S/A 4071: Social/Cultural Aspects of Health and Illness

Class 9: Social Inequality, Disease and Death 2:

Age, Gender, Racialization & Ethnicity

* Now that we have outlined the social determinants of health, today we will focus particularly on age, gender, racialization and ethnicity.

Age & Mortality:

* Rapidly aging population/ decrease in proportion of youth expected to continue until 2036. Increasing mortality for a while. Explanations:

- baby boom
- decline in birth rate (birth control)
- increased life expectancy (note: gender gap increasing)
- decline in infant mortality
- fewer accidents in male-dominated work
- less smoking

* Why do women live longer?

- female "genetic superiority" (but why would gap grow?)
- more male accidents, violent deaths & suicides in early/mid adulthood
- higher rate of smoking among men
- more risky industrial employment locations for

men?
- high fat diet of men
- greater alcohol consumption of men
- stress/ Type A behavior among men
- men more likely to drive

* Infants and youth more susceptible to illness and death, particularly those of low status and where status of women is relatively low

* Low birth weight babies have more health problems/ linked to age, social structural location & lifestyle factors. Youth tend to take risks

Age & Morbidity:

* Older people more likely to get sick, be hospitalized or prescribed medication than others. Demographics will feed this.

* As many as 19% of hospitalizations result from inadequate/ inappropriate drug prescriptions/ overprescribing practices/ mistakes by patients taking many drugs

* 8% of Canadians over 64 have some form of dementia / % expected to
grow

* Elderly have more chronic conditions/ use health care at a high rate, yet rate their own health well (i.e. compared to others).

* Women suffer chronic conditions more than men (11

vs. 4%). They are also more likely to be sick than men (who experience them more severely and are more likely to die). Men likely under-report, women's symptoms often less dramatic and preventative care more likely for women who seek help more readily)

Gender & Mortality:

* If we look at impoverished countries where women are less valued, women and female children are particularly likely to be ill, die, or be killed (either through sacrificing for others, female infanticide, sexual slavery or female circumcision).

* Yet, generally, gender differences in mortality & morbidity follow earlier pattern: men now more likely to die; women more likely to be ill (some historical variations in mortality)

* Female decline in mortality linked to better nutrition, contraception, & status for women

* Female cancer rates rising/ mens' falling (smoking)

* Men die at more than twice the female rate in accidents, heart disease & suicide

Gender & Morbidity:

* Women experience more years of life with illness/ disability than men (3% fewer "disease free years")

* Trade off in terms of quantity vs. quality

* Acute illnesses 20-30% greater for women (childbirth related illnesses only a small part of this)

* Non-fatal chronic illnesses also greater among women (e.g. migraines, arthritis, rheumatism & allergies)

Race, Ethnicity & Minority Status

* Definitions: (1) Race: a social/political construct used to distinguish
people on physical attributes
(2) Ethnicity: common cultural background
(3) Minority: numeric distribution in society of different
ethnicities

* Ethnicity linked with inequality/social class /education / occupations/ self-esteem: health likely also related

* Immigrants initially report better health than Canadians, but this
difference disappears the longer they are in Canada

* Aboriginals have serious differences in morbidity & mortality
compared to non-Aboriginal Canadians. Reasons:

- Younger population (higher birth rates/more teenage moms)
- More violent deaths
- STD's
- Colonialism
- Assimilationist policies (e.g. residential schools)
- Cultural loss

-Discrimination/racism
-Unemployment
-Poverty
-Epidemics
-Low educational levels
-Poor housing/relocation
-Pollution/lack of clean water/poor diet
-Social problems (e.g. substance abuse/violence/child welfare issues)
-Lack of empowerment
-Poor health care
-High infant mortality
-Injuries
-Suicide (e.g. Davis Inlet)

* Similar patterns likely appear for other ethnic minorities (e.g. Blacks)

* While self-report health measures are similar to non-Aboriginal Canadians, Aboriginals show higher rates of certain conditions (e.g. diabetes, various "disabilities", STD's)

Explanations for the Health Effects of Inequality:

* *Age:* older people more likely to experience chronic illness/ use medical facilities:

- susceptibility of infants, particularly at bottom of social structure
-undervalued youth/suicides and accidents
-older people's exposure to different historical

stresses vs. younger
-relative poverty falling heavier on women and kids
-marginalization removing social supports from others

* *Gender*: why women more likely to get sick; men to die

- women more likely to be poor/less access to education
- women putting kids/spouses first
- women facing social/political exclusion from power
- women's relative vulnerability to violence
- biological/lifestyle differences (women sick more/less often fatal)
- women more attentive to/talk about bodily sensations
- women better 'describers' of health problems/feelings
- women more willing to take preventative/ healing action
- men more likely to engage in risky actions
- men more likely to engage in violent actions
- men more likely to work in risky occupations

* **Class**: 4 explanations for differences in Health (the Black Report):

(1) *Measurement artifact*: Class related health differences are the result of biases during measurement & recording processes
(2) *Natural or Social selection* : Low class causes lack of resources/biological differences vs. biological differences

resulting in downward mobility (former view stronger)

(3) *Cultural/Behavioral*: Lower class/ethnicity status affects health through differences in lifestyle preferences & behaviors (exceptions exist, such as inverse alcohol consumption)

(4) *Materialist*: Poor work conditions, lack of income, diet, leisure time, transport, housing, environment, and water supply result in poor health.

(5) *Neo-Materialist:* health linked to availability of publicly accessible social capital and social/cultural inclusion

(6) *Life Course:* considers how materialist/neo-materialist benefits accumulate over the lifespan to either add/diminish health