gender differences in US health are even more complex because some racial and ethnic populations have health profiles that surpass the majority white population,

*Corresponding author. Tel.: +1 949 824 8411;
fax: +1 949 824 4717.

E-mail address: jennan@uci.edu (J.G. Read).

despite their being socioeconomically disadvantaged. Mexican Americans, for example, have lower morbidity and mortality rates than non-Hispanic whites, even though they rank low on most socioeconomic indicators (Palloni & Arias, 2004). Black Americans, on the other hand, are disadvantaged both in terms of socioeconomic status and health outcomes (Hayward, Crimmins, Miles, & Yang, 2000). Whether and how these patterns vary by gender is less understood, and whether socioeconomic status differentials can account for gender differences in health—both within and across racial/ethnic groups—is also less known.

This paper examines these questions by assessing the significance of race and ethnicity for gender differences in US adult health. Using data from the 1997–2001 waves of the National Health Interview Survey, we investigate gender differences in self-rated health, disability, and life-threatening conditions across five US racial and ethnic groups: non-Hispanic whites (hereafter “white”), non-Hispanic blacks (hereafter “black”), Mexicans, Puerto Ricans, and Cubans. The analysis is guided by two questions. First, what is the magnitude of gender differences in health within racial and ethnic groups? This section of the analysis compares the health status of women to men in their same racial/ethnic group. Second, does the size of gender differences in health vary across racial and ethnic groups? This section of the analysis compares the health of women and men in each racial and ethnic group to that of white men, a group that occupies the most advantaged position in US society. In both cases, we examine the extent to which socioeconomic factors account for observed health inequalities.

Socioeconomic explanations for health disparities

A wealth of evidence shows that men and women experience differential health outcomes, particularly when mortality is the measure in question. In 2003, life expectancy at birth in the United States was six years longer for women than men—80 years versus 74 years, respectively (Population Reference Bureau, 2003). The relationship between gender and morbidity is more complex, with recent studies finding that the size of women’s disadvantage relative to men may be smaller than previously assumed, varying by health status measure and age (Annandale & Hunt, 2000; Williams, 2003). Nevertheless, the picture of near-universal excess in female morbidity persists in the literature, and studies continue to document that women generally experience poorer health than men on a variety of outcomes, including self-rated health, life-threatening medical conditions, and disability (Macintyre et al., 1996, p. 623; Rieker & Bird, 2000).

Explanations for differences in men and women’s health highlight socioeconomic inequality as a fundamental cause for variations in their well-being, particularly when self-rated health is the outcome in question (Lillard & Waite, 1995; Ross & Bird, 1994). In general, persons of lower socioeconomic status report worse health, in part because they are exposed to more hardship and stress and have limited access to resources that can be used to prevent and cure disease (Phelan, Link, Diez-Roux, Kawachi, & Levin, 2004; Ross & Bird, 1994; Walters, McDonough, & Strohschein, 2002). Women are more likely than men in US society to work part-time, participate in unwaged labor, and receive unequal wages, all of which contributes to their lower socioeconomic position and drives down their health. Once these inequalities are considered, the effect of gender on health is often substantially altered, and in some instances even reduced to non-significance.

Socioeconomic status affects women’s health directly through access to resources and indirectly through psychosocial factors and social roles (Denton, Prus, & Walters, 2004; McDonough & Walters, 2001). Lower socioeconomic position is associated with lower levels of perceived control and self-esteem, both of which are associated with greater levels of depression and poorer self-rated health (Denton et al., 2004; Rieker & Bird, 2000). Depression contributes to poorer physical health through a decreased immune system and heightened blood pressure. Socioeconomic status also helps explain the well-established positive relationship between marital status and health, operating through increased social support for men and increased financial well-being for women (Lillard & Waite, 1995). Married women typically have greater economic resources than their unmarried peers, which translate into greater access to health care, lower levels of stress, and better overall health (Meyer & Pavalko, 1996).

Missing from much of the above literature, however, has been a systematic examination of the moderating influence of racial and ethnic group membership, itself a salient predictor of physical and mental health status. The relationship between race, ethnicity, and health status is well studied, with persistent and often large differentials in health status documented across groups (Hayward & Heron, 1999; Williams, 2002). Compared to all other US racial groups, black Americans have the highest rates of morbidity and mortality for almost all diseases, highest disability rates, shortest life expectancies, least access to health care, and startlingly low rates of the use of modern technology in their treatment (Hayward et al., 2000; Williams, 2001). In contrast, Hispanic and Asian Americans have health outcomes that are equal to or better than the majority white population, although recent studies indicate considerable subgroup variability within these large populations (e.g., Hummer, 2000). Further, the health gap between

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات