Reflections on 'Gender, Health and Ageing' – Continuity and change after 2 decades

After almost two decades, many issues raised in this article on 'Gender, Health and Ageing' still resonate today, but others seem outdated. The following is still largely applicable:

> *'It is ironic that such a small amount of research by medical sociologists is devoted to older people despite the high proportion of health resources spent on people above retirement age. What research there is tends to focus on sick older people who are already within the health care system. … The challenge is to build on the theoretical insights and methodological imperatives from feminist sociology and work on women's health and apply them to older people.' (Arber, 1994: 18)*

But other issues raised by the article no longer apply. Although, the importance of hearing the voices of older people and letting older people define issues of relevance to them is widely acknowledged, this is not always the reality in much research. Older people are no longer *primarily* seen as a 'burden', but the mandate is increasingly for older people to be active and engaged in 'productive ageing' or 'successful ageing'. However, this contemporary mandate for older people to be involved in paid work, voluntary work and unpaid care-giving for grandchildren, partners and others, may eclipse social divisions among older people, including their health and physiological capacity to engage in 'productive/successful ageing'. The great research taboo in terms of hearing the voices of older people increasingly involves those in the Fourth Age.

Gender has infused and become firmly embedded within both the Sociology of Health and the Sociology of Ageing, although these two fields remain two separate disciplines, with the former much stronger than the later (at least in Britain). There are still many research lacunae. For example, we know much less about older men and their health than about older women, and the tendency to treat older women (or older men) as a homogeneous group within research remains widespread. More nuanced research is needed which addresses class, ethnicity, partnership status and sexuality among older people, as well as gender, and fully examines the intersectionality that characterises and differentiates the everyday lives, health and health behaviours of older women and men.

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GENDER, HEALTH AND AGEING

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I am very pleased to be at York giving this plenary to the Medical Sociology Conference. I remember attending my first Medical Sociology Conference, 22 years ago, in York at the Viking Hotel, as a Student on the M.Sc. in Sociology as Applied to Medicine at Bedford College. I can honestly say that I remember nothing about the plenaries, but have vivid and fond memories of walking around the city walls and the disco!

We are all ageing. We all have a personal biography, and we are all influenced by the societal, cultural, economic and political context existing at different times throughout our life course. We are also profoundly influenced by our gender, and how our gender has varying effects at different stages of the life course.

Ageing has at least three meanings:

1. Ageing may refer to the passage of time. I would like to emphasise the importance of taking *a life course approach and life transitions*.

We can only understand people's current health, and ideas about health and illness, through understanding their situational context and their personal biography. So, ageing is about transitions and change.

2. Ageing also refers to *structural age relations*.

Chronological age is often simply 'controlled for' in social research, considered as a 'nuisance' variable which has to be controlled out of our analyses. Instead, we need to see age as associated with social behaviour and social structure.

It is commonplace to observe that our society is age-stratified. The varying norms and expectations of behaviour according to age are socially constructed. Some are enshrined in legal age barriers or 'privileges' for example, to retirement at a certain age, obtaining reduced fare public transport and other concessionary tickets, being allowed to drive a car, or forbidden from driving unless a medical doctor certifies fitness to drive. We need to understand how structured age relations relate to health and other inequalities within our society.

3. Ageing in sociological discourse is primarily identified with later *life, old age or the elderly*, or whatever euphemisms are currently in vogue.

In this paper I will focus mainly on the latter meaning of ageing, but will argue that we can only fully understand later life through using a life course approach, which is situated within the societal context of structured age relations.

Structured age relations and ageism

Ageism refers to structured disadvantages associated with chronological age, and/or negative attitudes associated with advancing age. Gendered ageism refers to the way in which ageism has a differential effect for women and men. For example, mid-life women suffer greater barriers to employment and promotion than men of the same age (Itzin and Phillipson, 1993; Bemard and Phillipson, forthcoming), and in popular discourse women are seen as 'over the hill at 40' (Itzin, 1990).

Societal attitudes towards older people have varied historically and between societies. Since the nineteenth century and increasingly during the twentieth century, older people have been seen as economically redundant, because of non-participation in paid work (Phillipson, 1982; Walker, 1980). In the late twentieth century older people are also portrayed as socially redundant and a burden on society, both financially through the growing cost of state pensions and health care, and a burden on their families, who are expected to provide informal care for them. The prevalence of these societal attitudes has developed into an alarmist 'moral panic' about the perceived growing numbers of older people in the population. This alarmism has been expressed in terms of 'intergenerational conflict' in the aptly titled Workers versus Pensioners (Johnson et al, 1989), where elderly people, especially in the USA, are blamed for the poverty of the young. Minkler and Robertson (1991) provide a cogent critique of such positions. Concern in the media and academia with 'demographic facts' about the size of the elderly population, especially the proportionate increase in the number of people aged over 65 or aged over 85, reflects contemporary ageism and reinforces stereotypes of older people as a burden and as a separate group from the rest of society.

The use of exclusionary terms like 'the elderly' draws an implicit contrast between 'us', the non-elderly, the normal, and 'them', the elderly the 'other'. Such terms reinforce perceptions of older people as a distinctive group, which Bytheway (forthcoming) argues characterise older people as a 'burden en bloc'. Yet, the period from 65 onwards spans thirty years and incorporates great diversity and differentiation.

The extent to which older people are seen in this negative light is not only ageist but sexist, since later life is dominated by women. Women outlive men by on average nearly six years (Table 1). This mortality advantage of women means there are fifty percent more women aged 65 and over than men, and among those aged 85 and over, women outnumber men by over 3 to 1. Thus, ageist concerns about the burdens of the very elderly primarily pathologise older women, who form the majority of the very frail and especially those in need of care by the state or from informal carers (Arber and Ginn, 1991a).

Half of women over the age of 65 are widowed (Table 1), yet there is very little sociological interest in widowhood. We know far more about unemployed people and lone parents, which are numerically smaller groups, than about people who are widowed. Widows are invisible both in society and in sociology. Widowhood is primarily an experience of women, there are over four times more elderly widows than widowers.

The Interconnections of Gender, Health and Ageing

Figure 1 illustrates the linkages between gender, health and ageing within sociology, The bold lines indicate strong linkages, and the broken lines suggest weak linkages. Each linkage, and in some cases the resulting sub-discipline, will be discussed; some very briefly, since the material is familiar, and others at greater length.

(i) **Sociology of Health and Illness**

Sociology of Health and Illness has flourished since the early 1950s, and for a number of year's has been the largest sub-group within the British Sociological Association. There is a strong interlinkage between the specialism of sociology of health and broader sociological concerns. Empirical and theoretical work in sociology of health has influenced broader sociological debates, and theoretical work from elsewhere in sociology is readily applied to the field of sociology of health and illness.

(ii) **Sociology of Gender**

Sociology has been transformed since the early 1970s by the work of feminist sociologists, and gender now forms an integral part of mainstream sociology. In early writing a key distinction was made between sex, primarily used as a variable in analysis and reflecting physiological differences, and gender, referring to the socially constructed nature of gender roles and gender relations as a key structuring force. I later draw contrasts between this distinction and the lack of differentiation in the meaning of the term age.

The methodological stance was crucial, especially in the early days. The dominant approach was qualitative methodology, to hear previously unheard voices and to make visible what was previously invisible. The overriding concern was to take the perspective of the woman within the context of women's own everyday lives. The 'personal is political' became a clarion call, associated with the recognition of how the researcher's own biography influenced the issues to be researched and the interpretation of research data. An associated theme within feminist methodology has been to break down the barriers between the researcher and the researched, to reduce the power imbalance, and where possible empower women through research. These methodological imperatives will be contrasted later with research on later life.

(iii) **Gender and Sociology of Health**

Research by feminist sociologists has redefined the agenda within the sociology of health. The study of gender roles and relationships is now embedded within the sociology of health, producing pathbreaking research in diverse areas, such as reproductive health, women's unpaid health and caring work, and the historical development of medical knowledge and the professions. The work of many medical sociologists has had a major impact on mainstream sociology, especially the work of Meg Stacey, Hilary Graham and Ann Oakley, to name but a few.

Thus, the triangle in Figure 1, which links sociology, health and gender is drawn with solid lines, demonstrating the integrated nature of work which embraces these three areas. But, the concerns within this triangle have been those of younger women with little application of their pathbreaking insights to the concerns of older women, to which I now begin to turn.

(iv) **Sociology of Ageing**

The Sociology of Ageing has yet to become a recognised sub-field within British sociology; there is no BSA study group on ageing, and very few (if any) specific courses in sociology of ageing taught within undergraduate sociology degrees. This contrasts with the USA where sociology of ageing has been buoyant for many years, and there is a Research Committee on Sociology of Ageing in the International Sociological Association.

In Britain, there is important research in this area (for example, Jefferys, 1989 and Bytheway et al, 1989), but the professional orientation has been towards the British Society of Gerontology rather than the BSA, and articles published in the journal *Ageing and Society*, rather than mainstream sociological journals. Another legacy has been within social policy,

with work in this area tending to emphasise the social problems of older people (for example, the work of Peter Townsend and Jeremy Tunstall).

It is impossible to do justice to the range of work in the sociology of ageing in this short paper, but my argument is that this work is largely ignored within British sociology. There is a need for a closer linkage which integrates the insights from the sociology of ageing within mainstream sociology, and the sociology of ageing needs to shift from a primarily social problem focus to one which focuses on older people as subjects rather than objects of research, and examines a wide range of sociological research issues focusing on older people (Arber and Ginn, 1991b).

The nascent state of the sociology of ageing can be seen from the lack of refinement of the term 'age'. A parallel distinction to that which contrasts sex and gender needs to be made for the term 'age'. Most writing makes no clear distinction between the following three meanings of age:

Chronological age, which refers to the individual's age in years. This is the variable most often used in research studies and is enshrined in legal restrictions and privileges. In research it is usually assumed to be closely identified with the other two meanings of age.

Physiological age refers to the ageing process as defined by the medical profession. Physiological age is a medically constructed concept associated with the ageing body. Physiological changes occur with ageing in terms of the composition of the bones, the process of degeneration of body tissue and functional impairment, but these changes cannot simply be read off from chronological age. We know that the level of functional impairment of people aged 65-69 who were previously in semi-skilled and unskilled jobs is greater than among the higher middle class who are over five years older (Arber and Ginn, 1993). Thus, physiological age is socially structured.

Social age is socially constructed and in some ways is comparable to the concept 'gender' However, social age has at least three different meanings: (i) it refers to the age norms about appropriate behaviours for someone of a certain chronological (or physiological) age; (ii) it refers to the subjective perception of how old an individual feels, and (iii) it refers to the age the individual is accorded by others.

At present it is problematic to discuss these three different meanings of age and how they interrelate, because of the lack of agreed terminology within sociology to make these conceptual distinctions.

The theoretical insights from excellent recent work in the sociology of disability (e.g. Oliver, 1990; Lonsdale, 1989; Morris, 1992) could profitably be applied to later life. But their focus is almost entirely on disabled people of working age. This again illustrates the privileging of the working ages over the retirement ages, since the vast majority of all disabled people are over age 65 (Martin et a1, 1988).

(v) **Sociology of Gender and Ageing**

It is surprising given the richness of work by feminist sociologists that there has been so little work on older women (Arber and Ginn, 1991b), although this relative neglect is beginning to be rectified (e.g. Peace, 1986; Arber and Ginn, l99la, forthcoming; Bemard and Meade, 1993).

The impact of feminist sociologists has not only been negligible, but has contributed to the pathologisation of older women, Countless studies of caring have examined the 'burdens' faced by younger and mid-life women in providing informal care to their ageing parents, focusing on how this has constrained women's opportunities for paid employment and other

activities (cf. Nissel and Bonnerjea, 1982; Lewis and Meredith, 1988; Brody, 1981). Since the majority of older people in need of care are women, these studies have in effect objectified older women as the 'problem' the 'burden' to be cared for, the 'other'.

Within official discourse on caring all elderly people arc seen as potentially in need of care. For example, the OPCS Informal Carers survey (Green, 1988) identified carers as anyone who 'looks after (or helps) someone who is sick, handicapped or elderly' This identity of age with needing care fuels ageist images of elderly people as a burden. It also makes invisible all Services, care, and unpaid work performed by older people for each other and to the younger generation. Older people's role in voluntary activities, political organisations and community activities is ignored. The following personal experience illustrates that the balance of support may be in the opposite direction from our conventional assumptions:

My 79 year old father-in-law provides all the required care for my 85 year old housebound mother-in-law, but he would be unlikely to define himself as a carer. He also does all our gardening, including growing vegetables, helps with decorating and does all our evening

'babysitting' for three children. My neighbour has an 80 year old mother who looks after her three children whenever required, including picking them up from school.

Older people's contribution through unpaid work to their own generation and to the younger generation is as invisible today as was the case twenty years ago for women's unpaid domestic and caring work.

(vi) **Ageing and Health within Sociology**

It is ironic that such a small amount of research by medical sociologists is devoted to older people despite the high proportion of health resources spent on people above retirement age. What research there is tends to focus on sick older people who are already within the health care system. There is very little research on the majority of older people, who have good health and no functional impairment. For example, medical sociologists have learnt a great deal over the last two decades about lay ideas of health and about illness behaviour, but these studies have all excluded those over the age of 65, as if their illness behaviour and ideas about health are uninteresting and unimportant.

The exclusion of elderly people from 'normal' medical sociological research, as opposed to focusing on the health care problems and needs of elderly people, is exemplified in the design of many studies, for example, the Glasgow cohort studies. These began in 1987 and aim to follow up three age cohorts, aged 15, 35 and 55, for twenty years. The lack of a 70 or 75 year old cohort suggests the implicit assumption that there are no (or few) social factors influencing health among older age groups, or that they are uninteresting. This is a false assumption, since inequalities in health are almost as great among those over age 65 as at younger ages (Arber and Ginn, 1993).

(vii) **Gender, Health and Ageing within Sociology**

Sociological work on gender and health in later life is almost uncharted territory, except for some notable exceptions, which should inspire others. The work of Helen Evers has been particularly significant (for example, Evers, 1981, 1985), and more recently Hockey and James (1993).

The challenge is to build on the theoretical insights and methodological imperatives from feminist sociology and work on women's health and apply them to older people. There is a need to take on the perspectives of older women and men, to give them a voice, and provide the opportunity for older people to define the issues of relevance to them. We need to move the personal concerns and priorities of older people to the centre-stage of research in

sociology of health and illness, seeing older people as the subjects rather than the objects of research.

The potential research agenda is long, and I can only give a partial list here, which should be seen as indicative of the potential for theoretical insight and understanding which would come from such research. Potential research areas include:

- the meaning of dependency, independence and autonomy to older people, and the strategies used to minimise dependence on others.
- the applicability of insights from sociological literature on disability and disabled women.
- the sociology of the ageing body, the meaning of ageing bodies to women and men. The key role of health and the functioning of the body within the everyday lives of older people.
- the contribution of older women and men to their own heath, the health and well-being of their peers and the younger generation.
- relations of power in interactions between older people and health care providers, the implications of age relations, and how these are cross-cut by the gender of the patient and the provider.
- age-relations at the macro-level, in terms of the position of older women and men in society and within the health care system.

Sociological research on the health of older women and men not only needs to build on the theoretical and methodological insights from feminist sociology, but needs to utilise a life course perspective, and be sensitive to structural inequalities among older people, in particular how material and social resources in later life are shaped by gender, class, and ethnicity.

Table 1.

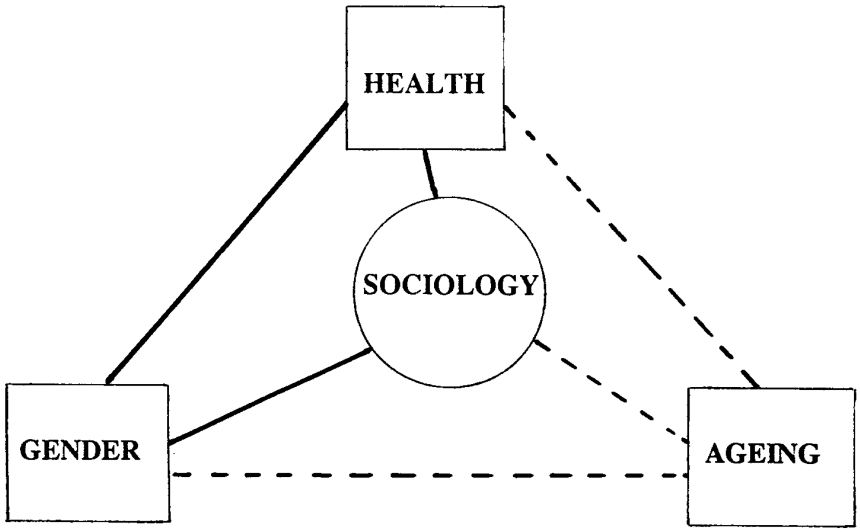
Demographic Characteristics of Women and Men Aged 65 and over, England and Wales.

	Women	Men	Sex Ratio (Women/Men)
(a) By Age Group % (1992)			
65-74	51.0	62.4	1.21
75-84	35.8	31.3	1.70
85+	13.2	6.3	3.12
	100%	100%	
All 65+ (thousands)	(4,879)	(3,283)	1.49
% 65+ in population	18.6%	13.1%	
(b) Marital Status % (1990)			
Married	38.3	72.4	0.79
Widowed	49.3	17.1	4.30
Divorced	3.4	3.1	1.65
Never Married	9.1	7.5	1.81
	100%	100%	
(c) Expectation of Life at Birth, Years			Sex Differentia
1971	75.2	69.0	6.2 yrs
1990	78.7	73.2	5.5 yrs

Source: OPCS. Population Trends 1993, **74**. London: HMSO, Tables 6,7 and 17.

Figure 1

Gender, Health And Ageing



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