Health inequalities have become recently one of the major concerns of European health policy. Observed differences in health status of men and women are also frequently discussed within this framework, and are becoming a subject of growing interest of researchers. Clinical and epidemiological researches document male-female health differences, trying to explain them within bio-medical model. However, apart of biological (sex) divergence, health inequalities reflect differences in social roles, social status and culturally established patterns and stereotypes of femininity and masculinity (gender differences). The article, using sociological perspective, attempts to show that observed differences in man's and women's health may be attributable to the differing sociocultural and structural arrangements, social support and lifestyle factors of both genders. As a result, many of these differences are of inequality character. Another dimension of inequality discussed in this article is the way man and women are treated by the institution of medicine.

Differences and inequalities in health
For many years the variable "sex" did not attract any particular attention from the researchers into the state of health; although medical statistics indicated differences in the health picture of both sexes, no attempts were made to either understand or interpret them. Women's lower mortality and on the average a longer life were often explained by their better health. However, there is a discrepancy between such an attitude and research results from several countries which establish that the phenomenon of women's longer life coexists with a worse state of health - and there is no inconsistency here [39]. Statistics concentrating on an average length of life do not take into consideration the loss of health as a result of chronic illness and disability. Taking this variable into account indicates that women's state of health is worse than that of men in different, comparable age groups and cycles of life, with a particular intensity of diseases and complaints in the most advanced age [22,38]. DALY is a good indicator of these differences - it shows the equivalent of years lost in health because of diseases and disability; it looks worse for women than for men, irrespective of the region of the world and the country's wealth [41]. Throughout their whole life women are exposed to more severe and chronic diseases which may lead to disability or which are characterized by considerable difficulties, but which are not linked directly to a risk of death. In women diseases of high morbidity but of lower mortality appear [9].

In recent years health specificity of the two sexes has become the subject of numerous studies which have tried to determine why women live longer than men, though they are characterized by higher morbidity. Looking for the reason of this state of affairs, first of all the biomedical model was referred to, explaining the differences in men's and women's health by biological dissimilarity and by inherited genetic predispositions. Nevertheless, the impossibility of explaining all differences in the state of health of the two sexes by referring to that
The differences in morbidity and mortality in men and women are compounded by factors which are a function of the place and the social status allotted to those two categories in the social hierarchy of needs and in the access to the socially appreciated goods is no longer questioned. However, disputes about the domination of the influence of nature versus culture continue. This perspective introduces the problem of biologically determined differences on the one hand and on the other that of social inequalities in health to the analysis of the state of health diversity; in the case of women these will be first of all derivatives of cultural sex - defined as "gender differences". In the ongoing debate on the subject, standpoints come up which see biology as a dominant influence ("each cell of the human body has a gender") as well as analyses pointing out that it is precisely environmental factors and the differences in the physical and social environment which are of major importance here [35]. Owing to the difficulties in dealing with this dilemma, in some analyses more complex differentiation into "gendered expression of biology" and "biological expression of gender" are introduced [21].

In research aimed at determining the question of socio-cultural versus biological differences in men's and women's health, one often looks for arguments referring to infancy, and even earlier - that is the period when the influences of culture seem still absent. However, already at that time differences can be observed in the parameters of development and in the mortality of the two sexes. Since mortality is higher in male infants than in female babies, it is generally interpreted as men's poorer health condition and the earliest stage of life. At the same time it is pointed out that already in that period physical and personality differences between newborn babies are beginning to show, which can be related to the influence of hormones on the foetus's brain in the prenatal period and which in future will have consequences for their functioning. These differences will manifest themselves through the different time in which basic stages of development appear in girls and boys. Female babies will reach stages conducive to social interactions and communication faster, while male infants will reach the stage of independent actions favourable to a different sex. In the light of these findings there would be a very early differentiation of psychological and behavioural resources essential for future health and health, based in the case of men on individualistic-instrumental goals, and in that of women - on pro-social-expressive ones. Explaining this situation, apart from the different hormonal environment, one also underlines the fact that already in the third month of life differences in the development of the central nervous system are apparent [32].

Undoubtedly, there exist biological factors which differentiate very early on the development of infants of the two sexes - however, the question remains what is their real influence on later life and health of individuals and whether the observed differences in behaviour are truly the result of these factors. Opponents of the thesis on the dominating influence of biology point out that the forming of particular, different positions towards types of behaviour is the effect of differences that occur very early in the models of baby stimulation, due to the existing gender stereotypes. Thus, the analysed differences would be the result of socialization and not of biological determinism. Parents, starting from the earliest stages of the child's life, treat girls and boys differently. As a rule boys are dressed in less restraining clothes and encouraged to exercise individually, whereas girls' games are more often based on interactive contacts. The choice of toys is different, too - some involve strength, skill and task orientation and others - gentleness and expression of positive emotions. Boys are stimulated to a higher degree to shape individualistic attitudes and girls to develop pro social types of behaviour [8].

Irrespective of the genesis of these differences, they are subsequently strengthened in the process of further life experiences, so as to - in accordance with the stereotype and the different social status of men and women - shape assertiveness, independence and a tendency to take risks in the former and the readiness to co-operate, a nice disposition and giving in to other people's influence in the latter. As we will demonstrate later these dispositions will be responsible for many types of behaviour influencing health in future.

These undoubtedly interesting studies on biological versus social health determinants - mentioned here as examples - are not caused by the researchers' curiosity only; they are relevant, first of all, for health policy, or social policy in general. In democratic societies each individual should have a guarantee of the same possibilities of good health and a long life. From the point of view of the social distribution of goods or social justice, the assessment of differences in the state of health due to natural processes is different from the assessment of differences (in this case, inequalities) in health resulting from social differentiation. Such inequalities are considered wrong and unjust and their abolishment or reduction can and should be the goal and object of social interventions. These interventions should take place in the earliest stages of life as the differences appear very early, they can be socially inherited in the same way that poverty is inherited, and they may last - with various degrees of intensity - until the end of life [25].

The differences in morbidity and mortality in the two sexes are often difficult to explain. "Health" and "illness" are complex phenomena - their definitions and notable scope can vary considerably and are not always coherent with each other. The study of difference in the state of health may therefore include many different aspects of pathology: social phenomena; pathological changes occurring in the organism, noticeable behaviour of individuals, being the result of these changes, their self-assessment regarding health, or definite medical diagnoses. For the time being, we do not have the data analyzing this problem in a detailed way. There is also little systematic research into the subject, and in Poland there is almost none. Nevertheless, one can search for dissimilarity in the factors of risk which women and men are exposed to throughout their lives. In this presentation I shall endeavour to ponder over what sociology can bring to the explanation of these differences.

The assumption of a sociological perspective does not compete here with explanations of a biological kind; rather, it shows in what way culture and the social structure bring into relief or level out the influence of biology, co-creating, as a result, health and illness phenomena - multidimensional and often hard to assess.

**Social factors responsible for inequalities in health**

It is worth preceding considerations devoted to social inequalities in health from the gender perspective with the identification of social factors, which can be responsible for inequalities in health in general. Irrespective of whether we compare particular social classes, ethnic groups or people of different sexes - the main explanatory hypotheses will oscillate around a few groups of factors:

- Socio-economic status
- Material and social conditions of work and life
- Access to medical care and models of using it
- Behavioural factors (types of behaviour related to health, life styles)
- Socio-cultural factors (health culture and awareness)
- Social support network
- Individual, psychosocial resources and coping styles

The above factors come down to two dimensions: life situation and access to goods fundamental to health - and life style plus the choices people make which influence their health. They are often considered with allowances made for the life cycles in which individuals find themselves; individual health is in our doing - and doing conditions - from childhood until old age - and the result of a cumulation of different experiences.

Explaining a relative worse state of health by the life situation indicates a potential deprivation of needs concerning the conditions of living, housing, harder working conditions, worse nutrition, a more difficult access to medical care and generally limited possibilities of treatment. Behavioural and socio-cultural explanations refer to differences in health awareness, life styles, kinds of stress and resources to deal with them, and pro and anti health habits and behaviour. Studies of the role of stress in
The aetiology of chronic diseases have also demonstrated that irrespective of kinds of every day life stressors to which people are subjected, their models of dealing with stress, the efficiency of fighting it and its importance to maintaining health also differ [2]. A separate factor is constituted by variables of a psychological character, which may also constitute specific resources conducive to maintaining health or vice versa - limit person's resistance to diseases and his/her ability to overcome them [3]. All these factors (determinants) influence people's health on different levels of the organization of the society. They are anchored in a comprehensive model of the society, its economics, class structure and the scope of social diversity, in culture elements (dominating values and social norms), in the structures of formal and non formal power, in the level of social cohesion and social solidarity. They are also the basis of a specific "contract of the genders", establishing the structure of mutual dependencies and duties. Since all these factors influence the quality of life - the differences existing in that respect between the sexes shape men's and women's health differently.  

The role of cultural factors
Cultural explanations take into account differences in social models and norms regulating men's and women's behaviour in various social situations. They also consider the differences between men's and women's social roles, the expectations directed at them, issuing either from the social division of tasks or from fixed convictions and stereotypes. The process of socialization is of key importance here; the process of social teaching and implementing of norms and contents of these roles, which - as we have pointed out - starts differentiating between the two sexes already in infancy. Men's and women's roles are different in many aspects; traditionally the two sexes are prepared for socially different tasks. Boys and girls are prepared for the difference of these roles from early childhood. The contents absorbed in the process contain also several elements that are not indifferent for the future health of men and women. From the earliest age girls are prepared for the role of a mother, a minder, also for the role of a mother, also for the child. Children's games and a large number of partners and also the sexuality favours more frequent changing of partners. Venereal diseases or AIDS incidence rates in men exceed several times that in women [18]. Women, on the other hand, are more often victims of rape and sexual abuse, and this concerns also children of the female sex. A study devoted to sexual abuse of children up to 18 years of age established that the occurrence of the phenomenon was several times more frequent among girls than among boys [15].

This problem brings us closer to the question of mutual relations between men and women in sex life. Patterns and frequency of intercourse are more often imposed by the man than they are the result of the partners' agreement. Various forms of violence, also in married couples, are not infrequent in this context. Research conducted in 11 countries revealed that the scale of applying pressure or even sexual violence in marriage/partnership relationships ranged between 15 and 71%, depending on the country, according to women's declarations [41]. It has to be pointed out, however, that it often happens with the woman's silent consent. In many existing models of mutual life, the female partner's readiness to perform sexual services and either authentic or faked satisfaction thereof is treated as the condition of a stable, "successful" relationship. One may suppose that in this respect Polish women remain much more under the influence of a "patriarchal" model of the relationship than women in other European countries. In studies concerning contraception, carried out in 14 European countries [5], Poland was one of the foremost among those countries where the women's choice of contraceptives depended on their partners' preference. In extreme and not infrequent cases, the dominating, male point of view, leads to violence, often physical [11]. Effects of such violence often hints at a disastrous impact on health. The model of masculinity and feminity, still present in our culture, and their defined mutual relations, makes itself felt yet again.

It is not possible, of course, to analyze in a short presentation the comprehensive, diversified impact of the contents and requirements brought by culture, addressed to men and women respectively. It is equally difficult to analyze all factors which come into play in the second type of explanations proposed here and referring to places which men and women occupy in the social structure. We will thus limit ourselves to mentioning economic factors, differences in power held and kinds of work performed.  

Place in the social structure
Socio-economic conditions influence men's and women's health in the same way. It is known that better housing conditions, better nutrition, a chance for a proper rest or, last but not least, access to better medical care are conducive to health. Availability of these resources is in general different for the two sexes. All over the world considerably more women than men live in poverty, likewise, in most countries women are on the average less well educated than men. Present analyses of the poverty phenomenon both in developed and developing countries and in the development process of poverty. In families with limited budgets men's needs have the priority over those of women. Moreover, health and wellbeing of men are often enhanced by women's work for the home and the family. It is also their duty to take care of the children and older members of the family.

It is a well documented fact that men hold higher posts in professional hierarchy, and women who do the same work earn less. Women are also more frequently eliminated from the labour market when there is unemployment. Not without importance for men's and women's functioning in various social circles and situations - and in conse-
life, everybody is also subjected to stress because of the problems they encounter, conflicts they expect to resolve, or difficulties or dangers of various kinds with which they cannot cope. Frequently they are of a continuous, "chronic" character and then, through the activated neurophysiological mechanisms - they present a threat to health. It is hard to say whether it is men or women who are more affected by stress, also because it is usually triggered by different stress factors. Stress in men is more often attributed to "management factors" - the necessity to shoulder responsibility, rapidity of decisions, and solution of conflictual problems. Of course, women may also experience such situations, but it happens less often.

Recently in Poland attention has been drawn to stress linked to unemployment and poverty - and this kind of stress affects both sexes, even though the direct source of perceived threats may be slightly different. Stress linked to unemployment disturbs more strongly the functioning of the man - because activity in the outside sphere, away from the family, allows him to define his role and identity assigned to him. The situation of being the only breadwinner may also be stressful, which makes the whole family's material conditions depend on the husband's financial success. On the other hand, however, in families with tight budgets it is the women who have to make difficult daily decisions concerning the management of limited resources and making the proverbial ends meet. In the situation of poverty, stresses which women are subjected to may be defined as issuing from "managing" the familial poverty [37]. In the case of women doing professional work, the stressful factor may be the inadequacy of salary (women's lower salaries in comparison with those of men in similar jobs) and the unprecipitated, devoid of gratification housework. There are studies [16], which consider this situation to be the cause of more frequent cases of depression in women than in men. They treat certain forms of depression as a medicalized social phenomenon. Women succumb to depression more often because they harbor guilt to do so. These are the guilt feelings mainly linked to the adverse setup of social roles and the structure of chances in the society.

Other researchers [34] trying to look at the problem of depression from a socio-cultural perspective point out that it is rather a set of social expectations and not the roles themselves that are conducive to depression. These expectations, stemming from patriarchal culture, combine such features as readiness to subject oneself, dependency, obedience, external direction, suppression of negative emotions. In this model there is little room for fulfilling one's own aspirations and desires, or self-accomplishment; women's successes are rather measured by the achievements of others - their husbands or children, for whom they should "sacrifice" themselves, according to the prevailing expectations. This situation causes numerous stresses and leads to passivity and withdrawal as well as to depending on others, even in such matters as the sense of satisfaction with life or with oneself. Keeping a low profile and subjecting one's interests to the good of others leads to a stressful sense of guilt, when one is able to reach her own goals. This thesis seems confirmed by the data on the occurrence of depression, which appears more often in housewives subjected to the influence of more traditional expectations than in working women in general.

The differences between the two sexes, substantiated by research, are linked to the ways in which men and women relieve stress [29]. Women more often than men use social support as a source of backup in difficult situations; they are more open in revealing their problems and ready to share them with their environment. Men's social support mechanisms are weaker and their alienation greater. Their emotional relations with those closest to them are as a rule looser and they are more oriented towards external goals than the ones at home and within the family. Presently it is believed that having social support and the ability to reach for it is one of the most efficient ways of dealing with stress [23]. Women's stronger role in a social group becomes stronger which makes problems and life failures lessen. Also "chemical" strategies which men and women apply to reduce tension are different. In the former case it will more often be alcohol, in the latter, sedatives [28]. It is difficult to say which of the methods is more efficient and at the same time less harmful in the longer perspective. Undoubtedly, however, these different models of reaction to stress are not without significance for the picture of their illnesses.

**Life styles chosen**
When returning to the aforementioned possibilities of shaping men's and women's health through different configurations of social and cultural factors which affect it, it is worth pointing out that a good illustration is provided by people's life styles. Their life styles are to an overwhelming degree shaped by the culture models that dominate their milieu and by the places they occupy in the social structure. Interest in the role of the life style for the factors favorable to building a health potential appeared in the West towards the end of the Seventies when longitudinal epidemiological studies, conducted independently from one another, indicated that the average length of human life depends to a higher degree on environmental factors, and particularly on the life style of the people. A new concept appeared in the literature - the "Healthy Patterns of Living" (HPL).

The research carried out enabled the identification of those life elements, which were of vital importance for maintaining health and longevity. They were: 7-8 hours of sleep per night, having breakfast daily, avoiding snacks between meals, maintaining the right weight, physical activity in leisure time, never smoking, moderate consumption of alcohol, undergoing regular checkups and doing self-checks (e.g. of breasts by women), moderate exposure to the sun, safe sex and fastening seat belts in cars. Prospective studies lasting for many years have established that regular abiding by these rules was indeed correlated with...
an average longer lifespan and that it was longer in the case of men than women [7].

Here, again one can observe discrepancies between both genders. The research conducted in Poland indicate that health related practices are more frequent among women than men [31]. As we can see, distinct differences are apparent, in the ways of eating, physical activity, patterns of rest, and in the use of substances; women observe the rules of a healthy lifestyle more rigorously than men - although its is not the rule.

The discussed differences have been presented as the result of the connection between the lifestyle and the social roles played, the different norms and stereotypes of behaviour, socialization processes as well as the conditions and type of work done. However, when considering the correlates of the society’s state of health, one has to note that gender is not the most important differentiating factor, nor are morbidity or mortality or various pro-health practices. Age, of course is of great importance (which is understandable), but a considerable role has to be ascribed to the social status enjoyed. The higher the status (and especially education) the better in principle are all parameters linked to health. Education is a kind of capital which represents better health awareness - the knowledge of health risk factors, ways of preventing them, models of health care. Affluence, on the other hand, guarantees a better possibility of putting them into use. Nevertheless, also here hierarchies of access to the realization of particular elements of life style may appear, concerning generation and sex differences.

Health inequalities and medicine

Many studies indicate differences in the use of health care by women and men. According to the study of the state of health of Poland’s population [17], women visit doctors and dentists more often, take more medicines, are a little more often hospitalized. Also every day observations make one aware that women appear more often in the role of patients. However, studies devoted to the use of health care tell us but little about the quality of the care received, apart from the general level of satisfaction from the received services. In general there is no distinct difference in their evaluation according to the two sexes. Does that mean that women and men are treated equally by medicine? Does medical science take sufficient account of the differences between men and women? This problem has been a subject of many studies in Poland, even though it increasingly rivets the attention of foreign researchers, studying the problems of health factors (i.e. conditionings) seen from the gender perspective.

For many years in medicine, problems of women’s health were identified solely with the problems of reproductive health. Thus, a woman - as a separate object of medicine’s interest - appeared in the context of menstruation, prenatal care or illnesses of the reproductive organs. Within the sphere of medicine’s interest was an undefined “patient” or “a sick person”, who was most of-

ten a man however. Symbolically it is visible in medical textbooks or atlases of anatomy in which elements of a woman’s body are present only when illustrating problems of reproductive health.

Although the situation is changing, still the specificity of women’s health is not sufficiently present in research or in medical practice. Problems of women’s health are not satisfactorily taken into account in epidemiological research. For example, research carried out several times on populations of many thousands, which led to the discovery of the pattern of type A behaviour [14], was carried out exclusively on men [42], although the result of that research was generalized for both sexes. Pharmacological research, requiring the use of laboratory animals is carried out almost exclusively on males (the exception being tests of medicines linked to reproduction and so-called women’s diseases), even though, as in the previously mentioned case, the results are then generalized for both sexes [26]. Several health problems in women (e.g. the results of long lasting taking of oral contraceptives - used only by women) do not meet with sufficient interest from doctors and are ignored in world medical research [1,4].

There is no unambiguous interpretation, either, of some of women’s health problems which makes the diagnosis and treatment more difficult. The syndrome of premenstrual disorders can be used as an example. Cyclical changes, appearing in many women, often causing them considerable discomfort, are generally treated by doctors as functions of hormonal processes taking place at that time. Treatment is based on this assumption. A strong conviction that women’s possibilities diminish in premenstrual period due to some kind of hormonal “play” leads in consequence to the perception of women as being unable to control their emotions or to carry out tasks requiring permanent responsibility. However, international epidemiological research indicates that the frequency and gravity of symptoms differ considerably in societies belonging to different cultures and may be considered typical of the highly developed countries. No systematic regularities have been discovered, either, concerning disorders of the hormonal balance in women combined with the disorders preceding menstruation [33].

It may also be suspected that men and women are treated differently in psychiatry. When one takes more frequent depressive disorders in women, visible in the statistics into consideration - they may be as much the effect of psychopathological differences and differences in the social situation of men and women which we have mentioned earlier - as partly of the doctors’ more frequent, conventional diagnoses of this condition in women than in men. This may be suggested by the difference between the coefficients from epidemiological and clinical tests (these coefficients are higher in the clinical tests) [35]. It may be the result of the fact that women more often than men suspect a depression in themselves and doctors legitimize this situation.

Women and men are not treated equally by health care systems either. The existing data indicate that the same complaints can be diagnosed and treated differently in men and women. In two American NERI research projects [36], it was stated that doctors, facing identical symptoms, diagnosed them in men more often as circulatory disorders, referring their patients to a cardiologist, recommending hospitalization or more invasive methods of treatment, while women more often received psychiatric diagnoses. These results are, to a large extent, a function of epidemiological tests results, but also of some stereotypes, persisting in the medical world, concerning illnesses and the way of presenting their symptoms among men and women. Also subsequent studies, concerning other conditions, confirmed that the presentation of the same symptoms by men and women led to a different diagnosis and therapy [13].

A conviction about the role of women’s “nerves”, “hysteria” and “hypochondria” in the aetiology of the presented condition appears quite often in medical diagnoses [26].

Possibly some of the responsibility for this situation can be linked to the different way of presenting the symptoms; one of the studies devoted to the diagnosing of rheumatic conditions (with available objective proofs in the shape of x-ray pictures) showed that during an interview with the doctor women concentrated on the presentation of pain less than men [10]. Macintyre [24] received the same results when comparing the ways of presenting the symptoms of a common cold; men tended to exaggerate their symptoms considerably more often than women. However, as a result, they were treated more efficiently than women.

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<th>Table I</th>
<th>The balance of health related behavior of men and women [14,17].</th>
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<td>Health related practices that are more frequent among men</td>
<td>Physical activity</td>
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<td>Health related practices that are more frequent among men</td>
<td>Consumption of fruits and salads</td>
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<td>Risky health practices that are more frequent among men</td>
<td>Tobacco smoking</td>
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<td>Risky health practices that are more frequent among men</td>
<td>None</td>
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<tr>
<td>Health related practices that do not differentiate men and women</td>
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be made more aware of the existence of stereotypes of masculinity and femininity standards, the power held, he adequate gender, it requires levelling the inequalities. In the case of inequalities generated by the acting them requires going to their sources, the richest countries. Because the inequalities grow, despite the better general (average) inequalities in health remain and may even the society indicate, however, that social structural conditions of life. Looking for the reasons in external, structural conditions of life.

What are then the possibilities of decreasing the inequalities between men and women? One hears frequently the opinion that along with the growth of affluence and the process of Poland's reaching the health care standards in the so-called "old" EU, not only will the health and longevity indicators improve but also, automatically, as it were, inequalities in health between different segments will diminish. Detailed analyses of the data concerning the general health of the society indicate, however, that social inequalities in health remain and may even grow, despite the better general (average) indicators - and this happens even in the richest countries. Because the inequalities - as I have tried to demonstrate - exist on different levels of the society and counter-acting them requires going to their sources, which is going everywhere they appear. In the case of inequalities generated by the gender, it requires levelling the inequalities existing in the conflicts of interests, the life standards, the power held, he adequate access to health care; it also requires changes of cultural patterns and patriarchal stereotypes of masculinity and femininity which do no good to either men's or women's health. First of all, however, the society must be made more aware of the existence of these inequalities.

References

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