Gender Roles, Family Roles and Health Behaviour: Pursuing the Hidden Link

Stella R. Quah
National University of Singapore

The interest of sociologists in the link between gender differences and health behaviour has been manifested over the past two decades but it has increased considerably in the 1980s. Yet, while data show persistent gender differences in health behaviour and many studies indicate a connection between sex roles and health behaviour, the reasons for such link remain unclear. The main objective of this paper is to present further empirical evidence that may contribute to clarify the impact of gender roles and family roles on preventive health behaviour in the context of Singapore, a modernizing and culturally heterogeneous Asian nation. Some of the findings of a larger study on preventive health behaviour in Singapore suggested that preventive actions were motivated differently in males and females regardless of ethnicity or social class background. Furthermore, certain preventive actions were found more susceptible to gender differences than others, for example, abstention from smoking and alcohol drinking and the practice of regular exercise.

The aim of this paper is to explore those gender differences in more detail. The discussion is presented in five sections. The first three sections review sociological findings first on the main assumptions on gender influence upon health behaviour, then the relevant findings on gender and health behaviour in Asian societies, and finally studies documenting the link between gender and disease prevention in Singapore. The fourth section focuses on the impact of gender and family roles on preventive health behaviour in Singapore based on first-hand data. The final section is a summary of the main findings.

Main Assumptions on the Gender Influence

A review of the relevant literature on the link between gender and health behaviour reveals four important sets of sociological contributions. One is the ideas of Mechanic and Suchman; the others are the three conceptual assumptions around which most of the sociological work on this problem
has grown namely, the “sex-role”, the “role-set” and the “stress” hypotheses. A brief description of each of these contributions will provide the necessary background for the subsequent analysis.

Mechanic's was among the first sociological discussions on significant gender differences in attitudes and behaviour towards health and illness. Based on his and others' studies from America, he examined the persistent gender difference in morbidity rates whereby females have higher rates than males although women live longer than men. Mechanic's views may be summarized in three points: (a) there is no gender difference in the rates of reporting of objectively verifiable symptoms by male and female patients, but women tend to be more willing to report subjective symptoms than men; (b) the learning of cultural values attached to their female roles, the internalization of “dependency patterns” and “modes of expressing distress”, and the possibility that women may have “more interest in and knowledge of health”, are partial explanations of gender differences; but (c) there are no satisfactory answers yet to the “sex differences in the distribution of illness”.

An illustration of the findings summarized by David Mechanic is provided by Suchman’s study. Suchman tried to identify the social patterns people follow when facing illness. In his brief discussion of sex differences, he reported that

women are likely to be better informed about disease than men and to be less skeptical of medical care, but to be about equally high in illness dependency ... It may be that health and medical care are areas of greater salience for women, as mothers responsible for the health of their families, and that for this reason, they learn more about disease and place more faith in doctors.

The sex differences in morbidity rates reported by Mechanic and Suchman are not exceptional. On the contrary, international comparisons of overall morbidity rates show a persistent pattern of higher rates among women. Most studies dealing with sex differences in health and illness do not venture beyond the description of morbidity rate differences or, at the most, a description of health services utilization by men and women as an indication of their help-seeking behaviour. Fortunately, during the past decade researchers have become more interested in testing the validity and reliability of those statistics and in investigating the reasons for the disparity in health-related behaviour between the sexes.

As indicated earlier, most of these studies center on one of three basic assumptions or hypotheses. These hypotheses are: (1) “the sex-role hypothesis” which states that as women are culturally expected to be dependent and more fragile than men, it is socially acceptable for a woman to fall ill while the masculine trait for men is to be and to remain healthy; (2) “the role-set hypothesis” indicates that people who have many important role obligations are less likely to acknowledge illness and to use health services, compared to people who have less role obligations; consequently, women — seen as housewives with less role obligations both in number and