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“Men Behaving Badly”: Patriarchy, Public Policy and Health Inequalities

Gender is under-represented in the literature on health inequalities and social determinants of health; the latter are in turn under-represented in the literature on gender in general and on men and masculinities in particular. Furthermore, research and policy on gender and health frequently individualise issues of inequality, neglecting structural and systemic root causes of differential rates and experiences of morbidity and mortality. This article highlights the patriarchal social structures, attitudes and practices that, we argue, are common antecedents of these inequalities and suggests ways in which research and public policy can begin to address them. Patriarchy and hegemonic masculinity must be challenged as part of a wider set of social structural determinants of health.

Keywords: patriarchy, public policy, health inequalities, masculinities, gender

Our title borrows from a popular 1990s U.K. television comedy series, whose central characters were “macho but lovable” young men sharing a London apartment during their (quasi-)single twenties and thirties. A typical episode revolved around a limited number of repetitive themes associated with archetypes of modern masculinity: a disdain for work as, at best, a necessary evil; a predilection for “risk taking” activities (drinking to excess, tobacco use); and a failure to engage with the safety and security offered by long term, committed relationships. In this way, the series effectively portrayed the superficial treatment of gender inequalities within “economically developed” societies. The “hegemonic” depiction of men as hedonistic risk takers, unwilling to manage their behaviours reflexively in line with good health promotion and lifestyle advice, became a commonplace in the pe-

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riod during which this show was broadcast. It was accompanied by other media phenomena such as the rise of men’s magazines (Benwell, 2004) that similarly depicted narrow constructions of masculinity and created forms of male identity typically described as “new lad”. The present article considers critically how patriarchal social structures as well as hegemonic forms of masculinity construct lived masculinities that are deleterious to men’s health (men behaving badly)—constructions that are potentially reified within the cultures and practices of real men in everyday life—and simultaneously impact upon more marginalised forms of masculinity (men of lower socio economic status). Importantly, these also interact with wider social determinants of health, long recognised to be fundamental in determining both morbidity and mortality across populations.

Researchers have noted the impact of the social organisation of gender relations with regards to hegemonic masculinity (Wall & Kristanjon, 2005) and patriarchy (Stanistreet et al., 2005), key concepts which will be elaborated upon below, in contributing to negative health behaviours and influencing men’s health beliefs and responses to illness, as well as shaping professional diagnosis and interventions (Riska, 2002). The problem of men’s health is said to be inextricably linked to structural, lifestyle and behavioural factors that combine to have a negative impact upon male wellbeing. The dominance of “hegemonic” masculinity (Carrigan et al., 1985) may mean that men both participate in risky practices such as excessive drinking, smoking, unsafe sex and dangerous driving (Courtenay, 2000; Salstonstall, 1993) and are less likely to take part in healthy activities or seek help when required. Health thus becomes a core aspect of gender identities, with “doing” healthy or unhealthy practices being associated with the feminine and masculine, respectively (Courtenay, 2000; Salstonstall, 1993).

CONCEPTS AND DEFINITIONS

Some further articulation of concepts and definitions will help clarify our analysis. By *patriarchy* we mean the systematic domination by men of women and of other men (Walby, 1990). *Masculinities* are the various ways—such as national, racial, cultural, or sexual identities—in which men’s gender relations are expressed and performed: for example, British, African-American, working class, and gay masculinities. *Hegemonic masculinity* refers to the form of masculinity that is culturally and politically dominant at a particular time and in a particular place (Connell, 2005). As a concept and a tool for the analysis of gendered power relations, hegemonic masculinity is closely related to patriarchy.

Hegemony is a subtle and complex process whereby particular beliefs, values and ideologies are diluted, internalised and reproduced by the powerful, such that they become perceived as both natural and inevitable—in the words of former U.K. prime minister Margaret Thatcher, speaking of market liberalism, “there is no alternative”. Hegemonic masculinity therefore refers to a dominant form of masculinity that is assumed to be “normative”, even though it may have little bearing on the lived reality of being male for most men. Like patriarchy, it persists as a cultural form not despite, but because of, its pyramid-like structure: although the powerful represent a numerical minority, the ideas they espouse and the practices they reproduce shape the expectations and norms of a much greater population. Health inequality refers to unfair or unjust differences in health determinants or outcomes within or between defined populations.

Central to our argument is the assertion that patriarchy and hegemonic masculinity interact in ways that are not just deleterious to the health of individual men, an argument that was the keystone of much early work on men’s health—see for example Sabo and Gordon (1995)

and Courtenay (2000)—but that are also harmful to a much wider population, promoting as they do aggressive, dominating and unempathetic policies that have impact on a global scale. As discussed below, this is in no small part related to the crossover in values, beliefs and behaviours between these dominant social and structural paradigms and an equally dominant ideology of political and economic organisation: neoliberalism. In turn, neoliberal economic policies and forms of social organisation are directly correlated with high levels of inequality and a concomitant increase in incidence of social problems, including higher rates of morbidity and mortality amongst groups with lower socio-economic status and other minorities (Wilkinson & Pickett, 2009).

HEALTH INEQUALITIES AND GENDER INEQUALITIES

Considerable bodies of literature exist on both health inequalities and the social determinants of health (SDH) (see for example Acheson et al., 1998; Marmot, 2010; WHO, 2008) and on gender equalities in health more specifically (see for example Read & Gorman, 2010; Sen et al., 2007). However, as others have noted (Scott-Samuel, Stanistreet & Crawshaw, 2009; Weber, 2006), there continues to be little overlap between them; that is, very little critical dialogue has taken place between researchers interested in gender and health and in health inequalities. Also notable is the fact that work on gender inequality overwhelmingly focuses on women and girls. This is not without good reason. Feminist health researchers have long described the inequities experienced by women in health care and the very real impacts of this on women's wellbeing (see for example Doyal, 1995). Further, others have documented how the early history of medicine is characterised by an assumption that women's bodies were merely an inferior derivative of the male body; a weaker and inverted form that did not necessarily merit its own specific field of study (see Laqueur, 1990).

More than four decades of activism and research has addressed some of these inequities, with women's health now high on the agenda in countries of the economic north and south alike, and often closely related to reproductive and child health. However, some of this work has been criticised for its failure to make more explicit the relationship between women's health and socio-economic status (Bambra et al., 2009; Broom, 2008; Williams, Robertson & Hewison, 2009). In the still new and emerging field of men and health *and* in the wider area of masculinities, there is similarly little cross-referencing to the broader picture of socio-economic inequalities in health.

In short, there is little or no real dialogue between a well-established and expanding body of research that has sought to document and explain often deeply ingrained inequalities in health, with a particular focus on the “developed” nations, and a new but growing literature on the health of men, much of which implicitly recognises the importance of social determinants of health and the complex interactions of structure and environment which shape the health of men, often, so the argument goes, with deleterious effects.

The aim of the present article is to critically consider why this division persists. Despite a growing call for intersectionality (see for example Schulz & Mullings, 2006; Tolhurst et al., 2012), academic researchers often continue to specialise in *either* gender *or* masculinities *or* health inequalities: a situation that is unhelpful when it comes to asking fundamental and cross-cutting questions. A further challenge is that much of the men and health literature individualises men and health issues by typically focusing on individual men as the agents causing or receiving health impacts (men behaving badly) and on interventions designed to change individual men's knowledge, attitudes or practices (man as inveterate risk-taker). This reflects the continuing dominance of both medical and psychological re-

search within men’s health discourses, informing a body of work that in many respects mirrors a dominant neoliberal model of society in which self-management and -actualisation are considered key to constructing healthy identities (see Crawshaw, 2007).

As a consequence, much less attention is given to structural and systemic issues. This is perhaps unsurprising. Robertson (2001, pp. 294-295) has noted that “Particular discourses on health emerge at particular historical moments and gain widespread acceptance primarily because they are more or less congruent with the prevailing social, political and economic order within which they are produced, maintained and reproduced”. Current dominant discourses within healthcare are characterised by the marketisation and fragmentation of welfare and by neoliberal modes of governance. These discourses are mirrored in the still emerging field of men’s health research. As Crawshaw (2009) has noted, research has tended to serve the health and medical sciences by, for example, providing insights into how behavioural change might be achieved with regards to primary or secondary prevention with men, rather than by working to provide more robust critiques of the complex social, structural and political factors that shape men’s experiences and ultimately determine their health.

REFOCUSING ON THE ROOT CAUSES

The divorce between work on SDH and on masculinities is illustrated in recent reports by the World Health Organization (WHO) Commission on Social Determinants of Health (Sen et al., 2007; WHO, 2008) and by the European Commission report on men’s health in Europe (European Commission, 2011). A key message of the WHO report, and of the work that followed its publication (Östlin et al., 2010), was the need to focus on the root, and not just the immediate, causes of unequal health outcomes. Such root causes tend not to receive the attention they deserve because they are rarely amenable to the simple policy responses (inevitably administered within short time scales) favoured by politicians. The root causes of gender inequalities, as revealed in a wealth of previous research, and those signalled in the recent European Commission report on men’s health, are no exception. Our key contention is that the patriarchal social structures, attitudes and practices that continue to dominate society on a global scale affect all areas of life, including health.

Here, our position mirrors perennial debates in social epidemiology, and in the health social sciences more generally, that have sought to explain inequalities or variations in the health expectations and experiences of individuals and communities in (post-)industrial societies (Crawshaw, 2009). Explanations have typically sat within two largely separate camps: those positing macro, structural determinants, and those who assert that individual lifestyle choices and agency determine health expectations. By critiquing the role of patriarchy in shaping men’s health, we are approaching the issue from a structuralist standpoint, highlighting how it operates, in the words of the French sociologist Pierre Bourdieu, as a “structuring structure” that has a profound impact upon the lived experiences of individual women and men. Bourdieu (1990) uses the concept of *habitus*, external structures that influence individual behaviours, themselves linked to wider “social fields”. In this way he attempts to offer an explanation for individual behaviours and practices that move beyond rational choice and agency and truly account for the impact of social structures in shaping lifestyle and disposition.

Similarly with regard to health inequalities, there is increasing evidence from social epidemiology that their sustained reduction can only be achieved by addressing their fundamental (root) causes (Phelan et al., 2004; Scott et al., 2013; Scott-Samuel, 2011). This is in

contrast to the much more common “downstream” focus (in health and public policy) on their proximal, immediate causes (such as social inequalities in smoking) or on the diseases through which they are expressed at any given time (such as the social patterning of lung cancer). This evidence explains both the persistence of health inequalities over time, and the failure of policies that only target their proximal causes and immediate manifestations. Fundamental causes of health inequalities include the unequal distribution of power, money, prestige, knowledge and beneficial social connections (Link & Phelan, 1995; WHO, 2008). Governments typically do little or nothing to address these issues, with the occasional exception of seeking to provide additional knowledge through methods such as social marketing, for which there is little evidence of effectiveness (Crawshaw, 2012)—and even here, the reasons why affluent people are more likely to act on health information are not seriously addressed by most governments. Rather, solutions are posited at the level of the individual and efforts put into the promotion of “better” lifestyle choices based upon increased knowledge of health risks.

PATRIARCHY AND PUBLIC POLICY

A key contention of the present article is that the entrenchment of patriarchy and hegemonic masculinity is clearly maintained through their affiliation with free market capitalism or neoliberalism. Neoliberalism dominates global economic relations through multinational corporations and multilateral agreements sustaining the “Washington Consensus” (Serra & Stiglitz, 2008)—a set of views about effective global development strategies associated with Washington-based institutions (the International Monetary Fund, the World Bank, the U.S. Treasury), and involving financial deregulation, trade liberalisation and the increasing privatisation of public goods and services. Neoliberalism, validated by the “non-science” of neo-classical economics, is closely tied to other “delusional systems” (Oakley, 2002) such as sociobiology: together these provide a self-sustaining system for maintaining hegemonic masculinity with all its associated behaviours and consequences (Oakley, 2002).

It is no coincidence that the attributes which characterise both successful market entrepreneurs and many successful politicians—toughness, competitiveness, aggression, excessive risk-taking and the suppression of human emotions—are also central to the stereotypical “macho” persona associated with hegemonic masculinity and which is reproduced in dominant gender relations on a global scale (see Connell, 1998). This persona is common among political leaders of both sexes—and tough, competitive, aggressive, risk taking, emotionally suppressed politicians generate tough, competitive, aggressive, risky, emotionally illiterate public policies. Concerns about developing fair and just social orders characterised by equality of opportunity are notably absent from such societies—for example, the U.S. and the U.K.—although politicians find it profitable to claim otherwise, and to identify with values like caring and decency, fairness and social justice. Unsurprisingly, it has been shown that the governments of nation states that include more women are less likely to instigate military conflicts (Caprioli & Boyer, 2001).

CAUSES FOR OPTIMISM

It is tempting to be fatalistic about endemic and deeply rooted issues such as patriarchy and hegemonic masculinity and their influence upon equally entrenched inequalities in health that have become the norm in much of the “economic North”. However, it is also important to acknowledge causes for optimism.

First, alternative forms of social organisation, as well as alternative masculinities, do indeed exist. In fact, the majority of men in all countries, social classes, ethnic and other social groups do not conform to the hegemonic form of masculinity we have described (see Whitehead, 2002, for a discussion). Although patriarchy and hegemonic masculinity structure gender relations and our ideas about what it means to be a man, neither is fixed and immutable. While key social institutions continue to impose patriarchal forms of governance and social systems on those whom they influence, more socially cohesive forms of masculinity can and do exist concurrently.

Second, the negative outcomes of hegemonic masculinity are—at least in principle—preventable through action at the level of public policy. As noted above, there is evidence that where higher proportions of women are politicians, war, violent conflict, and aggressive forms of masculinity are less common (Caprioli & Boyer, 2001). Early forms of gender stereotyping, for example those that occur in pre-school institutions can, as has been the case in Sweden, form the focus of policy recommendations (Delegationen för jämställdhet i förskolan, 2006). Provision of universal day care for young children has itself been shown to reduce the chances of health-harming behaviours among both men and women in adulthood (Zoritch, Roberts & Oakley, 1998). What is needed is the commitment to place such issues and strategies on the policy agenda (Barker et al., 2010a, 2010b).

Neither hegemonic masculinity nor patriarchy should be viewed as natural or inevitable. Rather, both can be challenged through upstream strategies that address “big” structural issues through radical public policies. Precedents exist for this kind of approach (Bambra et al., 2005). The case for placing masculinities on the public policy agenda has also been made in relation to the damage caused by male violence in particular and anti-social behaviour more generally (Cockburn & Oakley, 2011). What is needed is the application of this argument to public health advocacy for global social action on masculinities. Progress will also be needed in acknowledging how dimensions of inequality—gender, class, and ethnicity—intersect. A plausible hypothesis is that gender may mediate the influence on health outcomes of both socio-economic status and social integration (Ballantyne, 1999). A move towards intersectional research is especially called for among those who fund and undertake health inequalities research. It must not be seen as marginal—as has tended to be the case when conducted by feminist scholars (Sen & Iyer, 2012; Sen, Iyer, & Mukherjee, 2009; Weber, 2006). The power hierarchies underlying all inequalities must become a focus of analysis and action.

Recognition is growing of the importance of addressing masculinity as a social policy issue (Hearn, 2010). In the UK, for example, the Coalition on Men and Boys was launched in 2007 with government funding to bring together the work of relevant non-governmental organisations. However, the Coalition’s first report (Ruxton, 2009) discussed men’s health issues mainly in terms of the “men behaving badly” stereotype—as outcomes of men’s individual bad behaviour. Among the 28 member states of the European Union, only Ireland has a national men’s health policy; in the other states, it has not yet arrived on the policy agenda (Matcher, 2011; Varanka, Narhinen & Siukola, 2006). Elsewhere, however, Australia’s National Male Health Policy provides additional cause for optimism (Department of Health and Ageing, 2010). Future research and policy agendas must focus upon developing more nuanced understandings of how both hegemonic masculinity and patriarchy work to shape the health experiences and expectations of men as a heterogeneous population, and how these structural factors intersect with other determinants of identity such as ethnicity.

As Lohan (2007) has cogently argued, the time is right for health inequalities research to incorporate critical studies on men and masculinities; studies that acknowledge both the

role of hegemony and patriarchy, but also the established areas of material, psychosocial, cultural/behavioural and life course explanations. Similarly, men's health research must learn from these now well established approaches in order to build a complete picture of how a wide range of factors both shape, and can help us to explain, men's health experiences, alongside the influence of hegemonic masculinity and patriarchy. The fact that the issues discussed in this article are currently neither acknowledged nor addressed by most mainstream public policy makes them no less important as central, root causes of health inequality—and as key social determinants of suffering, sickness and survival on a global scale. Action is long overdue.

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