Social Context and the Gendered Life Course: What Do They Offer Our Understanding of Socioeconomic Inequalities in Health in Later Life?

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By
Laurie M. Corna

Lupina Research Associate, Comparative Program on Health and Society
PhD Candidate, Dalla Lana School of Public Health, University of Toronto
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Munk School of Global Affairs
University of Toronto
1 Devonshire Place
Toronto, Ontario, Canada M5S 3K7
Telephone: (416) 946-8891
Facsimile: (416) 946-8915
E-mail: cphs.munk@utoronto.ca
Website: www.utoronto.ca/cphs

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Laurie M. Corna

Abstract

In this paper, I address the problem of how we conceptualize and understand socioeconomic inequalities in health in later life. I suggest that it is difficult to separate the observed relationship between socioeconomic position (SEP) and health among older adults from the life course experiences that precede it. I draw on life course theory and theories of the welfare state to argue that current longitudinal approaches to understanding health inequalities in later life overlook the influence of labour market and family experiences during the "working" years and the ways in which these may be gendered. I also suggest that consideration of these relationships is largely de-contextualized in terms of social policy context, time, and place, all of which are likely to offer important insight into the patterns and processes we observe over time. In developing this argument, I discuss the gendered work and family experiences of current cohorts of older adults in Britain and their relationship to SEP and health in later life.

Laurie M. Corna, at the time of writing, was a PhD Candidate in the Social Science and Health Program in the Dalla Lana School of Public Health and a Lupina Research Associate with the Comparative Program on Health and Society at the Munk School of Global Affairs. Her doctoral research concerned the life course processes associated with socioeconomic inequalities in health in later life. She is currently a Postdoctoral Fellow in the Department of Sociology at the University of Western Ontario. Dr. Corna can be contacted at lcorna2@uwo.ca.

INTRODUCTION

Socioeconomic inequalities in health among working age and older adults are well documented. Although the relationship between socioeconomic position (SEP) and health among older adults initially received less research attention compared to that among working age adults, there is now substantial evidence suggesting the persistence of these inequalities in later life. Self-rated health, limitations in daily activities, functional limitations, serious physical illness, and mental health problems all appear to be patterned by various markers of SEP, including income, wealth, and last occupation (Berkman and Gurland 1998; Dahl and Birkelund 1997; Grundy and Sloggett 2003; Huisman et al. 2003; Schöllgen et al. 2010; Kneseback et al. 2003). Recognizing the limitations of a cross-sectional approach to studying health inequalities in later life, research is increasingly situated in a longitudinal framework to address the social, biological, and environmental factors that shape health and health inequalities over the life course. In particular, life course epidemiologists have taken an interest in how “exposures” during various critical periods or phases of the life course influence the development of disease or disease risk across an individual's life course (Kuh et al. 2003), while researchers from a social science tradition have addressed the early social conditions that shape subsequent trajectories across the life course, including the accumulation of health enhancing resources. Collectively, this work has contributed much to our understanding of the pattern that inequalities in health follow over time. Building on these advances, I argue, involves greater attention to the processes that give
rise to socioeconomic inequalities in health in the first place. This includes a clearer understanding of how experiences in relevant life course domains earlier in the life course — the labour market and the family — influence SEP and health over time, as well as how these experiences are gendered and influenced by the particular institutional or social policy contexts in which they unfold. Addressing both the personal and institutional factors that shape health inequalities over time promises to move us closer to the development of evidence-based social and health policy recommendations that address the proximal and structural determinants of health (Berkman 2009; George 2005). In what follows, I first briefly review existing life course approaches to the study of socioeconomic inequalities in health in later life. I then return to the argument that more explicit attention to the gendered labour market and family experiences of men and women in particular contexts may enhance our understanding of how inequalities emerge in the first place. In developing this argument, I discuss the gendered work and family experiences of current cohorts of older adults in Britain and their relationship to SEP and health in later life.

**LIFE COURSE EPIDEMIOLOGICAL MODELS AND THE CUMULATIVE ADVANTAGE/DISADVANTAGE HYPOTHESIS**

Life course epidemiological models are interested in the long-reaching effects that certain exposures (social, biological, environmental, etc.) during gestation, childhood, adolescence, young adulthood, and adult life have on chronic disease and disease risk much later in the life course (Ben-Shlomo and Kuh 2002). The first of these is a latency model, whereby early life conditions, including social conditions like childhood SEP, are thought to directly influence health outcomes in later life. To date, there is little evidence to support this framework given the difficulty associated with linking early life circumstances with health in later life (particularly chronic conditions) without also considering the multiple indirect pathways that could be operative (Berkman 2009). A second cluster of models specify various pathways through which disadvantaged circumstances early in the life course are linked to subsequent exposures over time. One specification describes a process whereby multiple exposures to disadvantaged circumstances (e.g., persistent poverty or smoking) over the life course take their toll on health. Here, it is the duration of exposure over time that is critical and can include both repeated and extended exposures to a single factor, or a series of exposures to different factors (Hertzman and Power 2006; Lynch and Davey-Smith 2005). A second specification is a social trajectory model whereby early life conditions, or negative exposures, influence adult social conditions, which in turn, influence health. For example, growing up in a socioeconomically disadvantaged household may be associated with poorer school performance, which may lead to more limited employment opportunities, lower earnings, and, overall, a disadvantaged SEP that negatively influences health (Hamil-Luker and O’Rand 2007; Hertzman and Power 2006). While these pathway models are not explicitly concerned with the development or emergence of inequalities in health over time, the latter two models are similar, conceptually, to the cumulative advantage/disadvantage hypothesis (CAD).

Rooted in a social science perspective, rather than an epidemiological one, CAD describes a process whereby initial relative advantage (or disadvantage) associated with structural location and resources results in systematic divergence in life course processes across individuals or groups over time (Dannefer 2003; O’Rand 1996). At least two specifications of this model have been proposed. In one, CAD is articulated as a path-dependent process of growing inequality where current levels of accumulation have a direct and causal influence on future levels of accumulation (DiPrete and Eirich 2006). Merton described this as the “Matthew Effect,” whereby scientists who excelled early in their careers were granted recognition, rewards, and resources that allowed them to continue to excel, while those same rewards and resources were withheld from those who did not have similar early achievements (Merton 1968). Consistent with this approach, we might expect to observe divergence in trajectories between individuals whose early position of relative advantage (or disadvantage) with respect to SEP subsequently leads to further advantages (or disadvantages) over time.

The second specification of CAD is consistent with the status attainment literature in relation to between-group stratification. Here, inequality between groups, such as social class groups, is emphasized, rather than within-group inequality. DiPrete and Eirich (2006) describe between-group inequality as a result of both
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direct and interactive effects of a status variable, resulting in different rates of return to socioeconomic resources for different status groups. This approach to CAD has also been generalized to consider long-term or cumulative exposure to a condition or treatment over time, such as growing up in a single- versus two-parent family, or years lived in a wealthy versus poor neighbourhood. Applying this specification to understanding the relationship between SEP and health in later life, it may be that persistently lower SEP (vs. persistently higher SEP) not only determines initial differences, but is also associated with differential rates of health decline, with faster rates of health decline expected among those who have experienced longer durations of lower SEP (Willson, Shuey, and Elder 2007). While there is some suggestion that inequalities in health may be greatest at mid-life and attenuate in later life (age-as-leveler hypothesis), the bulk of the evidence regarding socioeconomic inequalities and, in particular, income and wealth inequalities in health, favours a CAD pattern (but see Herd 2006).

While life course epidemiological models situate the relationship between SEP and health in a life course framework by specifying the various ways in which a variety of exposures influence subsequent health, they are not explicitly concerned with understanding the processes through which socioeconomic inequalities in health emerge over the life course. Conceptually, CAD moves closer to this goal by addressing the issue of whether socioeconomic inequalities in health are strongest among middle-aged adults or whether these disparities continue to grow with age. Support for a CAD process is instructive for informing policy regarding the necessity of addressing socioeconomic disadvantage earlier in the life course. However, the emphasis on the pattern of the SEP–health relationship with age in these frameworks diverts attention from the processes that are associated with, or give rise to, health inequalities across the life course in the first place. Income, wealth, and occupational class — all aspects of SEP — are at least partly constituted by work and family experiences across the life course, yet they are rarely assessed in relationship to trajectories in these domains. This omission overlooks how SEP, and its relationship to health in later life, may be shaped by gendered histories of work and family life and by the broader social policy context in which these histories unfold over time. Addressing this entails thinking about the life course in context and how social contexts not only shape and gender life course experiences, but how inequalities observed in later life are rooted in these earlier experiences. While it is often not possible to explicitly model the influence of social context on life course experiences, analyzing labour market and family experiences within particular contexts highlights the interdependencies between work and family life, as well as the gendered nature of labour market attachment. In what follows, I draw on key ideas from the life course and welfare state literatures to develop these ideas further.

THE LIFE COURSE IN INSTITUTIONAL CONTEXT

The life course perspective provides a lens through which socioeconomic inequalities in health in later life can be understood as processes that unfold over time. Here, the study of trajectories in multiple life course domains, and the transitions that punctuate and shape them, is of central interest (Elder 1985; George 1996). Importantly, individual trajectories do not unfold in isolation; rather, the various social roles that individuals occupy as workers, partners, and parents are interwoven to create what Elder and colleagues refer to as “social pathways” (Elder, Johnson Kirkpatrick, and Crosnoe 2003). In turn, social pathways are influenced by the time and place in which they are located, including the structural features of that context, and through their relationship to the social pathways of those around them.

The core principles of the life course perspective are useful for thinking about the relationship between SEP and health over the life course as being gendered and related to the social policy context in which they unfold. First, the principle of agency suggests that individuals construct their life course experiences, but that they do so within the constraints and opportunities of social circumstances (Elder et al. 2003). For instance, decisions about educational attainment, extent and type of labour market participation, and involvement in care work are likely influenced by the ideological, cultural, and normative ideas and pressures of specific contexts, as well as the social policies and provisions in place that either promote or hinder them.

Second, the life course perspective reminds us of the importance of the context in which individual lives play out. For example, in Britain, current cohorts of older adults were of working age in the decades
following the Second World War, a period of time in Britain characterized by strong support for the male breadwinner/female homemaker family model, a relative absence of state support for caregiving, and a pension system that privileged men's full-time, continuous employment (Creighton 1999; O'Connor et al. 1999). Not only would these measures influence the labour market activity of men and women, but we would also expect them to be consequential for the accumulation of resources over the life course and entitlements to benefits in later life.

Finally, this perspective draws our attention to the interdependencies within the family — the notion of “linked lives” (Elder et al. 2003). Decisions about paid work and family life are often made in tandem with those of spouses and in response to caregiving responsibilities for children and aging parents. As women are most often the primary providers of care in the family, the presence of dependants requiring care has implications for their ability to participate in the labour market on an equal footing with men and for the accumulation of socioeconomic resources and pension entitlements at retirement age (O'Connor et al. 1999). Marital status and transitions may also be important for understanding women's SEP over time, especially since a woman's attachment to a male breadwinner has historically been the basis on which she can make claims for support on the state in Britain (O'Connor 2004).

Current life course research on socioeconomic inequalities in health tends to emphasize the pattern that health trajectories follow with age, overlooking a fundamental tenet of the life course perspective — the dynamic interaction between individual biography and structural context as individual lives unfold over time (Elder 1985; Marshall and Mueller 2003). In comparison to their North American counterparts, European life course scholars have placed greater emphasis on the role of the institutions of the welfare state for understanding the life course and life course outcomes (Krüger 2003; Mayer and Müller 1986). Without assuming a deterministic role of the state, they point out that life trajectories are socially regulated through the institutions and policies that govern everyday lives and movement through various life phases, such as educational formation, the working years, and retirement. Yet, the ways in which the social policies of the welfare state influence or gender experiences in the labour market in the family, or their contribution to the development and emergence of socioeconomic inequalities in health over the life course, have not been well explicated. For this reason, greater integration of life course and welfare state theory may enrich our conceptualization of socioeconomic inequalities in health in later life by situating individual experiences in their broader social contexts. In what follows, I outline central ideas from the comparative welfare states literature and feminist critiques of this scholarship. I also make reference to Britain's classification as a welfare state and the related implications for understanding health inequalities from the perspective of the life course.

**SOCIAL CONTEXT AND THE WELFARE STATE**

The recognition that the welfare state and its related social policies and provisions are important for understanding social inequalities in health has led scholars to situate their research in a comparative framework to address questions concerning the interplay between context and individual outcomes (e.g., Bambra et al. 2009; Espelt 2008; Sacker et al. 2011). By definition, most capitalist economies are considered welfare states, yet there is considerable cross-national variation in the nature of these provisions and policies (Esping-Andersen 1990, 1999), resulting from varied historical, political, and social factors that shape decisions about, and responses to, the problem of “reconciling production and distribution” (O'Connor 2004, 181). Understanding a particular welfare state is often accomplished by analysing how and why it differs from other models in a comparative framework. Perhaps the best known of the comparative typologies is the “three worlds of welfare capitalism” articulated by Esping-Andersen (1990, 1991). This typology classifies countries on the extent to which they de-commodify or reduce market dependence for a living wage, on the extent to which they stratify individuals through access to benefits, and in reference to the relative roles of the state, market, and family in the provision of welfare. According to Esping-Andersen (1990) Britain is classified as a “liberal” welfare state, characterized by a low degree of de-commodification and a high extent of stratification, and where the emphasis is placed on private, market solutions. Since the publication of the three-worlds model, a number of alternative typologies for the classification of nation states have been advanced, showing both similarities and differences from Esping-Andersen's model (see
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Arts and Gelissen 2002 for a review). For example, according to the framework developed by Castles and Mitchell (1993), Britain does not neatly fall into any of the “worlds” described by Esping-Andersen, but instead, is characterized as “radical,” a fourth grouping of nation states distinguished by low social expenditure, but where redistribution is sought through targeted social policy instruments and progressive taxation. While my purpose here is not to compare the merits of various welfare state typologies, the classification of Britain as a liberal or radical welfare state has implications for understanding what we might expect in terms of social expenditure and the nature of social policies and provisions. As a liberal or radical welfare state, the market is emphasized as the source of income provision, while social (i.e., state) sources are generally means-tested and modest. Among other things, this helps to create divisions between those who are dependent on the state for social assistance and those who have other options in the private market (Esping-Andersen 1990). Indeed, one of the hallmark features of liberalism that underpins liberal welfare states is a means-tested approach to social benefits that seeks to ensure that social protection does not inhibit labour market efficiencies or undermine the commodity status of labour (O’Connor et al. 1999).

Although mainstream welfare regime typologies are useful for understanding the social policy context of a country, analyses that are guided by mainstream classifications alone run the risk of masking important sources of inequality, particularly that of gender inequality. In response to the inherent male bias in mainstream welfare state literature, feminist scholars have advanced alternative views that aim to make explicit the implications of welfare states for men and women. Central to a feminist analysis of welfare states is the recognition that gender is a fundamental structuring mechanism in society and within the welfare state (O’Connor 2004). Not only do gender relations shape the character of welfare states, but the institutions of social provision, social insurance programs, entitlements, and services all have a profound influence on gender relations (Bussemaker and van Kersbergen 1994; Daly and Lewis 2000; Orloff 1993, 1996; O’Connor et al. 1999; Sainsbury 1996). Notwithstanding this, however, welfare state models are nearly exclusively premised on a “male” worker or, at best, assume the gender neutrality of citizens (O’Connor 1996; Orloff 1993), obscuring the ways in which social policies and provisions may differentially impact men and women, with consequences for understanding SEP and health dynamics in later life. In particular, because the gendered division of unpaid caregiving work tends to be overlooked, along with the relationship between paid and unpaid work, women’s de-commodification remains problematic (Lewis 1998). This is especially so in contexts such as post-World War II Britain, where care responsibilities were predominantly relegated to the private sphere, but where “private” implicitly meant reliance on the family (i.e., women) as social caregiving supports were meagre or non-existent (Daly and Lewis 2000; O’Connor et al. 1999). As O’Connor (2004) points out, the notion of de-commodification implies initial involvement in the formal labour market, which necessitates policies and services that facilitate this for women with caregiving responsibilities.

Feminist concern with welfare state typologies also question who and under what circumstances claims for support on the state can be made. Access to benefits may occur through means-tested social assistance, through contribution-related social assistance (as in the case of unemployment benefits), or through entitlement based on social citizenship. In Britain, where most benefits are accessed through either means-tested claims or contributory social insurance schemes, claims made by women outside of the labour market typically fall into the former category. Entitlement to contributory-based claims assumes that men and women have equal access to the role of “worker” to begin with, an assumption that overlooks the fact that work in the home does not qualify for such benefits. As a result, divisions among women are created between those who are able to claim benefits as workers and those who must do so as wives and mothers.

Addressing gender’s absence from comparative welfare state research has taken the form of alternative ways of classifying countries, such as whether they promote a “male breadwinner” model versus an “individual” approach to social rights and entitlements (Sainsbury 1996), or by level of commitment to the male breadwinner/female homemaker family form (Lewis 1992). Other work suggests that the basis on which women can make claims is only one aspect of “gendering” an understanding of comparative welfare states. Analysis by O’Connor et al. (1999) also emphasizes the quality of social rights, the overall organization of services and income (including both private and public sources), and the ways in which labour market policies affect gender relations.
Broadly speaking then, welfare state typologies give us a broad sense of the nature and extent of social policies and social transfers we might expect in a given nation state. Feminist critiques of and contributions to this work provide a framework through which the gendered implications of social policies and provisions can be interpreted and evaluated. Linking these features to the specifics of the life course to question how this “structural” context may shape individual biographies, including the ways in which they may be gendered, necessitates greater attention to the country-specific policies and provisions in the historical periods under consideration. In particular, life course experiences in the labour market and the family involve decisions made in the context of opportunities and constraints within given social contexts at particular historical moments. It is here, I suggest, that further links can be made between the life course, the welfare state, and social policy to inform our understanding of socioeconomic inequalities in health in later life.

**BRINGING CONTEXT TO THE GENDERED LIFE COURSE: A SOCIAL POLICY EXAMPLE**

In my empirical research, I model the (gendered) life course experiences, and subsequent socioeconomic inequalities in health, among adults who reached the age of 65 years between 1992 and 2004. These cohorts were of working age in the decades following the Second World War. Consistent with life course theory’s call to bring greater attention to the context in which lives unfold, and mindful of the role of the institutions of the welfare state in shaping gendered life course experiences, I first provide some context in terms of the predominant family model — the male breadwinner/female homemaker model — and the social policy and provisions in place during this period of time. Specifically, I consider the key features of the National Insurance Act (Noble 2009) that was implemented in 1946 as one social policy measure that is particularly important for understanding gendered labour market attachment, access to benefits during the “working years,” resource accumulation, and pension entitlement in later life.

In the decades following the Second World War, family life in Britain was characterized by the male breadwinner/female homemaker model, where men assumed the position as earners for the household and women were responsible for domestic and care activities (Creighton 1999; Lewis 2001; O’Connor et al. 1999; Pedersen 1993). Creighton (1999) traces the rise of the male breadwinner model to at least two important movements. First, early initiatives were led by organized male workers who pressured employers to reserve certain jobs for men, while placing pressure on women (especially married women) to remain outside of the formal labour market. Secondly, recognizing that their collective bargaining efforts were insufficient, they pushed for a stronger role of the state in securing the family wage and provisions for families in the absence of a family wage. State support involved a number of measures, including legislated minimum wage rates in certain male-dominated industries, taxation policies that discouraged women’s employment, government subsidies for the household, and payments to families with children to supplement the family wage (Creighton 1999). Reflecting the entry of more married women into the labour market during the 1960s, others suggest that a male breadwinner/female part-timer model more accurately characterized the households of many British families (Price 2006; O’Connor et al. 1999). In either case, families continued to be mostly dependent on a male breadwinner’s wage for economic resources.

The work and home life arrangements of the male breadwinner family were associated with specific benefits for certain groups. Overall, the family wage helped raise living standards, secured the autonomy of the traditional family, and provided more time for family and childcare. However, there is little doubt that working males benefited most from these arrangements. Indeed, their gains were largely achieved at the expense of women’s full-time, unpaid domestic labour and resulting economic dependence (Lewis 2001). Policies consistent with the male breadwinner family also firmly entrenched the gendered division of labour in households and stigmatized other family types, such as single parent households. Since the 1970s, the male breadwinner model as the predominant family form has been on the decline, largely due to increases in women’s labour market participation and an increase in the number of households that do not include a male breadwinner (Creighton 1999; Lewis 2001). However, despite these changes, one-third of working age couples still resembled this model in the 1990s, and during this same period of time, part-time work characterized the labour market involvement of a high proportion of the women who were in paid work...
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(Creighton 1999). Further, among women engaged in full-time employment, many do not earn sufficient salaries to support a single person household (Arber and Ginn 1991).

The male breadwinner model in Britain during this historical period sets the context for understanding men's and women's experiences in the family and the labour market. Social policies enacted in the post-war years reflected the gender roles and division of labour of the male breadwinner family. It was only after the Second World War that policies were more systematized into the “modern welfare state,” including many of the reforms outlined by William Beveridge in his 1942 report (Beveridge 1942). Central to the vision put forth by Beveridge was a strong role for the state in ensuring protection from social risks such as illness, unemployment, and widowhood, by providing a minimum standard of living through contributory social insurance schemes (Disney 2001; Williamson and Pampel 1993). Key to these recommendations was full employment, as benefits would be largely funded through employment-based contributions.

Consistent with the recommendations made in the Beveridge report, the National Insurance Act of 1946 stipulated that all workers in the formal labour market who contributed would be entitled to sickness, unemployment, and old age benefits (Noble 2009). Unlike relief systems in place before the war, this modern welfare state program was premised on the notion of universality, and rights were not explicitly articulated in gendered terms, making it possible, in theory, for both men and women to make equal claims on the state. Yet, the ideological grounding of post-war social policy as articulated in the Beveridge report implicitly underscored the importance of gender and, to some extent, traditional gender roles in the family in terms of who could make claims (Noble 2009). Beveridge noted the virtues of marital relationships in which wives were rewarded for their valuable unpaid domestic and caregiving labour with their husband’s economic support.

Despite being premised on the notion of universality, a great deal of effort went into determining who and under what circumstances women could claim benefits under the National Insurance Act. This was particularly true for married women; special clauses provided them with the ability to opt out of the program, and married women who did elect to participate were provided with lower levels of benefits than their male counterparts (Noble 2009). Symbolically, opting out placed married women outside the boundaries of a universal program and, in practical terms, it reinforced their dependence on a male breadwinner. In the 1950s, more than half of the married women who were in the labour market opted out, meaning that they could pocket the flat rate weekly contribution, a sum of money that was not insignificant for women already in low paying jobs (Noble 2009). In addition, because labour market involvement had to meet minimum hour and pay requirements to qualify for National Insurance contributions, many women were unable to participate because they did not meet these criteria (Ginn, Street, and Arber 2001). Yet, the Basic State Pension, which is the foundation of the pension system in Britain, is calculated on the number of contributing years to the program. For this reason, one of the most important and long-term implications of the organization and implementation of the National Insurance Act was that many women were not accumulating the entitlement to a basic state pension for their retirement (Ginn et al. 2001). While married women are eligible to receive up to 60 percent of their spouse's Basic State Pension, a woman's own full Basic State Pension was initially contingent on 39 years of contributions to the program. Some changes made by the Labour Party in their 1975 Social Security Benefits Act (The National Archives 1975) helped women, given their more intermittent labour market activity patterns (O'Conner et al. 1999). For example, the introduction of the Home Responsibilities Program reduced the number of contribution years for entitlement to the Basic State Pension for women provided that recipients contributed for at least 20 qualifying years prior to retirement (Noble 2009). Nonetheless, many British women, even those who do qualify for a full basic pension, are still required to apply for means-tested pension credits to top up their own pension income in order to maintain economic independence (Ginn et al. 2001). Critics of the Basic State Pension argue that it was never designed to provide adequate economic resources, but, rather, was seen as a supplement to occupational pensions and private provision. Furthermore, although the percentage of women claiming the Basic State Pension has increased, owing to wage differentials, labour market disadvantage, and non-standard employment conditions, the percentage of married women whose entitlement on the basis of their husband's contributions is larger than their own is likely to continue to rise.
(O'Connor et al. 1999). For women, it appears as though dependence on a male breadwinner in retirement is simply an extension of their dependence on a male breadwinner during the working years.

As just one example of social policy in Britain in the post-WWII years, the National Insurance program and state support for the male breadwinner model begin to contextualize men's and women's experiences in the labour market and the family. The notion that individual agency is constrained by the social policy context is particularly relevant for thinking about individual decisions with respect to participation in the formal labour market and caregiving activities in the home for these cohorts of older adults in Britain. Compared to men, women were far more likely to be outside the formal labour market during the working years, and when they were employed, this work was often part-time. The implications of these gendered trajectories reach beyond the working years to influence pension entitlement and overall economic resources in retirement, highlighting the potentially important role that earlier experiences in the labour market and the family may have for understanding socioeconomic resources in later life.

THE GENDERED AND CONTEXTUALIZED LIFE COURSE: IMPLICATIONS FOR UNDERSTANDING THE RELATIONSHIPS BETWEEN SEP AND HEALTH IN LATER LIFE

In this paper, I argue that advancing our understanding of socioeconomic inequalities in health in later life necessitates greater attention to the processes that give rise to such inequalities in the first place. Because SEP in later life is related to experiences in the labour market and the family, I suggest that more explicit attention to their influence, including the ways in which they are gendered, is important. I also note that, consistent with the life course perspective, experiences in the labour market and the family cannot be fully understood outside of the social policy context in which they unfold. The framework proposed here therefore emphasizes the necessity to consider the implications of welfare state policies and provisions for (gendered) life course experiences. The assessment of these relationships outside their welfare state contexts runs the risk of attributing individual experiences to individual choices, emphasizing the proximal rather than structural determinants of health.

For current cohorts of older adults in Britain, state support for the male breadwinner model in the form of taxation policies that discouraged women's work, subsidies to the family (i.e., male) wage, and limited public support for child care undoubtedly shaped men's stronger labour market attachment relative to women, and women's greater likelihood of providing family care (Creighton 1999). In addition, the structure of the National Insurance Act, as just one policy example, has long-reaching implications for socioeconomic resources in later life. While it may not be possible to explicitly model the influence of specific policies, they provide the background for understanding why and how socioeconomic inequalities, including gender inequalities, might emerge in the first place and offer insight into where efforts aimed at policy reform may be most effective.

In this paper, I have focused primarily on how gendered and contextualized life course experiences in the labour market and the family may influence SEP and its relationship to health in later life. Moving forward will involve not only empirical analyses that incorporate the influence of detailed life course histories on SEP-health dynamics among older adults, but also greater specification of how these life course experiences may influence health directly over time. Consideration might be also fruitfully directed at linking childhood circumstances with adult experiences to provide a more comprehensive life course perspective.
References


