Measuring women’s social position: the importance of theory

Gender, science and politics

The classification of women's social position, an apparently technical issue, involves many of the classic themes in social science, where science and politics, the prescriptive and the descriptive, appear indissolubly entangled. Increasingly it has come to be regarded as unacceptable to use the occupation of a husband, male partner or father to allocate women to a social class. However, there is evidence that many social and political attitudes, aspects of consumer behaviour and health are strongly influenced by the social position of male next of kin. Little as we may wish women’s fate to depend on men’s, much of our observation of society indicates that to some extent it still does. Of course, if women's equality were unproblematic, we would not need a political movement committed to it. Such movements create a space and a need for what they are, have often been of benefit to science, because power and domination have a profound effect on the growth of knowledge.4

The relevance of employment

In this edition of the journal, Krieger systematically compares the “conventional” (some might say sexist) approach to social classification of women, which allocates social class on the basis of the husband or male partner, to a “gender neutral” approach and a “combined” approach.5 This is more than arguing over whether women are better classified according to their own or their husbands' occupation. In the mid-1980s women’s labour force participation was lower than it is at present: 32% of women at any one time were out of the labour force and 24% were working part time only; (by 1997 the respective proportions were 22% and 15% (Social Trends 1998 table 4.2 p 75)). Insofar as research in the relevant “exposure” studies in social aetiology, there were in fact rather good reasons for doubting whether it could have the same effect on women as men, merely on the grounds of a simple dose response argument.6

The argument went something like this: Why would we expect there to be class differences in health of men or women? Class is allocated according to occupation. Occupation affects health because of a combination of physical hazard exposures, psychosocial factors (“stress”) and economic factors, that is, the non-work environment to which income gives access (housing quality, neighbourhood quality, leisure activities, social participation). Now, if 40% or 50% of women were either not in paid employment at all or only working part time, this had two implications. They were either not exposed at all, or less exposed to the physical and psychosocial hazards; and the income of their household was either not at all or only part determined by their own income. Health gradients in women tend to be steeper than for men. In the mid-1980s women’s occupational status was lower than for men. In the mid-1980s, women’s labour force participation was lower than it is at present: 32% of women at any one time were out of the labour force and 24% were working part time only; (by 1997 the respective proportions were 22% and 15%). Insofar as research in the relevant “exposure” studies in social aetiology, there were in fact rather good reasons for doubting whether it could have the same effect on women as men, merely on the grounds of a simple dose response argument.6

The occupational structure for women has become “polarised”, with a greater degree of income inequality and an increase in both the numbers occupying well paid high status occupations such as catering and cleaning (some of the latter employed by the former in the rapid return of domestic service after its disappearance in the 1960 and 1970s). A similar polarisation has of course also taken place in the male labour force,8 the major difference being that more prosperous women employ poor women to care for their homes and children whereas men can still, to a much greater extent, depend on unpaid female labour for domestic services.9 This must be the major difference that needs to be taken into account when trying to understand the social epidemiology of women’s health. From description to explanation

Krieger's paper encourages us to look forward to an approach to health inequality research that is more firmly based in social theory. In this way, further progress can be made away from description of social variations in health and towards explanation. The theoretical approach favoured in the paper is one that focuses on where a given occupation is located in the wider system of relations of production in industrial societies. To a very great extent, it is occupation that determines two of the other major dimensions of social inequality: material living standards and status. But they do not coincide exactly. Membership of certain ethnic groups for example may give access to a degree of privilege in terms of status that is denied others in the same occupation. Another advantage of examining each dimension of inequality separately is most evident in the study of women’s health. This strategy allows us to classify household status, for example, according to a gender neutral method (according to the “dominant partner”) and ask whether patterns of health and health behaviour follow the status of their household or the prevalent pattern in the occupational group of each partner.10 Are nurses, for example (an occupation in which smoking is very prevalent in the United Kingdom) less likely to smoke if they live with managers than with bus drivers?
It is increasingly convincingly argued that there are psychosocial effects lying on the pathways leading from social position to chronic disease14;20;15; we know less about which aspects of social situations are most hazardous.20 From the point of view of policy debates on health inequality, it is of great relevance to know whether the same working conditions, such as high pace of work or long working hours for example, have different effects on men or women with different levels of prestige. Can having a high status in one's community defend against work stress, or even strengthen the immune responses to purely biological hazards?20 Alternatively, could greater work autonomy be a buffer against lower standing in the community, as is suggested by the recent report of unexpectedly low mortality in the self employed (regardless of status)?21 These questions only become clear when greater attention is paid to the methods by which we measure social position and circumstances for both women and men.

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Mel Bartley gratefully acknowledges the support of the UK Medical Research Council (grant no G8802774) and Economic and Social Research Council (grant no L128251001).