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How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health

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Abstract

For researchers interested in understanding men's health, there are two main literatures to harvest. The first is research on men's health arising from the study of men and masculinities. The second is the broader study of inequalities in health, including gender inequalities in health. However, these literatures have remained distinct. This paper seeks to develop a model of understanding men's health from both of these literatures. In order to achieve this integration, this paper argues that studies of men's health should be based on 'critical studies on men' which emerges from feminist theory. Critical studies on men's health is then integrated into the broader explanatory options identified in the health inequality literature in order to provide a more fulsome account of variance within men's health and between the health status of men and women. Given the amenability of men's health issues to interrogation within this resulting framework, it is argued that the inequalities literature should start to include men's health issues in its work.

Keywords: Men's health; Gender; Inequalities in health; Critical studies on men

Introduction

For researchers interested in understanding men's health, there are two obvious literatures to harvest. One is the traditional study of inequalities in health. Another is the recent explosion of studies of men's health arising from the study of men and masculinities ('men's health studies'). The literature on men and masculinities is diverse. Hearn (2004) usefully distinguishes between two types of writing on men and masculinities: men's studies and critical studies on men (CSM). Men's studies is based on an intellectual and community-based movement which seeks to re-affirm *essentialist* notions of manhood in light of the changing positions of women in the public and private sphere. Men's studies writing (for example, Bly, 1990; Faludi, 1999; Kenway, 1995; Phillips, 1999) speaks of a 'men's crisis' or 'the crisis in masculinity' because it is claimed that the natural order in gender relations has been severely threatened by women's 'misguided' attempts to transform the gender balance, resulting in men being increasingly disadvantaged in employment, education and intimate relations relative to women (Whitehead, 2002). In essence, and at the risk of over-simplification, men's studies seek to celebrate male bonding and tell men they are okay with no

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interest in promoting feminist theory or practice (Hearn, 2004).

The second approach to writing on men and masculinities is 'CSM'. CSM is the study of the gendered nature of men's lives which emerges primarily from within feminism and also gay and queer studies (for an overview see Brod & Kaufman, 1993; Kimmel, Hearn, & Connell, 2005). There are three central principles to CSM: (1) seeing gender as socially constructed; (2) challenging hegemonic masculinity; (3) challenging gender power relations. Most distinctly, the 'critical' in CSM is about prioritising the latter issue of power in gender relations. It is what Hearn (2004) describes as not just an interest in hegemonic masculinities but rather in the 'hegemony of men'. By this he means men's position of power in relation to women in society. CSM acknowledges that whilst power within and between gender relations may be complex, fluid and contradictory, it is imperative not to ignore the asymmetrical relationship between men and women and between masculinities and femininities in western societies. CSM seeks to theorise men's lives in a way which does not re-exclude women and femininities.

This paper focuses on the CSM approach (rather than the men's studies approach) within men's health studies. I seek to marry the CSM approach with the traditional inequalities in health approach, such that combining the key insights of both may lead to a more fulsome understanding of the health of men. Such an integrative explanatory framework is necessary because there is an urgent need to breathe new life into research on men's health which customarily talks of the influence of masculinities—and particularly hegemonic masculinities—on men's health behaviours but has been running into a 'masculinities road-block' for some time now. As Courtenay (2000, p. 1389) has argued, we have limited knowledge as to *why* masculinities should be related to health in the way they appear to be. I argue that we need to link theories of masculinities and health to a broader range of health inequality theories in order to elaborate the saliency and limitations of the influence of 'masculinities'—essentially a cultural theory—on men's health. I develop the debate between these two schools of thought by drawing on some key explanations in the inequalities in health literature and showing how CSM can be combined with these explanations. The argument will be illustrated inevitably in a selective way drawing from both fields of study. In particular, I have chosen to focus on three key contemporary explanations in inequalities in health as identified by Kawachi et al. (2002) and Bartley (2004): material/structural; cultural/behavioural and psychosocial explanations along with a life-course approach. I take each of these explanations/approaches in turn and suggest ways that they may be constructively combined with insights from the CSM approach so as to achieve a broader understanding of the health of men. To begin, however, I address the relationship of sex and gender in understanding men's health.

Men's health—the influence of sex and gender

Should we understand men's health—especially men's lower life expectancy in the western world and higher morbidity in relation to certain illnesses (Tsuchiya & Williams, 2005; White & Cash, 2004)—as a matter of sex or gender? The answer to this is both. Apart from some clear differences in health between men and women (notably reproductive health, (Doyal, 2001)), it is not always clear which differences in men's and women's health are the result of sex differences (what is inherent) and which are due to gender (which is socially acquired). This is for a number of reasons. Feminist research has illustrated the complex processes by which biological facts are contextually defined and therefore gendered (Martin, 1991; Oudshoorn, 1994; Sætnan, Oudshoorn, & Kirejczyk, 2000). For example, a significant body of feminist research has illustrated that biomedical research showing men's higher morbidity in relation to circulatory diseases fails to acknowledge the systematic trend of an *under*-reportage and under-diagnosis of heart disease amongst women, leading to an under-estimation of women's morbidity and mortality in this key category (Emslie et al., 2001; Lockyer & Bury, 2002; Pollard & Brin Hyatt, 1999). Thus, what is 'biological' and what is 'gender' is difficult to discern. Similarly, CSM's health research has been sceptical of a 'competing victims' approach to research which lists the various ways in which men's health is disadvantaged, relative to women's, without due consideration of the complex processes by which health statistics are gendered. According to Connell (2000, p. 182), no sex difference, or virtually no difference, is the finding of a good proportion of Australian research on health and he posits that there are probably many more nil findings that are not published because the interest lies in sex

differences. In addition, it is often claimed that small differences between some men and some women has led to erroneous aggregations in *overall* differences in men's and women's health, as well as specifically about *men's behaviours* and *men's culture* in the broader men's health literature (Connell, 2000; Robertson & Williamson, 2005; Schofield, Connell, Walker, Wood, & Butland, 2000).

A further reason why it is difficult to separate gender from biological sex is acknowledged in a revivalist interest in sociological research (and some biological research e.g. Rose, 1997) in exploring the ways in which the 'social' and 'biological' are mutually shaped, especially over time (Annandale, 2003; Birke, 2003; Fausto-Sterling, 2003; Krieger, 2003; Levine, 1995). Accordingly, to claim a biological difference is not to claim immutability. Rather, biology is seen as processual and in interaction with its external environment or 'as softly assembled states' (Fausto-Sterling, 2003, p. 127):

> [I]nstead of setting nature against nurture we reject the search for root causes and substitute a more complex analysis in which an individual's capacities emerge from a web of mutual interactions between the biological being and the social environment (Fausto-Sterling, 2003, p. 123).

Consequently, answering a question such as how do nerve cells translate externally generated information into specific growth patterns and neural circuits requires multi-disciplinary teams (Fausto-Sterling, 2003, p. 125). In summary, sex and gender are difficult to disentangle: 'we do not live as a 'gendered' person one day and a 'sexed' organism the next; we are both simultaneously' (Krieger, 2003, p. 653). Thus, the point of departure in this paper in bringing the two scholarships together is to develop understandings of men's health that take on board the biological (sex) and the social (gender) underpinnings of men's health as well as the relations between them. In the following discussion, I will identify how contemporary theories of inequalities in health are trying to 'get inside' the mutual interactions of the biological and social over time and how this debate could intersect with CSM.

Integrating theories of inequalities in health and CSM

To date, the major gap in male and female morbidity in the western world has been attributed to behavioural differences between men and women (Stanistreet, Bambra, & Scott-Samuel, 2005). In particular, studies of men's health have focused on the role of 'hegemonic masculinities'—the idealised notions of normative attitudes and behaviours of men in influencing men's health behaviours (as discussed further below, under cultural/behavioural explanation). In contrast, the inequalities literature is based upon seeing health as an outcome of the complex interplay of a range of factors associated with the circumstances under which people live out their lives. For example, a model of health developed by Dahlgreen and Whitehead for the World Health Organisation in the early 1990s, and used widely in inequalities in health research, represents the determinants of health as adjacent layers of influence, one over another (see Bejakel & Goldblatt, 2006). The model represents individuals as being endowed with age, sex and constitutional factors which influence their health potential, but which are fixed. Surrounding the individuals are layers of influence that may be potentially modified. These range from individuals' personal behaviours and ways of life to social and community influences which are formed through individuals' interactions within family, friendship and neighbourhood networks. The influence of an individual's social network also sits in relation to broader determinants of an individual's capacity to maintain health, such as living and working conditions and access to essential goods and services. The overall economic, cultural and environmental conditions prevailing in a society is located at the outermost level. The model is premised on the scientific evidence that determinants of health do not operate in isolation. Rather, they interact in complex relationships between the individual and the basic structuring of society (Bejakel & Goldblatt, 2006, p. 2). Thus, the scientific literature in inequalities in health draws together a literature which examines inequalities at a structural (community and global-level factors) as well as at an individual-level (propensity to smoke or take exercise) in a unified framework. However, there is also much debate within the inequalities literature on the relative importance of precise pathways of inequalities in health and, consequently, the most appropriate points of intervention to address inequalities in health. In order to draw out how CSM theories on men's health might link with the inequalities in health research, I am now going to look at three dominant explanatory pathways: a materialist/structural, cultural/behavioural and psychosocial along with the lifecourse

approach. For each, I address the questions: *what is the explanation?* and *how might the explanation be combined with CSM?*

Materialist/structural explanations

What is it?

The materialist explanation may be seen to operate at two of the inter-related levels of influence referred to above—the societal and individual level. At the societal level, the materialist argument, often referred to as the neo-materialist argument, suggests the need to examine how the material conditions of a society—such as investment in health and social care, education and public transport—affect the health of the population of that society. According to this argument, it is strategic investments in neo-material conditions via more equitable distribution of public and private resources that are likely to have the most impact on reducing health inequalities and improving public health in both rich and poor countries in the 21st century (Lynch et al., 2000, p. 1203). The materialist/structural explanation applied at the individual level refers to how one's access to tangible material goods and conditions (including food, housing, access to amenities, etc.) are associated with exposures that are damaging to, or protective of, health (Adamson, Ebrahim, & Hunt, 2006, p. 974). Observed inequalities in health are consistently found to be related to material factors, regardless of which measure is used. The explanation applied to understanding gender inequities in health suggests that gender health inequities are an outcome of inequalities in the socio-economic positions of men and women. Therefore, in so far as there is convergence in men's and women's material position, so too should there be convergence in men's and women's health. Indeed, studies that have specifically explored men and women with similar working, social and material circumstances show a reduction in, or absence of, gender-based morbidity (Arber & Cooper, 1999; Bartley, 2004; Emslie, Hunt, & Macintyre, 1999; Hall, 1992; Hraba, Lorenz, Lee, & Pechachova, 1996; Matthews, Manor, & Power, 1999; Schofield et al., 2000; Umberson, Chen, House, Hopkins, & Slater, 1996).

One of the key problems identified with the materialist argument within the inequalities in health literature, however, is that the identification of the precise causal pathways between lower social class or low income and health are difficult to determine (Bartley, 2004). This is particularly the case because the data shows not just a difference between those in the lower positions of the social class scale but, rather, a fine grain difference between each of the social classes—a stepwise gradient which shows an increase in ill health and premature death with each step down the social class ladder (Davey Smith, Neaton, Wentworth, Stamler, & Stamler, 1996; Davey Smith, Wentworth, Neaton, Stamler, & Stamler, 1996; Marmot, Ryff, Bumpass, Shipley, & Marks, 1997). It is difficult to tease out what exactly it is about social class or more broadly material conditions which influence health in this way. For example, Bartley notes that factors that can be clearly identified as 'material' do not seem to have much effect on health:

> There is a clear paradox here. When we look at income, social class or area of residence, those in the poorest circumstances have between 40 per cent and 150 per cent greater chances of illness and death in most studies. But when we look at hazards such as cold and damp housing, work hazards and inadequate (as opposed to 'unhealthy') diet, the effects are no where near as great (Bartley, 2004, p. 92).

This apparent contradiction can be resolved according to Davey Smith et al. (1994, pp. 139–140) through consideration of the meaning of social class because it points to the ways in which social structure leads to the clustering of advantage and disadvantage. Occupations which expose individuals to physico-chemicals are also likely to expose those individuals to psychosocial stress and to be physically arduous. Individuals who live in areas of pollution are more likely to reside in poor quality housing and more likely to eat a poor diet. Similarly, Macintyre (1997) argues that the impact of material factors can be illuminated through understanding the difference between a 'hard' and 'soft' version of the materialist argument. The hard version suggests that material, physical conditions of life associated with the class structure (principally income and wealth) are the complete explanation for class gradients in health. In contrast, the soft version suggests that the conditions of life which are determined by the class structure, and which may influence health and longevity, include psychosocial as well as physical factors and social as well as economic capital

(Macintyre, 1997, p. 728). In summary, it is argued that it is the clustering effect of material factors which appears to be important, along with the ways in which material factors interact with cultural and psychosocial factors.

How might this explanation be combined with CSM?

This explanation has been under-utilised in men's health research because, whilst socio-economic inequality between men and women can explain women's health disadvantages, it is thought that there is no *socio-economic* theory which can explain men's lower longevity in life expectancy to women (because men are recognised as the more economically and socially advantaged group) (Bird & Rieker, 1999, p. 750). The reduction in the gap in male and female life expectancy (the relative rise in male life expectancy), reported since the 1970s in advanced capitalist societies in which women show relatively high levels of emancipation, is attributed more to convergence in behaviours, such as increased smoking and drinking amongst women, which may have been encouraged by economic growth and development (Trovato & Lalu, 1996; Waldron, 1993). The materialist explanation has, however, been invoked in CSM's health research to distinguish *between* men of different socio-economic groups in relation to specific aspects of men's health, such as accessing healthcare, diet, health-damaging and health-promoting behaviours (Matheson & Summerfield, 2001; O'Brien, Hunt, & Hart, 2005; Prättäla, Karisto, & Berg, 1994; Robertson, 2006a; Roos, Prättäla, & Koski, 2001; Wilson, 1998). Looking at differences in material relations between men is important to teasing out the materialist underpinnings of diversity in men's health status, men's health behaviours and attitudes. However, comparisons with similar groups of women are usually omitted and, consequently, an analysis of the *connections* in the materialist underpinnings of men's and women's health (Sabo, 1999; Schofield et al., 2000). Research which does both—examines materialist relations between men as well as between men and women—is required around specific areas of health in order to tease out the interactions between social class and gender in men's and women's health.

A further way of opening up the debate between inequalities in health and CSM's health is to think of the materialist/structural argument as representing the symbolic power of men over women in society. The hegemony of men, in Hearn's (2004) terms, or masculine domination, in Bourdieu's (2001) terms, includes the symbolic power of masculinity over femininity as well as issues such as wealth and income. The symbolic power of men also fits with the aforementioned materialist/structural definition as including social as well as economic capital. In CSM's health (see in particular, Connell, 2000; Sabo, 1999; Schofield et al., 2000), there is an acknowledgement that it is this very power asymmetry in gender relations which is the underlying motivation for much of men's negative health attitudes and behaviours. As Courtenay (2000, p. 1833) notes, it is the very pursuit of this power and privilege which often leads men to harm themselves due to the fact that it is the very social practices which undermine men's health (assuming their physical and mental health to be strong and invulnerable) that also facilitate men to demonstrate manliness and acquire power in sexist and gender dichotomous societies. Locating the symbolic power of masculinity over femininity as a materialist argument also introduces the interaction between the materialist and cultural/behavioural explanations which will be elaborated below.

Finally, at the neo-materialist level, gender inequality at a population level is associated with gender *health* inequality at a population level. For example, at the state level in the US, women are shown to experience higher levels of morbidity and mortality in those states in which they have less economic and political autonomy (Kawachi, Kennedy, Gupta, & Prothrow-Smith, 1999). Stanistreet et al. (2005, p. 874) show how another measure of patriarchy (female homicide) is related to men's poorer health across a number of nations and have suggested that oppression and exploitation harm the oppressors as well as those they oppress. The neo-materialist argument is an important perspective on men's health. It can shed further light on the inter-relationship between hegemonic cultural practices—for example, working long hours, working overtime and the low take up of paternity leave amongst men—with the institutionalised practices of workplaces and nation states that reinforce different roles for men and women. These gender relations are lived out as general body practices, some of which produce illness, disability and premature morbidity (Schofield et al., 2000, p. 252).

Cultural/behavioural explanations

What is it?

This explanation suggests that health inequalities are an outcome of differing cultural attitudes to health and related health behaviours. There are two different models of this explanation—as Macintyre (1997) suggests, a 'hard' and 'soft' version. The hard version suggests that health-damaging behaviours freely chosen by individuals in different social classes *explain away* social gradients', whilst the soft version suggests that health-damaging behaviours are differentially distributed across social classes and *contribute to* observed gradients (Macintyre (1997, p. 727). The hard version owes its origin to the discipline of epidemiology and its concern with the identification of risk factors—most notably unhealthy behaviours and aspects of poor lifestyle management—associated with particular diseases. It suggests that addressing poor health behaviours is 'the most effective way' to prevent disease (Courtenay, 2000). The soft version owes its origin to the broader research on inequalities in health and is linked to the materialist/structural explanation which critiques the notion that one can separate individuals' lifestyle choices from individuals' social/cultural and economic milieu. The inequalities in health scholarship argues instead that the empirical focus should be on the context of people's lives which may provide the 'contextualised rationality' (Williams, 2003) of healthy or unhealthy behavioural patterns (for a review see Lynch, Kaplan, & Salonen, 1997).

The soft version of the behavioural/cultural explanation also differs from the materialist/structural explanations outlined above in that it tries to shift the emphasis from income and wealth towards attitudes, values and beliefs, and normative behaviours. However, getting inside the role of culture on health is complex. For example, there is no straightforward connection between attitudes to health and *actual* health behaviours (Bartley, 2004). In Blaxter's (1990) study of lifestyles and health, the strongest anti-smoking views were held by men who smoked. In addition, the inequalities in health literature challenges the idea that cultures (for example, ethnic, feminine, masculine, working class) are universal and unchanging. Consequently, even though we might assume that cultural processes may be in some way implicated in health outcomes, we cannot assume they will be the same for every member of that cultural group or that cultural norms do not vary in relation to other material and environmental factors.

How might this explanation be combined with CSM?

CSM could be usefully combined with the more sociologically/culturally informed version of the cultural/behavioural explanation. Research on men's health has consistently drawn a link between a pattern of men's poor health behaviours (such as adoption of high health risk activities and a reluctance to seek general health and medical advice) and hegemonic cultural constructs of masculinities frequently defined in terms of male stoicism and masculine invincibility (for example, Courtenay, 2000; Moynihan, 1998; O'Brien et al., 2005; Robertson, 2003; White, 2001). On the one hand, studies of men's health need to be able to acknowledge, where necessary, the relative stability of cultural notions of masculinity on men's health. On the other hand, they need to avoid essentialising characteristics, such as risk adversity, aggression and competitiveness as 'masculine' or endemic in masculine culture. CSM's health can contribute to the more sociologically informed—or 'soft'—version of the cultural behavioural explanation in inequalities in health research by highlighting the relative stability of hegemonic concepts of masculinity without relying on cultural reductionism. A key mechanism within CSM for taking culture seriously but avoiding cultural reductionism is prioritising a research focus on diversity in how masculinity and health operate in daily lives between men—and by the same men in relation to different health practices—*and* by relating this diversity to the broader social and economic milieu (see, for example, O'Brien et al., 2005; Robertson, 2006a). A CSM approach equally contrasts with an approach in some health professional literature which recommends programmatic ways of dealing with men and men's health issues and, therefore, treats the category of 'men' and 'hegemonic masculinity' as stable and static cultural traits (for critical review of men and health promotion see Robertson & Williamson, 2005).

CSM's health can also be combined with cultural explanations from the broader inequalities literature by a joint growing interest in an *embodied sociology*. The approach seeks to theorise how relations

between the biological and social are experienced through our embodied being in the world (Williams & Bendelow, 1998; Williams, Birke, & Bendelow, 2003). It may be distinguished from the disembodied rational actor in a lot of positivist social science as well as postmodernist theorising (or radically social constructionist models) of the body which deny the biological reality of the body, except as an object formed through situational discourses. Connell (2002, pp. 47–52), for example, writes of *social embodiment* meaning that bodies have a certain kind of agency and materiality—require food, eat, sleep, are sexually aroused, give birth and die—but are also socially constructed through long and continuous circuits of social structures. Specifically, Bourdieu's (1979) concept of habitus is used in some inequalities in health literature (Fassin, 2000; Lynch et al., 1997) and in some CSM's health (Robertson, 2006a, b; Watson, 2000) to describe how bodies become shaped through daily unconscious practices that are nonetheless socially located and gender specific. The embodied approach opens up more complex understandings of representations of hegemonic masculinities and empirical explorations of how men's bodies are experienced by men in everyday life (Chapple & Ziebland, 2002; Klein, 1993; Oliffe, 2006; Robertson, 2006a, b; Watson, 2000).

Psychosocial explanation

What is it?

The psychosocial model places primacy on the psychological impact of adverse psychosocial exposures, such as stress, hostility, hopelessness, loss of control or, collectively, the impact of 'misery' on health (Macleod & Davey Smith, 2003, p. 565). This explanation is also relevant at both the individual and societal or context level. At the individual level, the explanation purports that stressful social circumstances associated with lower levels of power and social support in the home, the work place or society at large, produce emotional responses which, in turn, bring about biological changes (for example, an impaired capacity for fibrinolysis) which may increase the risk of disease (for over-review see Adamson et al., 2006; Bartley, 2004). At the societal or contextual level, a major recent hypothesis is derived from the alleged psycho-social effect of the unequal incomes theory (Kawachi, Kennedy, & Wilkinson, 1999; Wilkinson, 1996, 1997). In particular, Wilkinson (1997) and Kawachi et al. (1999) have argued that income inequality in societies can create psychosocial reactions which change people's vision of self-esteem and forms of social cohesion or trust (measured in terms of social networks/social involvement) in society. They propose that this, in turn, leads to poorer health via psycho-neuro-endocrine mechanisms, as well as through unhealthy coping behaviours, such as excessive drinking and smoking.

However, the field of research—and specifically the unequal incomes thesis—is reported to be at a 'cross-roads' (Lynch & Davey-Smith, 2002; Lynch et al., 2004; Pearce & Davey Smith, 2003), with evidence for a correlation between population-level income inequality and the health of the population slowly dissipating (Mackenbach, 2002, p. 2). In a recent major review of studies on income inequality and health, Lynch et al. (2004) concluded that there is some evidence to support the thesis at the state level in the United States but not as a generalisable determinant of health in western developed countries. More broadly in relation to the psychosocial thesis, some authors (notably, Adamson et al., 2006; Lynch et al., 2004, 2001; Macleod & Davey Smith, 2003; Shaw, Dorling, Gordon, & Davey-Smith, 1999), whilst acknowledging that 'misery' and poverty may be inter-related, have contested the primacy of the *psychological* aetiological pathway implied in the psycho-social explanation, instead asserting that health differences are primarily related to the *lifetime* material well-being of social groups, including factors such as access to good-quality accommodation, diet and leisure pursuits, and not to the *psychological* effects of positions within hierarchies.

How might this explanation be combined with CSM?

The debate on the potential impact of psychosocial pathways on health is one of the most controversial debates in inequalities in health research. However, the ways in which psychosocial pathways may be gendered and, particularly, the way masculinities are implicated in these psychosocial pathways is neglected. At the individual level, the psychosocial hypothesis may be usefully combined with theories of protest masculinity from CSM (Connell, 1995). The combined explanation applied to men's health would propose that the effect on men of being economically and socially unequal (to other men especially, but possibly also

to some women) generates psychological feelings of poor self-esteem related to inequality which can itself be directly health damaging. Further, feelings of economic and social inequality may lead some men to engage in extreme macho behaviours in order to regain social status through appealing to hierarchies of masculinity rather than hierarchies of social class (see Canaan, 1996; O'Brien et al., 2005). The added value to men's health research of incorporating the psychosocial explanation is to look at the psychosocial effects of positions in hierarchies (class, gender, ethnic) simultaneously, such that the impact of masculinities may be seen in relation to class and ethnicity. In addition, it is to theorise some men's 'negative health behaviours' as a form of agency to overcome other types of inequalities which may also account for the relative obduracy of negative health behaviours amongst some groups of men.

A lifecourse approach to understanding inequalities in health

What is it?

A lifecourse approach to understanding inequalities in health is not necessarily a *different* explanation to those already discussed. Rather, a lifecourse approach incorporates elements of the materialist, behavioural and psychosocial pathways but lengthens the causal chain of these explanations. The lifecourse explanation suggests that health status at any given age for a given birth cohort reflects not only contemporary conditions but embodiment of prior life conditions from *in utero* onwards (Kawachi, Subramanian, & Almeida-Filho, 2002, p. 650). Furthermore, according to Ben-Shlomo and Kuh (2002, p. 285), the lifecourse approach is not simply about the collection of data cross the lifecourse but rather about understanding the temporal ordering of exposure variables and their inter-relationships. The lifecourse approach incorporates a range of conceptual models to capture these temporal relationships. The three models commonly identified are: critical period models, pathway models and accumulation models. The models may be seen as being broadly complementary in that all three models direct attention to biographies of disadvantage (Graham, 2002, p. 2008). A *critical period model* (also known as latent effects or latency model (Ben-Shlomo & Kuh, 2002; Kawachi et al., 2002)) suggests that diseases which make a greater contribution to the socio-economic gradient in health have their origins in critical periods of development. Critical period models tend to focus on the contribution of early life adversity, highlighting embryonic, infant and childhood periods (such as Barker's foetal programming hypothesis (Barker, 1998)) as major influences on disease risk in adulthood (Graham, 2002, p. 2008). The *pathway model* focuses on how early life environment sets individuals onto life trajectories which have implications for health (for example, how childhood disadvantage may restrict educational opportunities which may in turn restrict employment opportunities and health-related behaviours in later life). The *accumulation* or cumulative effects model suggests that the intensity or duration of exposure to unfavourable environments at different life stages has a cumulative or 'chain' adverse effect on health. According to this model, poor circumstances throughout life confer the greatest risk of poor health in adulthood (Graham, 2002, p. 2008). For example, many of the studies in this field have shown that it is the cumulative effect over time of low income in combination with other indicators of poverty such as, low birth weight, poor educational attainment and poor employment conditions that accounts for inequalities in health (see Graham, 2002; Lynch et al., 2001; Shaw et al., 1999). However, according to this model also, poor circumstances at one stage in life can be mitigated by better circumstances earlier or later in life (Graham, 2002, p. 2008).

How might this explanation be combined with CSM?

Again, there is potential for a useful synergy between this research and CSM's health. The longitudinal databases of men's and women's lives and health (e.g. the British birth cohort studies) are based on following up men and women at different age points. These could be supplemented with qualitative research which could contribute to a deeper understanding of the gendered effect on health of *key events/milestones* (or period effects) in men's lives—such as, transition to adolescence and transitioning out of school, becoming a parent and the onset of retirement—which the analysis of the age points might not capture. There has been quite a large body of work, going back some time, on differences in women's health in relation to what might be called points in the lifecourse; for example, differences in women's health in relation to marital

status, age of children, movement in and out of the labour force (for overview of this research see Arber & Cooper, 2000; Bartley, 2004, chapter 9). By contrast there has been comparatively little qualitative research identifying how key life moments/transition points may impact on men's health and well-being either in a positive or a negative way (for some exceptions, see Bartlett, 2004; Ferketich & Mercer, 1989; Robertson, 2003; Watson, 2000). In addition, there is a need to take an explicit lifecourse approach to this work. The lifecourse approach suggests that there is a need to conduct longitudinal panel studies in qualitative research which could look in greater depth at the contextualised *cumulative* effect of these events/milestones on gendered health patterns. One such research design may involve researching parental accounts of foetal and child health initially, until consent may be obtained to interview/collect diaries from young boys and adults at regular intervals throughout their lives. In particular, the lifecourse approach could strengthen CSM's specific focus on understanding masculinities and health by exploring the ways cultural constructions of hegemonic masculinity are subject to change over time. In research on African men's health, in particular, there has been a welcome attempt to unravel the antecedents of contemporary masculinities, in the historical gendered cultural politics through which they have been produced and to study their impact on men's health, especially men's sexual health behaviours in the context of HIV/AIDS (Hunter, 2005; Simpson, 2005).

Conclusion

Current understanding of men's health stands apart from inequalities in health research. This paper has sought to develop some intellectual cohesion between research on men, masculinities and health and the broader inequalities in health literature. I have argued that making this link relies first and foremost on a keener reading of CSM rather than *men's studies*. CSM is the more sociologically and feminist grounded wing of the men and masculinities literature and can, therefore, be more easily forged with the duality of structure and agency, which is a feature of the explanatory models of inequalities in health research.

The discussion has mapped out the ways in which CSM may be incorporated into inequalities in health explanatory framework in order to more fully explain men's health. I have looked at each of the primary explanations in the inequalities in health literature separately for the sake of conceptual clarity, but my ambition has also been to show the linkages, and particularly how these linkages may be applied more fully in men's health research. The vast majority of men's health research has heretofore drawn heavily on the concept of hegemonic masculinities to explain men's health status and health behaviours. Whilst this is a useful and plausible explanation, the purpose of this paper has been to show how this largely cultural/behavioural explanation can be situated in a wider explanatory framework derived from inequalities in health. The paper has suggested the need to study concurrently the impact of materialist/structural, cultural/behavioural, psychosocial explanations and a lifecourse approach in understanding men's health. The implication of this paper is that future studies of men's health as well as health promotion interventions for men should take on board the wider range of health determinant variables that are made possible by drawing from a combined explanatory framework of CSM's health and inequalities in health. Conversely, given the amenability of men's health issues to interrogation within this resulting framework, the inequalities literature should start to include men's health issues in its work.

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