CHAPTER 22

Health Care as a Gendered System

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1. INTRODUCTION

Healthcare in society emerges from a system of institutional arrangements and relationships, both formal and informal, that shape and are shaped by socially defined notions about women and men. Our analysis examines healthcare organizations, actors, and issues from a perspective in which gender is posited as a central analytic category and, more generally, as a fundamental means of social differentiation. While we incorporate research on gender differences in health behaviors, we do not intend to present gender as primarily a characteristic of individuals. Rather, we strive to locate gender as a socially constructed element of social relationships and institutions. Explained or justified on the basis of perceived male and female characteristics, gender is an often unequal way of distributing social power. Gender is best seen as an organizing principle of culture and a basic structural element of society.

We conceptualize healthcare organization as gendered in five basic ways following Acker (1990): (1) possessing a division of labor based on gender, (2) incorporating symbols and images to support these divisions, (3) hosting interactions that reinforce male dominance–female submission patterns, (4) producing gendered identities through organizational presentations of self (e.g., language and task orientation), and (5) providing assumptions and an organizational logic for rules and procedures. Rather than focus on these mechanisms sequentially, we weave them throughout our analysis. In healthcare,

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gender is perhaps most evident through a highly segregated, clinical division of labor, an equally segregated administrative structure, and a formidably complex body of knowledge in which gender-based assumptions, images, and categories are deeply embedded. The technical economy of medical care reflects these highly gendered divisions, contributing to the production of gendered selves and identities, and promoting gender inequalities. Further, the U.S. market economy of healthcare and related state policies reinforce gender divisions. In the following analysis, we also aim to reveal how gender intersects with race and social class inequalities in healthcare. Defining healthcare broadly to include the provision of both formal and informal services, we concentrate on the United States, although where possible we place our discussion in a comparative context. We begin with the rise of the modern era in healthcare in the United States in the latter part of the nineteenth century and end with the more ambiguous, postmodern period that characterizes the present.

2. GENDER AND THE EMERGENCE OF MODERN MEDICINE

Healthcare organizations, practices, and policies in advanced industrial nations have developed in close relationship with the rise of professional medicine (Starr, 1982). American healthcare is a hybrid of medicine and capitalism, both of which have arisen as highly gendered activities. Modern medicine in the United States evolved in the mid to late 1800s, during a period when the industrial economy was rapidly emerging and cultural ideologies were being transformed by technology, science, mass production, and the rise of professional experts. This massive restructuring of the economy triggered the separation of production from the home and radically redefined gender roles. The doctrine of separate spheres, an ideology that defined public economic, political, and professional life as the appropriate arena for men and the private world of home and domestic life as the proper place for women, took hold, creating a powerful public–private dichotomy in social life (Cott, 1977). With a legacy that is still evident, the concept of separate spheres had a profound influence on the healthcare work of men and women as well as on the overall organization of healthcare services.

2.1. Gender and the Provision of Healthcare

The delivery of healthcare is accomplished through a gendered division of labor and stratification system rooted in nineteenth century views of male and female. Physicians, from the time they arrived in America from Europe more than 300 years ago until the past two decades, have been predominantly white and male. They achieved professional dominance within the context of a newly industrialized economy, in which production was separated on the basis of gender and women's activities were confined to the private arena of home, family, and community. Although white men dominated the ranks of those then known as "regular" or allopathic physicians, healthcare in early America was supplied by an array of competing practitioners from all walks of life, including women (Ehrenreich & English, 1973). This variety of healers was integral to frontier survival, where both ideological and structural factors mitigated the dominance of any one group (Starr, 1982). Not only did early American physicians lack scientific medical knowledge, but their potential clients believed strongly in free competition and the self-sufficiency of families in caring for the sick. Moreover, rural isolation and the lack of rapid transporta-

transportation and communication made physician consultations difficult to obtain. Domestic medicine was popular and practical, and women were integrally involved in providing medical therapies and tending to sick family members (Cassady, 1991). Female practitioners prevailed in childbirth where midwives attended deliveries and provided other forms of basic primary care in many communities. By the 1920s, however, most women had been excluded from standard medical practice.

The rise to dominance of allopathic physicians conceals a history of gender struggle (Morantz-Sanchez, 1985; Walsh, 1977). Evidence dating back to the Middle Ages shows that women wanted to study medicine; yet medical education remained primarily a male institution. Early American healthcare providers varied greatly in their training and healing strategies, with allopathic physicians more likely than others to have been trained abroad and to use heroic, interventionist strategies (Starr, 1982). Medical apprenticeship programs began to mushroom in the United States during the middle and late 1700s. As early as the 1830s, there were some American women who apprenticed as physicians and, by 1845, women had applied to enter medical school (Walsh, 1977). Some were admitted, mostly to the women's medical schools that began to proliferate toward the turn of the century, but, for the most part, women were strongly discouraged and systematically denied entry. Those who managed to become doctors were often barred from practice opportunities and otherwise marginalized. Periodically, women mounted campaigns to change this situation; however, it was not until 1945 that the last of the elite U.S. medical schools opened its doors to women, 100 years after the first woman had applied there (Walsh, 1977).

Physician dominance was achieved at a time when there was firmly embedded support for racial segregation in American society. This meant that not only women but also, for the most part, people of color were excluded from becoming physicians (Hulston, 1996). In 1910, publication of the Flexner Report, commissioned by the Carnegie Foundation at the request of the American Medical Association, evaluated the quality of medical education in the United States and recommended the closing of a large number of small, inadequate, and poorly funded medical schools, including most of those educating women and racial minorities (Starr, 1982; Weitz, 1996). Part of a campaign between 1905 and 1920 to reform medical education, this report secured and protected the position of allopathic physicians, guaranteeing that medicine would remain white and male for the next half-century. Disparities in the health status of blacks and whites were documented by medical researchers during the 19th century, and were used to support the notion that blacks were more susceptible to illnesses and thus biologically inferior to whites (Williams, 1998). In addition, by the early 1900s, blacks had been barred from most medical school training and from internships and residencies in hospitals, except for the few with designated "colored wards" (Hart-Brothers, 1994). This situation did not change significantly until well into the second half of the 20th century.

The creation of the first hospital and the first formal medical school accelerated efforts among various groups of doctors to gain control over medical practice. Primarily through the discovery of scientific medicine (i.e., the germ theory of disease) and advances in surgical techniques, the predominantly male allopathic physicians prevailed among a host of competing medical practitioners. During the late nineteenth and early twentieth centuries, allopaths successfully pushed for legal statutes that defined the parameters of medicine and medical licensure in terms of their own interests (Freidson, 1988). By the early 1900s, modern medicine had emerged. As the influence and public trust associated with physicians increased, the prominence of women in the community

as informal healers attenuated to informal caregiving and the gendered division of labor in healthcare solidified.

Similar patterns of gender exclusion and segregation in medicine have occurred throughout the world, with women being barred entrance to medical school, especially to elite settings within medicine. There are no examples yet of countries that have achieved gender equity in medicine. In extremely sex-segregated societies, women have been allowed to become physicians solely to treat women and children. There is ample evidence that the gender-based division of labor in healthcare is an international phenomenon (Riska & Wegar, 1993).

2.2. Medical Dominance and Gender

The term "medical dominance" refers to the power and influence of physicians within the healthcare system. It encompasses medicine's attempts to control the conditions of its own work, and also the conditions of supporting and competing occupations (Freidson, 1988; Wolinsky, 1993). While physicians have dominated the medical division of labor, they also have been able to control the power relations and influence the professional activities of other healthcare occupations. Implicit in these arrangements is the fact that medical dominance has also been gender dominance. The divisions and power struggles in healthcare typically are discussed as conflicts over resource and professional turf issues with little, if any, attention to the underlying gender dynamics (Riska & Wegar, 1993). We contend, in contrast, that gender is an essential ingredient of dominance in the medical division of labor.

Gender has been a fault line in healthcare much as it has been throughout society (Doyal, 1995). The dominance of physicians, 80% of whom are male (Barzansky, Jonas, & Etzel, 1997), over nurses, midwives, therapists, and technicians is central to the understanding of healthcare as a gendered institution. Medicine has circumscribed the autonomy and scope of practice of nursing (Donovan, 1983), midwifery (Weitz & Sullivan, 1986), and physical therapy, as well as chiropractic (Coulehan, 1985) and other healthcare occupations (Wardwell, 1994). The American Medical Association's Committee on Allied Health Education and Accreditation oversees accrediting for some 28 allied health occupations, which together are approximately 75% female (Fauser, 1992). Nursing, in particular, has been described in terms of the traditional, patriarchal relationship between husband and wife (Ashley, 1976; Campbell-Heider & Pollock, 1987). The origins of this pattern can be traced back to Florence Nightingale's struggle to get nursing legitimated as a respectable and useful occupation in the nineteenth century. Physician endorsement was essential, but she could obtain it only by promising that nurses would serve and act only on physicians' orders. Nursing thus was defined as a subordinate part of the division of labor surrounding medicine (Freidson, 1988). The growth of non-physician clinicians (such as physician assistants, nurse midwives, chiropractors, acupuncturists, naturopaths, optometrists, podiatrists, nurse anesthetists, and clinical nurse specialists) is likely to alter physician dominance and, as a result, the gendered division of labor in medicine. Non-physician clinician graduates doubled between 1992 and 1997, and growth in their supply into the early 21st century will double compared to that of physicians (Cooper, Laud, & Dietrich, 1998). At the same time, there is evidence that the ability to practice autonomously is increasing for these same practioner groups (Cooper, Henderson, & Dietrich, 1998).

2.3. Male Doctors and Female Patients

Medical dominance also is linked to gender inequality through the historical significance of women as patients and research subjects. In pre-Flexner America, when practitioners were competing for prominence, solving women's health problems helped establish allopathic physicians' therapeutic value. With so many types of healers competing, allopaths needed to impress the public with positive medical outcomes. They required patients with troublesome problems that could be solved effectively enough to enhance medical credibility. To a large extent, women patients served this function. It is ironic that, although elite medical schools at that time barred entrance to most women and persons of color, physicians' scientific and technical expertise expanded in large part because of clinical access to these very populations (Zimmerman, 1987).

Then, as now, sexual and reproductive-related problems yielded eager and potentially enthusiastic patients. Both men and women were targeted as potential patients, sometimes by questionable physicians. Medical advice regarding appropriate sexual functioning abounded, for example, warnings about the presumed dire physical and social consequences of men's masturbation (Barker-Benfield, 1976). Dr. John Brinkley, a Kansas "physician," offered a cure for male impotence in the 1920s through a procedure in which he transplanted goat testicles into hundreds of adult men (Hudson, 1985).

Women, however, provided even greater opportunities for physicians to demonstrate their professional worth. In the late 1880s, Dr. Marion Sims developed a surgical procedure to repair uterine prolapse, offering relief to hundreds of mostly affluent women. A widely respected physician, Sims was able to perfect his procedure by conducting numerous experimental surgeries on slaves and indigent white women (Ehrenreich & English, 1978). Physicians of this period were sought after to treat another common disorder affecting primarily middle- and upper-class women, a complex of chronic fatigue, depression, and anxiety symptoms known as neurasthenia or hysteria (Smith-Rosenberg, 1972). It was thought that when women's delicate reproductive systems were "overly stimulated" by education or sexuality, both physical and mental health would suffer. Physicians treated this disorder with a range of therapies, from total bed rest in semidarkness to surgical removal of the clitoris and/or ovaries to complete hysterectomies. Sigmund Freud, another well-known physician, also relied mostly on women patients in the development of his revolutionary theories of the mind, which served to elevate and legitimate the field of psychiatry. It is interesting that physicians and their theories of female frailty overlooked the contradictory experience of emigrant and working-class women, who were able to labor strenuously as factory, field, or domestic workers during the day and again as wives and mothers in the evening.

Numerous explanations have been offered for the physical and emotional problems that appeared to increasingly afflict women in the newly and rapidly industrializing society. These include the bodily damage produced by tight corseting and other physical restrictions, the effects of drugs and alcohol stemming from unrestricted access to narcotics and patent "medicines," as well as the socioemotional consequences of the upheaval in gender roles (Ehrenreich & English, 1978; Smith-Rosenberg & Rosenberg, 1973). Whatever the cause, women's health problems clearly were medicine's gain. In turn, the new authority of modern medicine served in many ways to reinforce women's dependency and subservient social position.

2.4. Healthcare as a System of Social Control: The Concept of Medicalization

The advice and treatments given to the men and women of the late 1800s and early 1900s can be viewed sociologically as mechanisms of social control, complementing and validating narrowly defined and, for women, repressive social roles. Both medicine as a system of knowledge and medical care as a system of social relationships and institutions have been studied in terms of their coercive effects (Foucault, 1973, 1975; Zola, 1972). These effects include shaping behavior (e.g. sexual practices), identity (e.g. normal or abnormal), and self-worth of individuals (e.g. self-confident versus self-conscious). The notion of medicine as an institution of social control reinforces Acker's (1990) discussion of the impact of gendered organizations on individuals' behavior and life chances. Viewed in this way, medicine is an influential social institution, maintaining and perpetuating gendered assumptions and patterns of gender difference and inequality in social life.

In affluent nations, medical governance over key aspects of individuals' lives is expanding (Freidson, 1988). Growth in the scope of medicine, known as "medicalization," refers not to scientific discoveries, but rather to the process of defining nonmedical or behavioral events as healthcare problems (Conrad, 1992). Women's experiences seem particularly prone to medicalization (Riessman, 1983); however, uniquely male problems, such as impotency and baldness, also have been medicalized in recent years. When social phenomena are redefined as medical, medicine responds as it does to any medical problem, viewing it as pathological (deviant) or potentially pathological. Applying the usual clinical stance, medicine assumes responsibility for eradicating the problem or at least bringing it "under control." While the professional entrepreneurship of physicians (Freidson, 1988) offers one explanation for medicalization, the economic rewards of new treatment markets, in the context of for-profit medicine, provides another.

Feminist theorists have written about the medicalization of women's lives, beginning with the displacement of midwives by physicians (Riessman, 1983). They have pointed out that whereas midwives *assisted* women in the delivery of their child, physicians now *take charge* of labor and delivery. The medicalization of pregnancy and childbirth (Rothman, 1982) has roots, as we have seen, in the professional jurisdictional disputes of the latter 1800s, as does medical authority over menstruation and menopause (Bell, 1987). Another struggle over medicalization was the controversy surrounding the official designation, in 1986, of certain premenstrual symptoms as a mental illness, known since 1994 as premenstrual dysphoric disorder or PMDD (Figert, 1996). Many women's groups fought this decision because it stigmatized a normal characteristic of women. Others welcomed it because it legitimated their symptoms as a "real illness" for which they could claim access to treatment and insurance benefits. During recent years, yet other aspects of women's experience (and in some cases men's) have been medicalized: cosmetic surgery and body shaping (Sullivan, 1993), eating problems and exercise (Hesse-Biber, 1996; Wolf, 1991) and domestic and other forms of violence. As in the life-threatening problems created by the diet medication fenfluramine-phentermine (fen-phen) in the mid-1990s, these seemingly benign procedures may yet prove harmful.

Medicalization solidifies medical authority over events and behavior: physician advice is either required or advised, and physicians are granted authority to determine whether the parameters of the event or behavior are "normal" or "pathological." If pathological, then physician control extends into treatment—through drugs, surgery, or some other form of technological management—so that significant aspects of individuals' lives are brought under the scope of physician authority. To the extent that women have greater

portions of their lives under medical supervision than men, they are subject to loss of autonomy over decisions that may have substantial consequences for them. In seeking to improve the quality of their lives, women seeking medical help may end up with lower quality instead (Rothman, 1986, 1989).

It is difficult to avoid interpreting these developments in the United States from an economic perspective. Financial pressures on hospitals and medical practices in an increasingly competitive environment have encouraged newly medicalized areas of healthcare. Services such as surgical or pharmaceutical weight control, cosmetic surgery, and fitness have become lucrative ventures in many Western countries. Americans reportedly spend more than $30 billion in pursuit of weight loss, $43 billion on fitness, and millions more on plastic surgery and infertility (Hesse-Biber, 1996). In these areas, women in particular stand vulnerable to fraud and overtreatment by medicine. In 1990, for example, the Federal Trade Commission settled out-of-court at least four times with infertility clinics that claimed their success rates were substantially higher than they in fact were (*Modern Healthcare,* 1991).

Childbirth in the United States is the prototypical example of medicalization and marketing. Prospective parents with insurance are enticed by hospitals offering sophisticated technology and extra amenities for what is typically a nonmedical event with an increasingly short length of stay. Hospitals want high-volume maternity services to "bond" with their customers, especially women, and establish ties that may bring them future business. In the 1970s, when insurance payments for complicated surgeries were generous and the use of technology unrestrained, medicalization of childbirth was manifest in an escalating Cesarean delivery rate that rose from 5% in 1970 to 25% of all births in the late 1980s (Public Citizen Research Group, 1994). In the 1990s, financial incentives shifted under managed care, and Cesarean rates began to decline. In 1992, state rates varied between 16% (Colorado) and 28% (Arkansas). Moreover, rates within health systems varied to an even greater extent between for-profit systems, on the one hand, and not-for-profit and public systems, on the other. In one study, Cesarean rates ranged from 12.8% in a public system to 28.1% in a for-profit system (Public Citizen Research Group, 1994).

The situation in affluent countries, such as the United States, where childbirth is relatively safe—despite issues of medicalization and loss of women's control—stands in sharp contrast to childbirth experiences in developing, less affluent countries where survival is a key issue (Doyal, 1995). It is important to keep in perspective that the developed world's average maternal mortality rate of 26 deaths per 100,000 live births is only a fraction of the average rate of 420 in developing nations, or 630 in Africa (Lorber, 1997). In the next section, we explore further the implications of capitalism for a gendered healthcare system.

3. HEALTHCARE IN THE CONTEXT OF CAPITALISM AND PATRIARCHY

Healthcare itself is embedded in larger processes, socially shaped by government policies as well as by broader social forces. Healthcare services, and their implications for men and women, differ from country to country; they are defined variably within the apparatus of state governments as part of national and international market economies, and also by the nature of civil society within households and communities. In the United States perhaps more than in any other country, healthcare reflects the combined forces of capitalism and patriarchy.

3.1. Gendered Healthcare and the State

Governments can have a profound impact in organizing gender relations as part of how they adjudicate the delivery of healthcare services. The relationship between individual and state is a fundamental and central issue, specifically the role of the state in providing for the basic welfare of citizens. Welfare, in this sense, refers to healthcare as well as to education and basic sustenance. Esping-Anderson (1990) has suggested comparing nations based on how well individual citizens are able to obtain basic welfare services outside the market—that is, on their "decommodification" or to what extent welfare will be provided if citizens cannot buy the resources they need. His model posits a state–market–family nexus to differentiate types of national systems wherein each of these three social institutions is defined as a potential welfare provider. In the case of healthcare, if the market fails and citizens are unable to purchase healthcare, then the state or family has to take over. If neither the market nor state can provide, then the individual family is left as the sole source of care. A fully decommodified worker presumably would be one for whom the state would provide the full scope of welfare support. This scheme has been criticized for ignoring gender, the gendered nature of care provision, and for building its concept of state–market–family on the experience of male workers rather than on both males and females (Hobson, 1990; Orloff, 1993). In the traditional family configuration of breadwinner husband–homemaker wife, a male workers' ability to purchase welfare services or to be decommodified by the state does not automatically signal that his wife is equally well taken care of. The question of how independent women are outside the market (their decommodification) remains. Feminist social scientists also have pointed out that much standard research on welfare (including healthcare) and the state obscures and undervalues the considerable unpaid work, largely done by women, that exists as a key element in all healthcare systems (Glazer, 1990; Orloff, 1993).

Healthcare services in the United States are commodities, offered either on a fee-for-service or prepaid (capitated) basis. In Canada and Western Europe, the state plays a stronger role than in the United States, which relies primarily on the market and family as the means of access to healthcare (Graig, 1993). Since it is the responsibility of individuals and families to purchase these services, healthcare has become a privilege for those who can afford to pay. Unlike many other market commodities, however, in healthcare those with the least ability to pay—women, children, and disabled persons—are often those who need the goods and services most. The United States stands alone among industrial and postindustrial, democratic nations in having failed to enact a national health insurance plan (Evans, 1997; Steinmo & Watts, 1995). As a result, the existing patchwork system mixes public and private services in a way that leaves more than 17% of the population, 40.3 million individuals, with no way to pay for healthcare except from their own pocket (Fronstin, 1997), and millions more with coverage inadequate to protect them against financial ruin in the event of a major illness (Himmelstein & Woolhandler, 1994). In contrast, most advanced nations consider healthcare as a right of citizenship and provide access for the entire society (Anderson, 1997). Despite being by far the most expensive healthcare system in the world, fragmentation of healthcare services, inefficiency, bureaucratic top-heaviness, as well as inequities in quality and access to care have become the hallmarks of healthcare in the United States (Evans, 1997). The effects of this system are compounded for women both because of their location in the economy and because of the gendered nature of medical care. As we shall see, much of the gendering of medicine, including the ownership and financing of healthcare facilities, access to health

insurance, and the use of health services, reflect both the profit-driven economy and the gendered, public–private dichotomy that emerged during the nineteenth century.

3.2. The Contradictions of Public and Private

Healthcare in the United States, for the most part, maintains the ownership and financing structure of the white, patriarchal, capitalist world in which early healthcare organizations and professional relationships developed (Starr, 1982; Stevens, 1989; Steinmo & Watts, 1995). Both hospitals and physician practices originated and have functioned predominantly as privately owned entities, hospitals tending to be not-for-profit and physicians mostly practicing in for-profit arrangements. Accordingly, the healthcare system in the United States reflects the same inequalities in gender relations that exist in other types of private, corporate settings (Spence, 1994; Wiggins, 1994). The board room and highest administrative and clinical positions are occupied overwhelmingly by men, while lower-level occupations, such as nursing assistants, clerks, and cleaning staff, are composed mostly of women (Butter, 1985). Men predominate as physicians and women provide the majority of other types of healthcare, both formal and informal.

The gendering of healthcare systems is organized structurally around two types of public–private dichotomies. On the one hand, there is the economic distinction between public and private, reflecting healthcare ownership and financing accomplished through public taxation as opposed to private capital. Publicly financed and private healthcare are differentially populated by men and women. Women are more likely than men to be employed in the public sector (including publicly funded healthcare), and women are also more plentiful than men among those who seek care from public institutions. Public versus private can also refer to spheres of activity, corresponding in healthcare to the distinction between formal and informal care. In this sense, private means unpaid care delivered usually by family or friends in the personal environment of home or community. From the standpoint of informal caregiving, the gendered nature of healthcare becomes particularly pronounced because of the huge proportion of such services delivered by women (Glazer, 1990; Olesen, 1997).

Public financing of healthcare and related public administrative and regulatory agencies has grown steadily over the last several decades in the United States, mostly owing to the commitment made by the federal government in the 1960s through the Medicare and Medicaid programs, extensions of the Social Security system. Because women live longer and are poorer than men, the major beneficiaries in both programs are women. Sixty percent of U.S. citizens 65 and older are women; 70% of those are 85 and older (U.S. Department of Commerce, 1977). Furthermore, the poorest groups in America are women over 65 living alone, and women raising children alone, together comprising 70% of all people in the United States (Allen & Pifer, 1993). Medicare provides comprehensive health insurance benefits and nearly universal coverage to workers and their spouses over 65. Of the 5% of elderly persons not eligible for Medicare, most are women. Medicaid, on a more limited basis, provides healthcare to those with extremely low incomes, with the vast majority of benefits going to mothers and children as well as to frail, elderly women in long-term care. Twelve and a half percent of the U.S. population received benefits from Medicaid in 1995 (U.S. General Accounting Office, July, 1997). Still, since states determine their own eligibility guidelines, as many as 50% of the poor are not covered by Medicaid (DeLew, Greenberg, & Kinchen, 1992).

There are other public programs as well that are providing healthcare benefits for women, including federal family planning legislation that opened family planning centers throughout the United States in the 1970s and the WIC (Women, Infants and Children) program which stresses proper nutrition during the prenatal period and early childhood. In addition, public sector employment typically provides opportunities for minorities and women (Higginbotham, 1997) with the prospect of greater gender and racial equity than in the private sector. Women are increasingly being covered by public healthcare services; however, in the United States, the proportion of the healthcare system that is public, approximately 43%, is the lowest among major industrialized nations. Comparing the United States to Europe reveals that countries with a higher proportion of public spending for healthcare, in most cases, appear to have better life expectancies for males and females and lower maternal mortality rates (Table 22-1).

3.3. Gender Differences in Public and Private Health Insurance Coverage

Health insurance, whether private or public, must be considered another significantly gendered aspect of the healthcare system in the United States. As we have seen, public health insurance and related health programs focusing on women are generally increasing. For the majority of Americans, however, employment-based health insurance is the primary way of paying for healthcare in the face of rising healthcare costs. During the late 1930s, labor unions successfully negotiated with employers for health benefits and an employment-based health insurance system emerged. Employment-based health insurance was an especially attractive option for business, as state laws were passed making contributions to employee health insurance plans tax deductible for employers (Starr, 1982; Staples, 1989). Because women had limited participation in the labor market until recent decades, their access to formal healthcare services was often possible only through the resources of male family members: 40% of privately insured women were covered as dependents even in 1995 (U.S. General Accounting Office, February 1997). As Meyer &

TABLE 22-1. Private Health Care Spending and Selected Health Care Outcomes in the United States and 10 Western European Countries

Country	Private Health Care Spending as a % of Total[a]	Maternal Mortality[b]	Life Exp (F)[b]	Life Exp (M)[b]
Austria	36	1.1	80.3	73.7
Belgium	13	5.6	79.9	73.
Denmark	15	4.3	78.3	72.9
Finland	21	1.6	80.4	72.9
France	28	11.7	82.8	74.4
Germany	20	5.2	79.7	73.1
The Netherlands	22	6.1	80.5	74.7
Sweden	7	5.1	81.0	75.6
Switzerland	35	3.6	82.1	75.3
United Kingdom	10	7.9	79.6	74.2
United States	57	7.2[d]	78.9[c]	72.1[c]

[a] *Source*: Esping-Anderson (1990), p. 70.
[b] *Source*: World Health Organization, Health for All 2000 Data Base, 1997.
[c] *Source*: National Center for Health Statistics.
[d] *Source*: Horton (1995), p. 23.

Pavalko (1996) point out, employment-based health insurance assumes more stability in family life and employment than currently exists in America, especially given the economic restructuring and the growing number of people who are single, divorced, or widowed (Fronstin & Snider, 1996/97). Moreover, healthcare policies are often devised either for women of childrearing age or for the elderly, thus disadvantaging middle-aged women who are more often unemployed or single than their younger counterparts (Doress-Worters, 1996; Keith, 1987; Tallon & Block, 1987). Today, even though more women are employed, labor market inequalities still affect healthcare access for many women, as well as for minorities. Employment-based health insurance provides men and women with differential healthcare access and services, and women's coverage remains inadequate compared to men's.

Recent erosion in employee benefits means that differential placement in the labor market is increasingly important in determining healthcare access for women, as well as for minorities. The percentage of the U.S. population with private health insurance dropped from 80% to 70% between 1980 and 1995 (U.S. General Accounting Office, July, 1997). Escalating healthcare costs in recent decades have caused many employers to reduce the healthcare benefits they offer to workers or to increase premiums and out-of-pocket costs, pricing lower income workers out of coverage even when it is offered (Cooper & Schone, 1997). This is a particular problem in lower level jobs and, therefore, disproportionately affects women and minority workers who tend to be in such jobs. In addition to declining coverage levels and rising out-of-pocket costs, the adequacy of coverage for the dependents of workers has also deteriorated (Fronstin, 1997). Although women's labor force participation has increased, compared to men they tend to work in lower positions, for less hourly pay, in smaller firms with fewer benefits, with less union representation, and more frequently in part-time jobs—all factors that work against favorable insurance coverage (Lindsey, 1997). Even among full-time employees, men are more likely to have employer-paid insurance (68.3% vs. 60.5%). The same discrepancies are found for those working part-time (26% of men and 17% of women) and among discontinuous workers (Miles & Parker, 1997).

Gender differences in insurance coverage are important to explore as yet another part of the gendered healthcare system. On the surface, gender statistics on private health insurance coverage in the United States suggest only small differences. For example, in 1993, 73% of women and 74% of men reportedly were covered by private insurance in the U.S. (Table 22-2). Recent in-depth analyses, however, suggest that aggregate percentages mask significant discrepancies in how healthcare insurance serves the healthcare needs of men and women. Miles & Parker (1997) conclude that in all forms of insurance—in Medicare and Medicaid as well as in private coverage—men are served better than women in relation to their needs. Men and women have different life spans and

TABLE 22-2. Percentage of Women and Men 18 to 44 Years Old with Health Insurance Coverage in 1993

Type of Coverage	Women	Men
Private	72.7	73.9
Public	8.4	3.8
Uninsured	19.0	22.2

Source: Women's health care costs and experiences. Washington, D. C.: The Women's Research and Education Institute (1994), p. 5.

illness patterns, making their healthcare needs substantially different and requiring accessibility to different types of healthcare services. For example, a 1998 survey of health insurance plans found that 93% excluded infertility treatment while only 15% excluded impotency or sterilization on services (*Medical Benefits*, 1998). Nine percent of privately insured women have policies that exclude maternity coverage (Braveman, 1988) while 27% and 36% of insurance plans do not cover induced abortion (Horton, 1995). All but 16% of health maintenance organizations cover oral contraceptives, but no more than 31% to 60% of other plans provide such coverage.

Gendered insurance coverage is also important to explore because these biases may lower the quality of healthcare for women (Burstin, Lipsitz, & Brennan, 1992). For example, women are more likely to move in and out of jobs due to childbirth, making them vulnerable to loss of services or higher premiums to cover medical conditions that develop while they are between jobs. Women require preventive screening that is not always provided, such as mammograms and Pap tests, as well as birth control and abortion services. Because women live longer than men, they are more likely to require nursing home services. Associated with living longer, older women have chronic illnesses and disability and are, therefore, more likely than men to require adaptive aids, home health and community-based services, and out-patient prescriptions. Medicare covers most hospital costs, but provides less adequate coverage for nonhospital care, including the very services women need most, such as home healthcare, out-patient medicines, and adaptive aids. Among poor elderly in 1986, Medicaid paid 49% of the healthcare expenses of unmarried men compared to 33% of the expenses of unmarried women (Allen & Pifer, 1993).

Data on the specifics of healthcare coverage are difficult to find; however, it appears that the most generous and unrestrictive healthcare benefits are unevenly distributed by both gender and race. Those with the most abundant insurance coverage and the freedom to choose nearly any provider tend to be white men in upper-level jobs. Women workers, on the other hand, particularly women of color, are likely to be in lower level-jobs that provide poor health coverage or none at all. As indicated previously, coverage varies greatly with the type of employment. In 1996, only 42.7% of workers in jobs paying $7.00 or less per hour were offered health insurance compared to 93.4% of workers making more than $15.00 (Cooper & Schone, 1997). Clearly, gender differences in the quality of insurance coverage is a key aspect of the gendered healthcare system.

4. THE GENDERED PROFESSION OF MEDICINE

The demands of illness have brought men and women together around the delivery of healthcare across both the public and private spheres. This has not, however, accomplished or even in most cases promoted gender equality in medical practice. Despite some significant changes that have occurred in the past two decades, medicine and medical care continue to reproduce aspects of society's gendered and racist past (Abraham, 1993; Morantz-Sanchez, 1985; Walsh, 1977). Medical education has been the site of perhaps the most dramatic gender changes in medicine. In the world of medical practice, both the gender of the physician and the gender of the patient make differences in the dynamics of the doctor–patient relationship. The length of medical education prolongs the time it takes for changes in gender composition to filter through and have noticeable impact among practicing physicians. As the proportion of women physicians increases, however,

it is of great interest whether or not their practice styles differ from men's. In the following section, we touch upon these issues.

4.1. Medical Education

For much of last century, medical schools were restricted primarily to white men. As we have discussed, strict standards imposed on U.S. medical schools in the early 1900s forced many women's medical colleges to close and the remaining elite institutions admitted few, if any, women. Admissions of women rarely exceeded 5% until the 1960s. Then, by the 1970s, applications began to increase substantially (see Table 22-3), fueled by federal civil rights legislation and the enthusiasm created by student activism and the women's movement. In 1997, women constituted 43.5% of the entering class of U.S. medical schools (Barzansky, Jonas, & Etzel, 1998). Increasing numbers of women medical students brought a new gender consciousness which resulted in complaints about gender-based discrimination and stereotyping among physicians (Boston Women's Health Book Collective, 1992; Campbell, 1974; Scully & Bart, 1973). Over the same period, medical students became more racially and ethnically diverse. One third of the 1997–1998 entering class of U.S. medical students came from either African-American, Asian, Hispanic/Latino, or Native American backgrounds, with greater numbers of women among the African American students and more men among the Hispanic/Latino and Asian students (see Table 22-4). Data from 1997–1998 also reveal a decrease in underrepresented minority students (African American and Hispanics), a matter of some concern given attacks on affirmative action programs (Barzansky, Jonas, & Etzel, 1998). Similar declines occurred for both men and women.

Gender issues in medical education appear in three major areas: the gender distribution of students and faculty, the treatment of gender in the curriculum, and the gender climate in medical schools and institutions (Zimmerman, 1996). The gender balance of students admitted and graduating has improved in recent years, yet imbalance persists in residency programs and among faculty as they progress through the professorial ranks (Bickel, 1995; Bickel & Ruffin, 1995). About one fourth of U.S. medical school faculties are women, with proportionately more women among junior faculty than senior faculty. Full professors and top administrators are overwhelmingly men. In 1997, only 7 of the 125 accredited U.S. Medical Schools were headed by women (Barzansky, Jonas, & Etzel, 1998).

Medical specialization also is gendered in that women and men are disproportion-

TABLE 22-3. Proportion of Women Students Entering U.S. Medical Schools, 1950–1998

Years	No.	Percentage
1949–50	387	5.5
1959–60	494	6.0
1969–70	929	9.1
1974–75	3263	22.4
1979–80	4575	27.8
1989–90	6404	38.2
1997–98	7325	43.5

Source: Association of American Medical Colleges, Section for Student Services.

TABLE 22.4. Gender and Racial/Ethnic Backgrounds of Students Entering U.S. Medical Schools, 1991–92, 1996–97, and 1997–98

	% Women			% Men		
	1991–92	1996–97	1997–98	1991–92	1996–97	1997–98
African American (non-Hispanic)	4.2	5.2	4.9	3.3	3.4	3.1
Native American/ Alaskan Native	0.3	0.4	0.4	0.2	0.4	0.4
Hispanic/Latino	2.4	3.2	2.9	3.4	3.9	3.6
Asian/Pacific Islander	6.4	7.4	8.0	9.5	10.2	10.6

Source: Association of American Medical Colleges, Section for Student Services.

ately represented in most fields of medicine. In 1997, for example, 62% of pediatrics residents and 60% of obstetrics–gynecology residents were women, as were 43% of the residents in both family practice and psychiatry. On the other hand, men dominated general surgery (81%), particularly in specific areas such as orthopedic (93%) and thoracic (95%) surgery. Internal medicine had the largest number of residents, approximately one third of whom were women (Barzansky, Jonas, & Etzel, 1998).

An even more fundamental aspect in the differential treatment of women and men in the medical curriculum reflects the way medical specialities are organized. Women's healthcare is partitioned between three different specialties: internal medicine, obstetrics–gynecology, and family medicine (Bartman & Weiss, 1993; Zimmerman, 1996). Internal medicine physicians, the most common provider of healthcare to adults, rarely provide gynecology services themselves. Instead, they typically refer women to an obstetrician–gynecologist for reproductive-related care. Such fragmentation occurs less frequently for men, whose routine care can be provided by a single, primary care specialist.

Medical school curricula have been criticized for focusing on the average white male to the neglect of adequate material covering women and men of color (Harrison, 1990; Lillie-Blanton & Laveist, 1996; Roberts, Kroboth, & Bernier, 1995). In part, this reflects a longstanding gender bias in medical research (Kirschstein, 1991; Rosser, 1994) compounded—at least until recently—by a narrowly defined cultural perspective on gender. Major, federally funded research studies on heart disease, cancer, and other common health problems in the United States routinely excluded women until the 1990s. Although women constituted a majority of the population over age 65, the Baltimore Longitudinal Study of Aging included *no* women (Weisman, 1998), raising questions about the appropriateness of the study report entitled *Normal Human Aging* (Weisman, 1998). In addition to bias in research, medical advice transmits clear gender assumptions. Brochures and other information on caring for sick children may be written to mothers, not to both fathers and mothers. Contraceptive education is often targeted to girls rather than to both boys and girls. Medical attitudes and advice frequently assume the traditional "male breadwinner" family model for the position and roles of men and women, failing to address adequately the circumstances and health needs of dual-earner and single-parent families as well as gay men and lesbians (Doyal, 1995; Zimmerman, 1987). Biases such as these may be particularly difficult to alter because of the nature of medical education, and the way knowledge is transmitted. Much of the clinical teaching in medical schools is conducted on a tutorial basis, meaning that faculty supervise and instruct students as they work. Standards, attitudes, and values are communicated daily, frequently without con-

scious attention. Faculty awareness and sensitivity to gender and race in these practice settings can have marked impact.

Gender and racial bias in medical education also has been associated with the culture of medical schools and institutions (Grant, 1988), with women and minorities reporting more discrimination and harassment than white males (Lorber, 1984; Baldwin, Daugherty, & Rowley, 1994; Komaromy, Bindman, Haber, & Sande, 1993). Hostler and Gressard (1993) developed a scale to measure gender fairness in the medical school environment that they used to survey all University of Virginia Medical School faculty, residents, and students. They found marked gender differences among both faculty and students: in both groups, women's scores indicated gender inequity and sexism while men's scores did not. In addition, gender climate is also defined by the policies and programs instituted by medical schools, such as maternity and parental leave policies and insurance coverage for reproductive care. A 1995 survey of teaching hospitals affiliated with medical schools found that only 41% offered medical residents paid maternity leave and 23% had no written maternity and parental leave policies at all (Philibert & Bickel, 1995).

4.2. The Doctor–Patient Relationship

Despite dramatic shifts in the gender composition of medical school classes, more than three quarters of practicing physicians in the United States are men. This, in combination with the fact that women make more medical visits than men (Horton, 1995; Marcus & Siegel, 1982; McCaig, 1994), means that the physician–patient relationship remains predominantly a gendered encounter: a male physician and a female or (slightly less often) a male patient. Of central concern is whether this gender skew makes a difference in the nature of the interaction between physician and patient and, ultimately, the quality of medical care. Women have claimed that male physicians strive to dominate medical encounters, failing to listen or to take their complaints seriously (Fisher, 1986; Zimmerman, 1987). Both male and female patients express a preference for physicians of the same sex when discussing issues related to sexuality (Miles, 1991). Difficulties in the doctor–patient relationship are exacerbated for gay men and lesbians, who may delay seeking care as a result. Lesbians frequently do not reveal their sexual orientation to physicians, although this information is considered vital for appropriate healthcare, and often when they do physicians are reported to respond negatively (White & Dull, 1997). A recent study by Stevens (1996) analyzed several hundred healthcare encounters between a racially diverse group of lesbians and their physicians. She found that 77% of the encounters with male physicians were characterized as negative, for example, involved withholding information, sexist comments, etc., compared to 44% of the encounters with female physicians. While the evidence as a whole is complex and difficult to interpret, women primary care physicians appear to be better communicators then men, communicating more emotions, more information, eliciting more patient disclosure, facilitating more patient participation and being better and more empathetic listeners (Weisman, 1998). Women tend to provide more preventive measures and spend more time with patients (Lurie, Slater, McGovern, Estrum, Quam, & Margolis, 1993). Women patients' encounters with women physicians may be particularly beneficial (Weisman, 1998). Franks and Clancy (1993) found the patients with female physicians were less likely than those with male physicians to be deficient in breast examinations, Pap tests, and mammograms. Lorber (1997) has considered the question of whether there are gender differences in

"humane" practice style and found mixed results, in part because patients also have gendered expectations. Women medical students were found to have stronger attitudes of responsibility toward disadvantaged patients (Crandall, Volk, & Loemker, 1993); however, how these attitudes might translate into actual practice behavior was not investigated.

There is also evidence that medical encounters are different for women patients than for men. Healthcare researchers have found that men and women who appear to have similar health problems are sometimes treated differently. A number of studies indicate that women are likely to receive less than adequate care in cardiology (Ayanian & Epstein, 1991; McLaughlin, Soumerai, & Wilson, 1996), although it is also possible that some cardiac procedures may be unnessarily high among men. Coronary heart disease is the leading cause of death for both men and women; in fact, since the 1950s the incidence has risen for women while declining for men. Still, it is treated less aggressively among women, who are less likely than men to undergo standard tests or bypass surgery when hospitalized for several different cardiac diagnoses (Ayanian & Epstein, 1991; Maynard, 1997) even when adjusting for age and severity of illness (Iezzoni, Ash, Schwartz, & Mackiernan, 1997). Giacomini (1996) found similar gender inequities for heart-related as well as for other high-technology procedures, and also fewer procedures for blacks, Latinos, and Asians compared to whites. Inadequacy in care may also exist for specifically female health problems. Citing data from the National Health Interview, Woods (1996) found that fewer than half of American women had a Pap smear or professional breast exam within the previous year. Black women have the highest rates of death from breast cancer, yet the use of mammography is lower for black women, regardless of their income, than it is for white women (Avery, 1992; Burack et al., 1983; Burnset et al,, 1996).

Most research on the doctor–patient relationship has focused on communication and decision-making with little attention to gender. Both British and U.S. researchers have looked indepth at the content of doctor–patient communication, documenting a pattern wherein women's complaints are selectively attended to in a context of physician dominance. West (1984) found that women physicians tended to be interrupted more by male patients than the reverse in doctor–patient encounters. Phillips and Schneider (1993) have recently studied sexual harassment of female doctors and found that 77% reported having been sexually harassed at least once in their career. In the majority of these incidents (92%) the perpetrator was male. With women's health activism in the 1970s, more public attention was placed on informed consent and an egalitarian relationship between a woman and her doctor (Zimmerman, 1987). Nelson (1981) studied these new, informed consumers in the context of childbirth experiences. She found that there was little difference between the well-informed, doctor shoppers among expectant mothers and their more traditional counterparts. Both groups had similar birth experiences, including similar rates of Cesarean sections, episiotomies, etc., even though the informed women had attempted to negotiate less intervention with doctors ahead of time.

5. GENDER STRATIFICATION IN HEALTHCARE WORK

Healthcare involves the ongoing application of technology and knowledge. This process is an organized effort among multiple practitioners and caregivers, including highly trained professionals as well as family members and friends. It is important that healthcare work refer to the activities of informal as well as formal caregivers. Across the occupational spectrum, the healthcare division of labor is highly gendered (Riska & Wegar, 1993).

Gender differences abound among healthcare practitioners, including differences in power and autonomy, practice style, and behavior. Some of these differences reflect the different clinical roles men and women occupy (Anspach, 1987), and the organizational environments in which they work (Floge & Merrill, 1986). Other differences have been attributed to ways in which the backgrounds and experiences of men and women differ (Lorber, 1997).

5.1. Gender and Caregiving

Our analysis of the gendered healthcare system has revealed how the state interfaces with market and family in the delivery of healthcare services. The growth of the elderly population, the development of life-extending medical technologies, and rising healthcare expenditures have all contributed to a growing demand for family members to provide unpaid caregiving work for chronically ill relatives. Caregivers for disabled persons over the age of 50 are fairly equally divided by gender, 56% women and 44% men, although women devote significantly more time performing caregiving work, an average of 14.2 hours per week compared to 7.5 for men (*Washington Post*, 1994). Despite the seeming gender equity in providing healthcare to older persons, studies show that, overall, women perform as much as 75% of all caregiving work. Care for sick children, especially those with chronic illnesses, is largely the responsibility of women (Glazer, 1990; Hill, 1994; Hill & Zimmerman, 1995; Zimmerman, 1993). This informal, unpaid work is required by patients and is an essential component of healthcare in all countries. Even so, it is often invisible, rarely acknowledged as "real" productive labor in terms of tax relief and other forms of compensatory benefits. Unlike social welfare states, such as Sweden, where caregivers may receive compensation, the United States recognizes informal caregiving as work only under very limited circumstances. Doress-Worters (1996) places the value of time spent caring for elderly parents alone at $7 billion annually. Noting that women spend about one third of their lives caring for dependents, Hooyman and Gonyea (1995) argue that female caregiving embodies (and perpetuates) the most basic cultural ideologies: that families are natural caregiving institutions and that women are available in the home to provide this work. The same cultural ideologies create barriers for men caregivers.

Increasingly, there are debates over caregiving and its social implications. Caregiving is a form of caring, an act of love and a family responsibility. Yet, it is also a duty, obligation, and a service to the public. Furthermore, when state support is limited, family caregiving can become a form of social coercion that pulls women (more frequently than men) out of paid labor, limiting their life chances and opportunities for social and economic advancement. Glazer (1993) uses the term "work transfer" to describe the process by which paid medical labor is decommodified and then reassigned to women as unpaid, caregiving work. Women are doubly penalized by this work transfer, as it not only decreases the amount of paid work available to women (e.g., as nurses, nursing aides, etc.) in the healthcare sector, but also increases the amount of unpaid medical work they are expected to perform. The stress and burden associated with caregiving work often undermines the health of caregivers, increasing their own need for medical care, while increasing the dependency status of women (Glazer, 1993; Hooyman & Gonyea, 1995). As more healthcare moves outside institutional boundaries, this raises serious questions about gender equity, especially for women as major providers of these services. As discussed earlier, feminist theorists have argued that welfare state researchers too often avoid or gloss over

the issue of gender stratification. When healthcare provision comes primarily from the family, "women/wives/mothers" can replace "family" with little loss in accuracy, and the subordinate status of women is reinforced. On the other hand, when the provision of these services comes from the state, which takes on the "social mothering tasks," women can claim more independence and empowerment.

5.2. Occupational Stratification in Healthcare

Gender and racial equality within the healthcare system can be viewed within a broad, structural context, particularly the advancement opportunities and decision-making authority accorded to women and men of color, and in microbehavioral contexts where the focus is on interpersonal communication, cultural sensitivity, and behavioral inclusiveness (Floge & Merrill, 1986). Structurally, the hierarchy of healthcare occupations reflects the gender and racial stratification systems found in the larger society: those with high-level, prestigious healthcareers are primarily white males, with women and racial minorities "overrepresented" in low-status, low-paying health occupations. Women now constitute 75% of all medical workers and 85% of all hospital workers (Doress-Worters, 1996), yet they continue to be concentrated in low-paying, sex-segregated sectors of the healthcare system. In addition, given the dominance of physicians, female healthcare workers rarely have sufficient autonomy or prestige to be considered professionals.

The most notable example is nursing, the single largest group of healthcare workers. Nursing is highly stratified by both gender and race. More than 90% of practicing nurses are women, with white women most likely to be registered nurses or nurse practitioners and racial minorities most likely to be nursing aides, orderlies, or attendants (Hart-Brothers, 1994). Manley (1995) notes that black women make up only 7% of RNs, but nearly 31% of all nursing assistants. Men are increasingly entering the field of nursing: they now comprise nearly 10% of all nursing students. Interestingly, while women in nursing have struggled for decades to professionalize and upgrade the status of their occupation (Manley, 1995), male nurses have been able to gain status in nursing primarily on the basis on their gender. Williams (1992) points out that, unlike the "glass ceiling" that women encounter in traditionally male occupations, men in nursing often experience a "glass escalator:" they are viewed as more authoritative and capable of administrative and managerial work. Bias in this case works to the advantage of men. Underrepresented in a lower status, female occupation, men are privileged with selective promotion into administrative and other upper-level positions.

The historically gendered and frequently contentious division of labor between physicians and nurses (see, e.g., Donovan, 1983) is closely entwined with the struggle of women for greater gender equality. Women's battle for greater autonomy in marriage and as citizens parallels nursing's efforts to achieve greater professional autonomy. There has been a debate as to whether male dominance reflects men's hold on the powerful positions within organizations or whether it is a consequence of generic masculine characteristics. The "doctor–nurse game" (Stein, 1967) was suggested as a gendered "script" for interaction between (male) doctors and (female) nurses whereby nurses conspired to have decision input while maintaining the illusion of physician dominance. The central norm was for nurses to fulfill a passive role, avoiding open disagreement with physicians at all costs. Nurses' recommendations for care, therefore, had to appear to be ideas initiated by physicians. There is disagreement over the degree to which this interaction pattern has

persisted into recent years (Pillitteri & Ackerman, 1993; Stein, Watts, & Howell, 1990). Building on the work of Kanter (1977), Floge and Merrill (1986) studied the interaction and dynamics in hospitals associated with situations of gender reversal, where there was a token female physician or a token male nurse. They found that gender was a more powerful predictor of behavior than occupational status. Hierarchical relations perpetuating racial inequality have also characterized the relations between physicians and lower-level healthcare workers, where there are higher proportions of minorities. The paternalism shown toward minorities in some medical institutions has given way to more bureaucratic policies, with increasing financial competition.

A positive, collaborative relationship between physicians and nurses is critical to successful healthcare outcomes (Aiken, 1995; Mitchell, Shannon, Cain, & Hegyvary, 1996). When these relationships are subject to conflicts produced by gender or racial inequities, quality of care can be seriously compromised.

6. THE USE OF HEALTHCARE SERVICES

Medical sociologists have developed several models to explain the use of healthcare services. The health belief model, developed by Irwin Rosenstock in 1966, attempts to explain why people engage in preventive health behaviors or, once diagnosed with an illness, comply with medical regimens. He saw health behaviors as based on one's belief in susceptibility to a serious illness that could be prevented with medical care, and the lack of barriers to care. A more gender-focused analysis of the model would reveal how social norms and inequities operate to shape perceptions of health and access to care. For example, women are typically socialized to be more attentive to bodily symptoms and more compliant to medical authority, and to embrace social roles (e.g., homemaking) that may facilitate access to physicians. The health belief model, however, has been criticized as oppressive to women and people of color because it focuses on the subjective states of individuals and embodies a patriarchal world view that centers on predicting and controlling behavior (Thomas, 1995). A second widely used model focuses specifically on three variables that predict the utilization of medical services: predisposing, enabling, and need variables (Andersen, 1995; Anderson & Newman, 1973). Here again, each predictive variable clearly includes sociodemographic factors, such as gender, social class, and race, as these factors affect health attitudes and beliefs, access to care, and health status. Research has found that the most salient factor in the use of healthcare services is actual or perceived need for medical care services, but health status and access to care also affect utilization (Rowland, Lyons, Salganicoff, & Long, 1994).

Women have long been thought to use health services more frequently than men (Macintyre, Hunt, & Sweeting, 1996; Verbrugge, 1985). They make approximately one third more physician visits, comprise one fourth more hospital discharges, and spend slightly more time in the hospital than men (Friedman, 1994). Of the 10 most frequently performed surgeries, four are procedures limited to women (C-section delivery, total hysterectomy, repair of obstetric laceration, and low forceps delivery with episiotomy), while only one procedure (transurethral prostatectomy) is limited to men (*Healthweek*, 1991). Recent research indicates that women are more likely than men to have at least one mental disorder (43% vs. 33%), with the excess of female morbidity concentrated in mood and anxiety disorders (Linzer, Spitzer, Kroenke, Williams, Hahn, Brody, & deGruy, 1996). A closer look reveals that women have higher rates of healthcare seeking than

men only in certain age categories, for specific types of problems, and using certain measures. measured by physician consultations (Tables 22-5 and 22-6). Further, recent data indicate that when childbirth is excluded, men use more hospital services than women (see Table 22-7). Men also have higher rates of involuntary admission to state, county, and veteran psychiatric facilities than women, although the rates of admission to other mental healthcare settings are about the same for both sexes (Hurst, 1998). As indicated on Tables 22-5 through 22-7, the gender gap in the use of healthcare services tends to decline with age. However, because women live an average of 7 years longer than men, women represent a disproportionate share of the elderly population and of those residing in nursing homes. According to Woods (1996), women age 65 and older are nearly three times more likely than their male counterparts to reside in nursing and other personal-care homes. These institutions in 1985 housed 334,000 men and 983,000 women. In many ways, the problems of the elderly are the problems of women, and both are reflected in the use of health services.

6.1. Explaining Gender Differences in the Use of Healthcare Services

Biological factors, socially constructed gender norms, acquired risks, and differential exposure to environmental stress all shape gender patterns of sickness and utilization of health services. Medicine's traditionally sexist notions about women's bodies, the medicalization of normal reproductive functions, and the impact of social factors on physical health all have made the role of biology in health status and the use of health services a highly contested political issue. Still, biological functions, such as pregnancy, childbirth, menopause, and the longer life spans of women, have traditionally contributed to the greater use of medical care services by women than men. Males have higher rates of sickness and healthcare use than females from birth to middle childhood; however, as Sweeting (1995) has shown, gender reversal occurs around puberty or earlier. Using cross-national data, Sweeting pointed out that an excess in female morbidity and healthcare use emerges between the ages of 7 and 15, as girls start to experience and report more physical and mental disorders than boys. This gender reversal in patterns of sickness and healthcare use, Sweet believes, is the result of children incorporating more gendered responses to illness during adolescence, a diminution of female self-esteem, and different social expectations and stresses for males and females. This suggests that by the age of

TABLE 22.5. Percentage of Acute Conditions Medically Attended in the United States, 1995 by Sex, Age, and Type of Condition

	Male		Female	
Type of Acute Condition	18 to 44 Years Old	45 Years and Over	18 to 44 Years Old	45 Years and Over
All acute conditions	59.5	72.0	63.7	71.3
Infective/parasitic diseases	54.9	57.5	57.8	65.8
Respiratory conditions	38.9	53.9	45.0	51.4
Digestive system conditions	70.9	81.6	59.5	87.2
Acute musculoskeletal conditions	95.0	86.3	79.2	88.9
Injuries	91.4	91.7	94.9	88.3

Vital and Health Statistics, Current Estimates from the National Health Interview Survey, 1994. Series 10, No. 199. U.S. Department of Health and Human Services. October 1998, p. 21.

TABLE 22-6. Average Number of Physician Contacts per Person per Year: United States, 1995

Characteristic	All Places	Telephone	Office	Hospital	Other
All persons	5.9	0.8	3.3	0.7	1.1
Males					
Under 18 years	4.4	0.6	2.6	0.6	0.6
18 to 24 years old	3.3	0.4	1.7	0.5	0.7
45 to 64 years old	6.0	0.7	3.2	0.8	1.2
65 years and over	10.4	1.0	5.9	1.1	2.3
All ages	4.9	0.6	2.7	0.7	0.9
Females					
Under 18 years	4.2	0.6	2.4	0.5	0.6
18 to 44 years old	6.4	1.0	3.6	0.7	1.0
45 to 64 years old	8.1	1.0	4.5	1.0	1.4
65 years and over	11.6	1.2	6.0	1.2	3.1
All ages	6.9	0.9	3.8	0.8	1.3

Vital and Health Statistics, Current Estimates from the National Health Interview Survey, 1995. Series 10, No. 199. U.S. Department of Health and Human Services. October 1998, p. 109.

puberty, social factors may start to play as important a role in perceptions of health as biology.

Gendered activities and patriarchal norms and values clearly shape patterns of healthcare utilization, as they help produce specific acquired health risks for men and women. Men acquire more health risks from factors such as substance abuse and hazardous work and leisure activities, while the health of women is often impaired by socially prescribed gender roles and norms (Waldron, 1995). Being a full-time homemaker, for example, has consistently been linked to high rates of physical and mental illness and more doctor visits (Avis & McKinlay, 1990; Verbrugge, 1985). While some have argued that the homemaking role may simply be more compatible with seeking healthcare (Marcus & Siegel, 1982), it is also true that homemakers often experience more distress, isolation,

TABLE 22-7. Number of Short-Stay Hospital Days During the Year Preceding Interview per Living, for All Causes Excluding Deliveries, United States, 1995

		Number of Episodes		
Characteristic	All Statuses	1	2	3 or more
Male				
All ages	8.2	5.3	13.8	26.2
Under 18 years	7.3	5.8	9.0	42.3
18 to 44 years	6.0	4.0	12.5	23.3
45 to 64 years	8.0	5.1	11.7	25.2
65 years and over	10.6	6.6	17.1	25.8
Female				
All ages	7.3	4.7	13.0	25.4
Under 18 years	5.8	4.4	10.9	24.7*
18 to 44 years	5.2	3.6	8.4	23.1
45 to 64 years	7.8	4.5	13.5	25.8
65 years and over	9.5	6.1	16.4	26.7

*This figure does not meet standard of reliability or precision.
Vital and Health Statistics, Current Estimates from the National Health Interview Survey, 1995. Series 10, No. 199. U.S. Department of Health and Human Services. October 1998, p. 117.

and devaluation than employed women, and may be overwhelmed by the demands of nurturing and caring for others. Employment, however, does not equalize the health risks of men and women, as employed married women still perform most of the domestic work and frequently hold sex-segregated jobs with low pay and little autonomy, prestige, and career mobility. Gender norms in a state of transition lead women to experience strains as they renegotiate family work and move into new labor market roles. Charlotte Muller's (1986) study of employed men and women found that, overall, occupational quality did not affect the use of medical services, and other gender-related factors did. Women had more doctor visits than men, but women in occupations that were sex typed for men—perhaps because they were under more scrutiny and thus more stress—experienced even higher rates of utilization of medical services. Stress or role overload may also account for her finding that single parents had higher rates of hospitalization than did men and women who were married and/or childless.

Domestic violence, undergirded by norms supporting male dominance and aggression, also leads to a higher utilization of medical services by women (Candib, 1995). Domestic violence is now recognized as one of the most serious public health issues in America, with women of all ages more likely than men to be victimized. More than 4 million women are assaulted by domestic partners each year, resulting in literally thousands of physician visits and hospital days each year (Gerbert, Johnston, Caspters, Bleecker, Woods, & Rosenbaum, 1996). The American Medical Association's Council on Ethical and Judicial Affairs (1992) reported that injury to women from battering and rape (most often committed by a current or former male partner) accounted for as much as 35% of all emergency room visits. Moreover, the rate of physical battering of women increases with pregnancy, thus jeopardizing the health of both the women and that of her unborn child. Medical professionals, however, rarely identify domestic violence as the cause of problems, even when the patient has repeatedly sought medical care for similar injuries (American Medical Association Council on Ethical and Judicial Affairs, 1992; AMA Council on Scientific Affairs, 1992). Thus, battered women, many of whom fear retaliation from their partners if they report their abuse, view physicians as disinterested or unsympathetic toward their needs (Gerbert et al., 1996).

Social factors, especially those linked with gender inequality, contribute significantly to the excess in sickness and use of healthcare services by women. Still, women may not receive healthcare adequate to meet their needs. As noted earlier, preventive healthcare, such as Pap smears and breast exams, are often neglected, and potentially life-threatening illnesses, such as heart disease, may be treated less aggressively in women (Young & Kahana, 1993). Some studies have found that having a regular source of medical care is the most important factor associated with receiving preventive health services (Bindman, Grumbach, Osmond, Vranizan, & Stewart, 1996; Burns et al., 1996). For women, finding a healthcare setting that is both accessible and equipped to offer a full range of services can be difficult. Bartman (1996) found that the majority of women over the age of 44 prefer a family or general practitioner to an obstetrician–gynecologist. Those who did not go to obstetrician–gynecologists received less screening for cervical and breast cancer. Similarly, a study of black women between the ages of 18 and 44 living in Chicago found that they often had to choose between going to a more geographically accessible, office-based physician who offered more limited care, or traveling to a less accessible clinic to receive more comprehensive care and better family planning services (Kelley, Perloff, Morris, & Liu, 1992).

The lack of adequate healthcare and poverty also diminish the quality of healthcare

available to women. The lack of adequate insurance significantly diminishes the likelihood of consulting a physician (Hafner-Eaton, 1993). Women with health insurance also experience more gaps in their coverage than do men. As noted in the concept of the feminization of poverty, women are overrepresented among the nearly 39 million Americans who are poor (Beeghley, 1996). Older women, single mothers, and women of color are especially likely to be overrepresented among the poor and near-poor: women represent 58% of the aged, but 71% of the aged poor, while African-American women constitute 5% of the elderly, but 16% of the elderly poor (Doress-Worters, 1996). Studies have consistently found those who are poor have the highest rates of sickness and the greatest need for healthcare services (Abraham, 1993; Dutton, 1986; Krieger & Fee, 1996; Navarro, 1991; Riessman, 1990).

7. CONCEPT OF WOMEN'S HEALTH

We have argued that medicine is an institution of social control, regulating gender as well as other social relations. Medical knowledge both reflects and reproduces gendered cultural and social structures, and thus serves as a primary social control mechanism. Medical research and the clinical treatments and advice given to patients form this body of knowledge, which, although constructed largely from a male standpoint, is applied to both men and women. Women's health and health-related experiences, for the most part, have been understood—whether correctly or not—through this male perspective. The women's health movement was responsible for articulating a critique of these circumstances and stimulating social change to remedy them.

7.1. Women's Health: Social Movement to Market Segment

The concept of women's health as a distinct discipline or subdiscipline within medicine, with the potential to define a unique segment of the healthcare delivery system, has developed recently, roughly since the mid-1980s. The roots of this concept can be traced to the women's health movement of the late 1960s and 1970s, when the gendered nature of medical knowledge, the doctor–patient relationship, and the entire healthcare system came under critical scrutiny in the broader context of political protest and civil rights activism for minorities and women (Ruzek, 1978; Zimmerman, 1987). Weisman (1998) locates apsects of the women's health movement even earlier in the 19th and early 20th centuries. Women's control of their own health and healthcare was the central objective. The movement called into question the increasing medicalization of women's lives; the narrow, treatment-oriented focus of medical care, relying on intervention and technology rather than prevention and self-care; and the hierarchical inequality of medical power relations, including the doctor–patient relationship. The women's health movement was pivotal in drawing attention to what we now refer to as the gendering of healthcare. It created a coherent, consumer-driven critique with specific issues that have since been forged into a new agenda for research, for conceptualizing medical knowledge, and for organizing healthcare services (Rodwin, 1994). In many ways, the original women's critique of mainstream healthcare has been co-opted by the healthcare marketplace. While the social movement politics have been discarded, there is spreading recognition that many health problems of women are unique relative to those of men, and programs are

being implemented to increase women's health research and to reform the medical curriculum (Zimmerman, 1996). Out of this critique has come a framework for how women's distinctive healthcare needs can be better met.

Women's health as a concept was adopted by mainstream healthcare organizations in the United States in the 1980s, just at the time competition and market forces were becoming prominent. Hospitals were beginning to more aggressively market their services in an attempt to secure market share, and to begin reclaiming the area of outpatient and ambulatory services that they gave up in the early part of this century. A healthcare consultant, based in Chicago, developed the concept of hospital-based Women's Health Centers in the mid-1980s (Thomas, forthcoming). While presented as improved quality of care for women, the centers frequently provided little more than a repackaging of existing obstetrics–gynecology and diagnostic screening services. The concept of arranging services in this way was sold to hospital boards using the idea that women make healthcare decisions for the entire family. If women preferred a specific hospital or clinic, it was thought that the entire family would become clients. According to estimates, in 1993 some 3,600 women's health centers were in operation, the majority sponsored by hospitals (Weisman, 1998).

The initial Women's Health Center model incorporated movement principles, such as more decision-making control for the patient, more quality time in the doctor–patient relationship, and women physicians. Many centers, however, were unable to move beyond the library and health education programs they featured, and never provided actual medical services. Those that did had to secure established medical practices whose partnership with the hospital did not threaten previously established medical staff relations. The very medical practices that were needed to make the Women's Health Centers successful—those that were financially stable with a sizable patient load—were the most likely to threaten existing physicians and generate conflict. Inevitably, for financial and internal political reasons, the innovative aspects of Women's Centers in many hospitals were phased out, leaving standard services, such as maternity and gynecology, renamed as women's healthcare. By the mid-1990s, the promise of a fundamental shift in the philosophy and organization of private sector healthcare for women had largely disappeared.

7.2. Women's Health as a National Initiative

While the private side of the healthcare system in the United States lost currency in the change-oriented agenda of the women's health movement, the public sector did not. The 1990s saw the longstanding criticisms of the United States' biomedical research establishment and its history of gender bias result in significant social change. After years of pressure, culminating in several task forces and their reports, in 1990 the National Institutes of Health established an Office of Research on Women's Health, and in 1991 a federal Office of Women's Health was established within the U.S. Department of Health and Human Services (Narrigan, Jones, Worcester, & Grad, 1997). In addition, in 1991 the NIH launched a Women's Health Initiative to study three diseases that are leading causes of death in women: cancer, cardiovascular disease, and osteoporosis. During this same period, national medical organizations also mounted significant efforts to reform curricula and develop medical school programs to enhance gender equity (Zimmerman, 1996).

It is too early to evaluate the impact of these developments. Nonetheless, they represent a recognition by the U.S. government of the gender bias and inequities in medical research and practice (Auerbach & Figert, 1995). It also is clear that they represent a federal mandate to address these problems. Women's health as a concept has begun to be integrated into standard practices of medical research and medical education, a process that will result in further changes and eventually alter the gendered nature of healthcare.

8. HEALTHCARE REFORM

Providing health services within the framework of the capitalist economy of the United States has led to escalating medical expenditures and an erosion of healthcare services to all but the most affluent. Dissatisfaction with the inefficiency, inequity, and cost of healthcare paved the way for healthcare reform, beginning with the gradual implementation of cost-cutting strategies in the 1980s. Prior to 1983, hospitals and physicians were reimbursed by insurance for the "reasonable and customary" costs of medical treatment. Owing to escalating costs, the government's Medicare program began to pay hospitals a preestablished sum based on the patient's diagnosis-related group, or DRG. These new arrangements placed more financial risk on healthcare providers, with the goal of eliminating unnecessary treatment and encouraging efficient, cost-effective care. By the late 1990s, a patchwork of regulations had evolved to regulate the excesses of the marketplace, and there was a pronounced social shift toward the notion of individuals being responsible for avoiding sickness through healthy lifestyles. In examining these trends, Clancy and Massion (1992) concluded that the pronounced capitalist and entrepreneurial activity in healthcare in the United States had resulted in significant gender inequities in healthcare quality to the particular disadvantage of women.

8.1. The Gender Implications of Managed Care

Managing healthcare resources efficiently in relation to the processes and outcomes of care has become a prominent idea in American healthcare policy and the focus of health reform. Notoriously difficult to define, managed care refers to a variety of organizational and financial arrangements designed to eliminate unnecessary and inappropriate healthcare, reduce costs, and increase efficiency (Congressional Budget Office, 1992). There is a broad array of managed care initiatives, such as DRG-based reimbursement, mandated second opinions, medical practice guidelines, and health maintenance organizations (HMOs), which themselves vary widely from tightly structured group and staff models to looser, independent practice associations (IPAs). By the end of the 1990s, managed care covered a large segment of Americans, both privately and publicly insured and including Medicare and Medicaid. Women were approximately 53% of all enrollees in 1993 (Weisman, 1998). Publicly funded managed care particularly affected women, since they are disproportionately represented among the poor, disabled, and elderly. In 1997, Medicaid in nearly every state delivered services on a managed care model. Private insurance for middle- and lower-level employees also relies heavily on managed care plans. Most women in the labor market are employed at these levels.

Managed care has significantly different implications for men and women

(Zimmerman & Hill, 1999). Four features of managed care provide insights into how men and women are affected differently. First, managed care, compared to other care arrangements, provides more prevention and early intervention services (Miller & Luft, 1994). A 1993 survey found that women in HMOs received more screening tests for early detection of disease, such as clinical breast examination, mammography, pelvic examinations, and Pap tests, than insured women not in HMOs (Alan Guttmacher Institute, 1994; Louis Harris & Associates, 1993; Makuc, Freid, & Parsons, 1994). Further, HMOs are substantially more likely to cover all types of reversible contraception than other forms of health insurance (Alan Guttmacher Institute, 1994). For example, 81% of HMOs covered diaphragm fittings whereas only 21% of conventional plans did so. The increased access provided to women, combined with the long-established finding that women are more likely to engage in preventive health practices than are men (Miles, 1991), seem to suggest that managed care will enhance preventive care among women. The effects for men are less clear. While research suggests that men are less oriented to prevention, much also depends on the extent to which HMOs and other managed care organizations emphasize screening and encourage prevention practices appropriate for men.

A second feature that may result in differential effects for men and women is that managed care commonly relies on primary care. Primary care typically is more complicated for women than for men because women often have multiple physicians for their regular source of care while men require only one. Women often receive gynecological care from obstetrician–gynecologists and general care from internists or family practitioners (Bartman, 1996). As of 1994, 70% of HMO plans in the United States allowed women to self-refer to an obstetrician–gynecologist other than their primary care provider, but half of these plans limited the visits to one per year (Bernstein, 1996). Managed care organizations that require women to choose a single primary care provider may, in so doing, be putting women at increased risk of inadequate prevention and monitoring for key women's health problems (Johns, 1994). Multiple providers are not consistent with the efficiency concepts of managed care, so over the long term, women's healthcare may need to be reorganized to be efficient.

The third issue in managed care concerns restrictions on services. Available data show that HMO members have lower hospital admission rates, shorter hospital length of stay, and less use of expensive procedures and tests (Bernstein, 1996). This becomes a gender issue because women are disproportionally more likely to use these services owing to childbirth and age. There is particular concern over whether managed care can successfully manage the disabled and chronically ill, groups also disproportionally composed of women. Mental health services and their coverage under managed care, especially depression, may also be a special problem for women.

The fourth feature with implications for gender is the managed care practice of restricting access to physicians and other providers. Consumer choice has become a central issue in American healthcare reform. Moreover, being able to maintain continuity of care with the same physician, or physicians who work closely with each other, promotes positive health outcomes. Being able to choose one's physician or hospital is a particularly prominent concern in managed care plans where choice can be severely limited. Because more women than men receive health coverage in heavily managed plans, having access to the providers one chooses is another gendered issue that disadvantages women. The potential problems related to women's lack of choice are compounded because women need and use healthcare services more frequently than men, and because, as

has been discussed, their routine healthcare is divided among multiple providers. Individuals who have a usual source of care also have better healthcare access and a higher likelihood of receiving needed medical services. Between 1987 and 1992, the estimated proportion of adult Americans with no usual source of care rose from 17% to 21% (Moy, Bartman, Clancy, & Cornelius, 1998). This raises additional concerns about the effects of managed care, which significantly expanded during the same time period.

8.2. Individual Responsibility for Sickness and Health

A second force for change in the healthcare system is the focus on personal responsibility for health. Social theorists have analyzed this trend as part of a broader cultural shift from modernism to postmodernism. In healthcare, this transition signifies a move away from the positivism of biomedicine to a more eclectic model of health and illness with greater awareness of the body and personal responsibility for it (see Hall, 1998). Prior to the modern era, disease was feared, but accepted as outside humans' ability to govern or control. During the rise of medicine in the modern era, disease was seen as part of the human struggle against nature, a challenge to be conquered. Science was viewed optimistically as the ultimate weapon in the war against disease. In the last half of the twentieth century, however, social awareness about the limits of scientific medicine and skepticism of the biomedical model of disease, along with the political–economic difficulties of distributing healthcare resources, encouraged yet another shift in cultural thinking about disease. As the role of individuals in the etiology of diseases began to reemerge, people began to be seen as contributing to—even responsible for—their own illness (Hall, 1998). Disease, within this framework, could more easily be viewed as a person's own fault. Lifestyles and behavioral risk factors in chronic diseases received increased attention, with government sponsorship in the 1970s and 1980s emphasizing the effects of diet, exercise, smoking, and stress on heart disease and cancer. The implications of this approach could be viewed alternatively as either heightened accountability or "blaming the victim."

The gender question in this shift to greater personal responsibility is whether its consequences differ for men and women. Miles (1991) argued that women are more easily placed in the sick role than men. As personal accountability increases, this suggests that women also will be more likely to be blamed for illness. The theory of the sick role (Parsons, 1951) holds that sick individuals are exempted from normal social roles and from responsibility for their illness, provided they demonstrate the desire to get well. For Parsons, the sick role allows society to differentiate the "sick" from the "bad," a distinction that is blurred when individuals are seen as causing their own illnesses by either engaging in risky behaviors or failing to engage in healthy ones. Holding individuals responsible for illness contradicts the Parsonian sick role, and opens the possibility that those who are blamed will be subjected to further negative sanctions. Parsons did not offer a gendered perspective on the sick role; however, if the sick role is more readily occupied by women, then they might, in turn, be more readily blamed for their illnesses than men. This is particularly ominous if punishment follows blame—for example, if health benefits were disproportionately denied to women because they are perceived to have contributed to or "caused" their own illness (for additional discussion, see Doyal, 1995; Miles, 1991).

Taking personal responsibility for health can also be viewed from the standpoint of

participating in self-care. Men have been found to be more stoic in responding to symptoms and therefore less likely to take corrective actions, while women are thought to pay greater attention to their bodies and to monitoring health signs and symptoms (Mechanic, 1968). To the extent that personal responsibility encourages more self-care, these gender differences may become more significant. Self-care is consistent with the principles of the women's health movement in that it represents individuals taking more control over their bodies and lives. Women, therefore, may be prone to adopt self-care while men would do so less, depending instead on women. Increasing self-care, on the other hand, focuses attention on health as a product of what men and women do as individuals, rather than on what their environment and society does to them sometimes without their knowledge, that is, unsafe conditions and toxic exposures through food, water, air, job and travel safety, etc. Self-care can be a way to deflect attention away from the deficiencies of the healthcare system, including restricted access to care, and can lead to inadequate supervision of both men's and women's healthcare needs.

9. CONCLUSIONS: QUALITY OF HEALTHCARE

Analyzing healthcare as a gendered institution has revealed significant differences in healthcare systems on the basis of gender, and has suggested even more complex differentiation when race, social class, and sexual orientation are taken into account. We have argued that gender is a fundamental way of organizing social life, deeply embedded within the social fabric of society. Consistent with this assertion, we have emphasized gender as a characteristic of organizations rather than solely an individual variable. Healthcare is gendered because men and women occupy different positions within the system, both as patients and providers. Moreover, these differences are such that, often, women are disadvantaged. Women, compared to men, have more illnesses and use more healthcare services, are more likely to have their behaviors medicalized, and are less likely to receive aggressive medical intervention for life-threatening illnesses. As workers, they are more likely to be concentrated in the lower echelons of the healthcare system or, in the case of unpaid workers, to have their labor ignored altogether. We have analyzed gender within the context of macro-level forces such as patriarchy, capitalism, industrialization, and the doctrine of separate spheres for men and women. These forces fostered the ability of white male physicians to achieve medical dominance and construct gender norms that stereotype women and marginalize their roles in medicine. The result has been a gendering of medical knowledge, access to medical education, the organization of healthcare work, and the doctor–patient relationship. Despite some notable gains by women since the 1970s, recent healthcare developments, masked as healthcare reforms, have often served to strengthen and perpetuate the gendering of healthcare. The relegation of unpaid caregiving work to women is a prime example.

Ultimately, healthcare quality is the central issue for both women and men. While the defects and excesses of American healthcare affect both men and women, the consequences are not the same. Women and men occupy different places in social life, and are regarded differently in cultural attitudes and values. Furthermore, in the evolution of healthcare, male dominance has positioned women as "the other," adding to their vulnerability in this type of gendered healthcare system. We have argued that the quality of healthcare available to women has been and still is undermined by patriarchy and capitalism. Women have been primarily patients and (until recently) rarely physicians. The

perspective of white men has been the basis for medical education which, until the last few years, has been rife with erroneous and stereotypically gendered information. More recently, this bias has served as a rallying point for consumers and groups within the women's health movement. The quality of healthcare given to women has been shaped by the gendering of the doctor–patient relationship, which has placed women in a subordinate and dependent position. During and following industrialization, women became the primary clientele for physicians and the unwitting victims of allopathic medicine's efforts to prove its efficacy; yet, in the modern era, women are often excluded from systematic medical research.

The medicalization of common female experiences, such as pregnancy, childbirth, and menopause, as well as the more recent emphasis on cosmetic surgery, eating disorders, and fitness, has extended medical control over the lives of women. Yet, while women are often overtreated for problems that are only questionably medical in nature, there is growing evidence that they may be undertreated for serious health problems, such as coronary heart disease. Narrow views of gender roles, such as the well-documented tendency in medicine to think of women's health problems first in relation to the reproductive system, may in part explain these inequities in medical practice. Stereotypes have been cited by minorities, as well as by gays and lesbians, as discouraging their use of medical care with the potential of compromising their health. Limited access to healthcare is also a quality of care issue of special concern to women. Health insurance historically been linked to employment at the same time socially prescribed roles for women precluded employment. Thus, women have been more likely than men to be insured as dependent spouses and, with the recent entry of women into the labor market, to hold positions that lack health insurance. As we have shown, women are overrepresented among the poor and among those likely to receive their healthcare in the public sector of the healthcare system.

Despite continuing gender inequities in healthcare, our analysis has revealed significant challenge to the patriarchal nature of medicine. Women have historically fought for the right to acquire a medical education and to practice medicine, a cause that now has support from both men and women within the medical leadership. In the past 25 years, women have made notable gains in terms of entry into medical schools, challenging the sexism of the medical curricula and sexual harassment in medical schools. The evidence so far suggests that, as physicians, women add desirable and complementary attributes to the doctor–patient relationship. Perhaps most significantly, the women's health movement has provided a patient-oriented critique of healthcare, enhancing the gender consciousness of many women, creating a sense of consumer choice, and empowering both men and women to seek a greater voice in healthcare decisions. If the goal for the future is continued improvement of healthcare, then consumers must continue to be vigilant lest new health reforms repeat and reinforce the inequities of the past.

9.1. Future Research

There are important questions and issues for researchers to explore in each section of this chapter. After years of domination, the biomedical model's hold over medical thinking appears to be weakening and the positivistic notion of medicine's scientific objectivity can now be more easily challenged. There are vast, new opportunities to understand healthcare as a social system where attitudes, values, and ideologies play a role. Gender

study in relation to health and medicine has been particularly slow to develop; yet, looking at gender as an organizational phenomenon holds particular promise as a new way to understand healthcare as well as to analyze processes of social inequality.

Three areas are especially important for future research. First, we need to better understand and untangle the way culturally based stereotypes about gender confound medical diagnoses and treatment decisions. This should help to establish the valid healthcare needs of men and women and to clarify issues of overtreatment and undertreatment. Next, more research is needed on the organization of healthcare—the policy arrangements set by insurance schemes (public as well as private) and the ways professional and institutional providers organize services around these policies—in terms of the differential social and health impacts for men and women. This includes studying informal caregiving in relation to broader institutional policies and practices, keeping in mind that both public and private organizational arrangements can structure the lives of men and women differently by influencing the need for family caregiving. Finally, it is essential for researchers to devote greater attention to the social conditions under which variation occurs in gendered healthcare. Male and female are master categories that, despite their analytic significance, dissolve into a multiplicity of subpatterns when additional factors are considered. While the feminist critique of the healthcare system has often focused too narrowly on middle-class white women, studies of racial inequities in healthcare and health status have tended to overlook the issues of gender entirely (see, for example, Williams, 1998). Specifically, future research should systematically consider class and race differences to more fully explore the complexities of healthcare as a gendered system.

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