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Feminist perspective on healthcare: A critical analysis of power dynamics

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Abstract
This paper presents a critical examination of healthcare through a feminist perspective, focusing on the ways in which power dynamics, social hierarchies, and gendered norms shape access, experiences, and outcomes in health systems. It emphasizes that healthcare is not neutral but is embedded within broader social, cultural, and institutional structures that produce and perpetuate inequalities. By reviewing existing literature, the study explores how gender intersects with other social identities such as disability, ethnicity, and socioeconomic status, influencing both patient experiences and professional roles within healthcare. The analysis highlights that men and women, as well as marginalized groups, navigate health systems differently due to socially constructed expectations and systemic barriers. The paper also critiques traditional biomedical and policy frameworks, which often focus narrowly on clinical aspects and fail to address the social determinants of health. It underscores the importance of inclusive, intersectional, and context-sensitive approaches that recognize diverse identities, challenge normative assumptions, and promote participatory care models. Furthermore, the study points to the ways in which professional hierarchies and institutional power relations affect healthcare delivery and workplace equity, revealing the need for structural reforms to foster fairness and responsiveness. Finally, the paper suggests future directions for research and practice, including the development of feminist-informed interventions, longitudinal studies on gender-sensitive policies, and integration of intersectional approaches in health program design and training. Overall, the study provides a conceptual framework for understanding healthcare as a socially and politically embedded system and offers insights for creating more equitable, inclusive, and just health practices.

Keywords: Feminist perspective, healthcare inequalities, intersectionality, gendered power dynamics

Introduction

Healthcare systems are often perceived as spaces of care, healing, and equality. Yet, from a feminist perspective, they are also sites of deeply embedded power dynamics that reflect and reproduce broader social hierarchies based on gender, class, race, and disability. The feminist critique of healthcare challenges the neutrality of medical practices, policies, and institutions, arguing that these are shaped by patriarchal and capitalist structures that privilege certain bodies and identities over others. Within this context, feminist scholars highlight the intersection of gender with other axes of oppression such as disability, sexuality, ethnicity, and occupation, emphasizing how these intersections define individuals' access to care, their treatment within medical systems, and their roles as both providers and receivers of healthcare.

The gendered nature of care work and health institutions continues to influence both patients' experiences and professionals' identities. Lotan (2019) [22] explored how female nurses construct their professional identity through hierarchical relationships with physicians, revealing how gendered subordination persists within healthcare organizations. This mirrors the broader patriarchal dynamics where women, despite being central to the delivery of care, remain marginalized in decision-making and leadership. Similarly, Giesbrecht *et al*. (2016) [14] examined men's caregiving experiences for family members with chronic illnesses, demonstrating how masculinity is negotiated in traditionally feminized spaces of care. These studies reveal how gender norms dictate expectations of caregiving, emotional expression, and professional identity, reinforcing the unequal distribution of power within healthcare.

Feminist scholarship also interrogates the intersection of gender and disability in healthcare contexts. Abbott *et al*. (2019) [1] and Rice *et al*. (2015, 2018) [28, 29] provided critical insights into how disabled individuals, particularly men, navigate gendered expectations of strength and independence while managing chronic conditions. Their research exposes the social construction of bodies deemed "unruly" or "deviant," illustrating how medical institutions regulate and marginalize those that fall outside normative ideals. Through projects like *Re•Vision*, Rice and colleagues (2015) [28] offered representational interventions that challenge ableist and gendered stereotypes, proposing more inclusive pedagogical and representational practices. These works

emphasize that healthcare is not only about biological well-being but also about the sociocultural recognition of diverse bodies and identities.

At the global and structural level, feminist perspectives illuminate how health inequities are produced by social, economic, and political forces. Shannon *et al*. (2017) [33] applied a structural violence framework to understand gender and health inequities in the Peruvian Amazon, highlighting how intersectional factors—such as poverty, ethnicity, and colonial legacies—shape women's access to healthcare. Likewise, Storeng *et al*. (2019) [35] revealed how international NGOs influence reproductive health policy in Malawi and South Sudan, showing how global power relations and donor-driven agendas can undermine local agency and women's reproductive rights. These studies collectively underscore that feminist health analysis must go beyond individual experiences to critique the global governance of health and the neoliberal politics that commodify care.

The politics of disclosure and control also emerge as central feminist concerns in mental and reproductive health. Trevillion *et al*. (2014) [38] synthesized qualitative studies on disclosure of domestic violence in mental health settings, revealing how institutional cultures of silence, stigma, and fear often prevent survivors from seeking help. Feld *et al*. (2019) [11] similarly discussed how women in low-resource settings navigate pregnancy intentions within restrictive sociocultural contexts, exposing the limits of reproductive autonomy. Both studies foreground the need for trauma-informed, gender-sensitive healthcare systems that center women's voices and lived experiences.

Feminist analyses further critique the medicalization of social issues and the ways emotional and political expressions are pathologized. Degerman (2019) [8] explored how "Brexit anxiety" was framed within medical discourse, illustrating the depoliticization of dissent and the therapeutic governance of emotions. Salmenniemi (2019) [30] extended this critique through the concept of "therapeutic politics," where individual healing practices are co-opted into neoliberal agendas that deflect attention from structural inequalities. These perspectives resonate with Johnson and Lindquist's (2020) [18] study on migrant care and control, which shows how care regimes are intertwined with power, surveillance, and labor exploitation across transnational spaces.

Feminist engagement with health research and intervention design emphasizes collaboration, ethics, and reflexivity. Yassi *et al*. (2014) [41] highlighted lessons from a South African–Canadian health partnership, underscoring the importance of equity and mutual learning in global health research. Fraser (2019) [13] reinforced this approach by advocating for the inclusion of social institutions and civil society in the domestic implementation of human rights frameworks, moving beyond state-centric models. Together, these studies demonstrate that feminist perspectives not only expose inequalities but also propose transformative pathways grounded in justice, participation, and care ethics.

In essence, the feminist perspective on healthcare reveals how power circulates through everyday interactions, institutional structures, and transnational policies. By centering marginalized voices—whether of disabled individuals, women in low-resource communities, or caregivers negotiating gender norms—feminist scholarship disrupts the taken-for-granted neutrality of medicine and policy. It invites a reimagining of healthcare as a space of empowerment, solidarity, and social transformation, where care is both a political act and a collective responsibility.

Review of Literature

Feminist theories have significantly shaped contemporary understandings of health, healthcare systems, and social inequalities by challenging traditional biomedical models and emphasizing the interplay between gender, power, and social structures. From a feminist perspective, healthcare is not merely a neutral site of healing but a social arena where inequalities are both reproduced and contested. Feminist scholarship highlights how gender intersects with other axes of identity such as disability, race, socioeconomic status, and sexuality, influencing access to care, health outcomes, and experiences within healthcare institutions. The feminist critique underscores that healthcare practices and policies are deeply embedded in patriarchal and neoliberal structures, which shape who has authority, who receives care, and how care is delivered and valued.

Abbott *et al*. (2019) [1] examined how disabled men with muscular dystrophy negotiate gender, revealing the tensions between societal expectations of masculinity and lived experiences of chronic illness. Their work highlights how healthcare systems and social discourses often impose normative expectations of strength, independence, and productivity, which marginalize those whose bodies do not conform. Similarly, Giesbrecht *et al*. (2016) [14] explored the caregiving roles of men looking after family members with multiple chronic conditions, illustrating how caregiving—a task traditionally feminized—is negotiated by men within the context of masculine identities. These studies collectively demonstrate that caregiving, health management, and professional roles are all shaped by gendered norms, which influence both patient and provider experiences in complex ways.

Jewkes *et al*. (2015) [17] further expand this discussion through the concept of hegemonic masculinity, combining theory and practice in gender interventions, and showing how societal expectations of masculinity affect men's

engagement with health behaviors and services. The implications of these findings extend to the design of interventions that consider gendered socialization, emotional labor, and access to support systems in promoting health equity. Feminist perspectives also illuminate the intersection of disability and gender in health contexts.

Rice *et al*. (2015, 2018) [28, 29] through Project ReVision and related pedagogical work, examined how "unruly bodies"—those that deviate from socially constructed norms—are represented, regulated, and marginalized within healthcare and educational settings. Their research highlights the importance of inclusive representations, which not only challenge ableist and gendered stereotypes but also provide strategies for empowering marginalized populations. Through the lens of intersectionality, Shannon *et al*. (2017) [33] investigated gender and health inequities in the Peruvian Amazon using a structural violence framework, demonstrating how health disparities are produced by overlapping structural factors including poverty, ethnicity, and historical colonial legacies. This approach underscores the importance of examining healthcare not only at the individual level but also in relation to broader socio-political and economic structures that shape access, treatment, and outcomes.

Dean *et al*. (2017) [7] similarly applied an intersectional framework to study disabled women's sexual and reproductive health and rights in Gujarat, India, revealing how cultural norms, systemic barriers, and social stigma intersect to restrict autonomy and access to care. These intersectional analyses emphasize that health interventions must account for multiple, overlapping identities and structural constraints to achieve meaningful equity. Feminist critiques of traditional biomedical models point to the reductionist focus on biological differences between men and women while often neglecting social determinants of health.

Annandale *et al*. (2018) [2] theorized women's health by exploring the "gender-biology nexus," arguing that biological processes are inseparable from social, economic, and political conditions. Such critiques stress that health disparities are not solely the result of biological differences but are co-constructed through socially mediated processes including discrimination, occupational inequality, and access to resources. These arguments align with broader critiques of gendered medicalization, where social phenomena such as emotional distress or political dissent are pathologized. Degerman (2019) [8] examined the medicalization of Brexit-related anxiety, demonstrating how political dissent can be reframed as an individual mental health issue, thereby depoliticizing structural and social concerns. Salmenniemi (2019) [30] extended this critique in the context of "therapeutic politics," where individual healing practices are co-opted into neoliberal agendas that obscure structural inequalities, illustrating how health discourse can function as a site of governance and social control. Feminist perspectives also interrogate the legal and policy dimensions of healthcare. Fraser (2019) [13] emphasized the role of social institutions beyond the state in implementing international human rights law domestically, advocating for frameworks that include civil society in health-related decision-making.

Mohapatra (2019) argued that feminist legal theory offers critical insights into health law, applying frameworks such as relational autonomy, intersectionality, and vulnerability theory to highlight inequities in access, choice, and quality of care. These legal and policy analyses reinforce the argument that healthcare is inseparable from broader social, political, and economic systems, and that feminist approaches are essential for identifying and rectifying structural inequities. The experiences of healthcare workers themselves are also shaped by gendered hierarchies and institutional power relations. Lotan (2019) [22] examined female nurses' professional identities, showing how interactions with physicians perpetuate gendered subordination within healthcare settings. Similarly,

Cottingham (2017) [5] explored masculine emotion practices among male nurses, highlighting the complex negotiation of gender norms within a feminized profession. These studies demonstrate that both patients and providers navigate gendered expectations that influence professional identity, emotional labor, and care practices. Global health interventions have also been critiqued from feminist perspectives for reinforcing inequitable power dynamics. Yassi *et al*. (2014) [41] highlighted lessons from a South African–Canadian partnership aimed at improving health workers' conditions, stressing the importance of equity, reflexivity, and collaboration in intervention design.

Storeng *et al*. (2019) [35] explored how international NGOs influence reproductive health policies in Malawi and South Sudan, illustrating how donor-driven agendas can undermine local autonomy and reinforce global hierarchies. These cases underscore the need for feminist-informed approaches that center local voices, promote agency, and critically assess power relations in global health initiatives. Reproductive and mental health domains provide further examples of how feminist perspectives illuminate inequities.

Trevillion *et al*. (2014) [38] conducted a meta-synthesis on disclosure of domestic violence in mental health settings, revealing institutional barriers that prevent survivors from accessing care. Feld *et al*. (2019) [11] explored pregnancy intentions in low-resource Ecuadorian communities, highlighting constraints on reproductive autonomy due to sociocultural and economic factors. Sen *et al*. (2018) examined drivers of disrespect and abuse in obstetric care, demonstrating that systemic inequities are embedded in care practices and social norms, which affect patient dignity and outcomes. These studies collectively highlight the importance of trauma-informed, gender-sensitive healthcare systems that prioritize equity, safety, and autonomy. Feminist scholarship also

addresses the ethics of biomedical research and innovation. Thompson (2018) [36] discussed ethical considerations in gene drive research, emphasizing the need for governance frameworks that account for social, ethical, and ecological implications.

Schicktanz (2018) [31] explored genetic risk and responsibility, underscoring the complex relationship between scientific knowledge, individual agency, and social expectations. Merleau-Ponty *et al*. (2018) [25] traced the transnational reproduction of human embryonic stem cell lines, revealing ethical, legal, and social complexities in biomedical research. These works exemplify how feminist approaches insist on integrating social justice, ethical reflexivity, and stakeholder engagement into scientific and health research. Community-based and educational interventions have also been informed by feminist thought. Maber (2016) [24] and Narayanaswamy (2016) [26] examined how feminist activism and professionalization influence participation and knowledge production, demonstrating that community education can serve as a tool for empowerment and health literacy. Radicioni and Weicht (2018) [27] explored caring spaces that challenge normative expectations, offering strategies for inclusive and supportive health environments.

Wiklund *et al*. (2018) [40] analyzed young women's health experiences in marginalized communities, highlighting how respectability and social positioning shape health behaviors and access. These studies illustrate the potential for feminist-informed pedagogy and community engagement to transform health practices and environments. The intersection of health, migration, and labor also reveals gendered inequities. Johnson and Lindquist (2020) [18] studied care and control in Asian migrations, showing how transnational care arrangements are entangled with surveillance, labor exploitation, and gendered expectations. Ip (2017) examined rural migrant women in Shanghai's beauty parlors, emphasizing affective labor and the negotiation of singlehood, autonomy, and social norms.

Vrăbiescu and Kalir (2018) [39] explored auxiliary assistance for Roma migrant women in Spain, demonstrating how well-intentioned support can inadvertently compound marginalization. These studies collectively highlight the necessity of intersectional analyses that account for labor, migration, and social hierarchies in health research. Historical and social movements have also shaped feminist approaches to health. Crook (2018) [6] traced grassroots activism and therapy in the women's liberation movement, demonstrating the role of collective action in promoting mental health, empowerment, and community participation. Archer (2018) [3] examined working-class narratives in Belgrade, revealing the role of social memory in shaping health perceptions and experiences.

Lilja (2017) [21] highlighted embodied resistance and public assemblies as forms of health-related political action, demonstrating the inseparability of social justice and well-being. Taken together, these historical and social perspectives underscore that feminist approaches to health are not only analytical but also transformative, linking scholarship, activism, and practice. In sum, feminist perspectives on healthcare offer comprehensive frameworks for understanding and addressing health inequalities, power dynamics, and social justice. By integrating critiques of biomedical models, intersectional analyses, legal and policy perspectives, global health ethics, and community-based interventions, feminist scholarship illuminates how healthcare is deeply enmeshed with gendered, social, and structural forces.

This body of literature demonstrates that health inequities cannot be addressed solely through clinical interventions; instead, they require attention to social determinants, power relations, and inclusive practices that empower marginalized populations. By centering the experiences of women, disabled individuals, migrants, and other marginalized groups, feminist scholarship provides pathways for more equitable, ethical, and socially responsive healthcare systems that challenge existing hierarchies and promote transformative social change.

Methodology

This study adopts a qualitative theoretical approach to examine the feminist perspective on healthcare, particularly focusing on power dynamics, gendered experiences, and structural inequities. As a theory-based paper, it does not involve primary data collection or empirical analysis but relies on an extensive review and synthesis of existing literature to develop conceptual insights. The research methodology is therefore centered on a critical review of scholarly publications, including peer-reviewed journal articles, books, and policy documents, to explore how feminist theories illuminate inequalities in healthcare systems, the negotiation of gendered roles, and the impact of social structures on access to care (Shannon *et al*., 2017; Abbott *et al*., 2019; Giesbrecht *et al*., 2016) [1, 14, 33].

The study employs an interpretive framework to understand the intersection of gender, disability, caregiving, and social determinants of health. The literature is analyzed thematically, focusing on recurring patterns, concepts, and debates within feminist health scholarship. Key themes include gendered caregiving, intersectionality and structural violence, critiques of biomedical models, feminist legal perspectives, and the influence of global and local health policies. The methodology emphasizes reflexivity and critical engagement, ensuring that the

discussion is grounded in feminist epistemologies that challenge traditional assumptions about neutrality, objectivity, and power in healthcare (Lotan, 2019; Dean *et al*., 2017) [7, 22].

Objectives of the Study

- To examine how feminist perspectives explain power dynamics and gendered inequalities within healthcare systems.
- To explore the intersectionality of gender, disability, and other social identities in shaping access to and experiences of healthcare.
- To critically assess feminist critiques of biomedical and policy frameworks in healthcare.
- To identify theoretical insights from feminist literature that inform inclusive, equitable, and socially responsive health practices.

By employing a theory-based, literature-driven methodology, this study contributes to a deeper conceptual understanding of feminist health scholarship and provides a foundation for future empirical research aimed at addressing healthcare inequalities (Rice *et al*., 2015; Trevillion *et al*., 2014) [28, 38].

Discussion

Feminist perspectives provide a critical lens to examine the complexities of healthcare systems, highlighting how gendered power dynamics shape both access to care and experiences within medical institutions. The first objective of this study—understanding power dynamics and gendered inequalities—reveals that healthcare is not a neutral domain but one deeply influenced by social norms, hierarchical structures, and institutionalized gender roles. Abbott *et al*. (2019) [1] demonstrate how disabled men with muscular dystrophy negotiate masculinity within health contexts, reflecting broader societal expectations of strength and independence that often marginalize those who do not conform. Similarly, Jewkes *et al*. (2015) [17] argue that hegemonic masculinity shapes men's engagement with health services, influencing both their willingness to seek care and the types of care considered appropriate. These insights underscore that gendered expectations affect both patients and healthcare providers, shaping professional interactions, caregiving responsibilities, and treatment practices.

The second objective—exploring intersectionality and social identities—highlights how overlapping forms of marginalization impact health outcomes. Shannon *et al*. (2017) [33] use a structural violence framework to show how ethnicity, poverty, and gender intersect to produce inequities in healthcare access in the Peruvian Amazon. Dean *et al*. (2017) [7] similarly explore how disabled women in India face barriers to sexual and reproductive health due to cultural norms, systemic discrimination, and limited agency. Intersectional analyses reveal that health inequities cannot be fully understood through singular categories like gender or disability alone; instead, multiple, interacting social determinants must be considered. This perspective is essential for designing health interventions that are inclusive, equitable, and responsive to diverse populations.

The third objective—critically assessing feminist critiques of biomedical and policy frameworks—shows that traditional medical models often neglect social determinants of health. Annandale *et al*. (2018) [2] highlight the "gender-biology nexus," emphasizing that biological processes cannot be separated from social, economic, and political contexts. Feminist critiques also extend to global health interventions, as Yassi *et al*. (2014) [41] and Storeng *et al*. (2019) [35] note that externally driven programs can reinforce hierarchies and marginalize local voices if gender and power are not explicitly addressed. Furthermore, Trevillion *et al*. (2014) [38] show that mental health services often fail to support survivors of domestic violence adequately, reflecting systemic inequities in care provision.

Finally, the fourth objective—identifying theoretical insights for inclusive health practices—highlights the practical implications of feminist scholarship. Rice *et al*. (2015, 2018) [28, 29] emphasize the need for inclusive representations and pedagogical approaches that challenge normative assumptions about bodies, abilities, and gender roles. Lotan (2019) [22] and Cottingham (2017) [5] demonstrate how professional identities are shaped by gendered hierarchies, suggesting that institutional reforms are needed to create equitable work environments and improve care quality. Overall, feminist perspectives reveal that addressing healthcare inequalities requires a multifaceted approach that incorporates intersectionality, critiques of biomedical norms, and structural reforms to ensure socially responsive, inclusive, and just healthcare systems.

Major Findings

1. **Healthcare is deeply gendered:** Feminist scholarship highlights that healthcare systems are not neutral; they reproduce societal norms and expectations about gender. Men and women experience care differently, influenced by socially constructed roles, such as masculinity shaping men's reluctance to seek help (Abbott *et al*., 2019; Jewkes *et al*., 2015) [1, 17].

2. **Intersectionality amplifies health inequities:** Multiple overlapping social identities—such as gender, disability, ethnicity, and socioeconomic status—interact to create unique barriers to healthcare access and quality. Disabled women, ethnic minorities, and marginalized populations face compounded disadvantages (Dean *et al*., 2017; Shannon *et al*., 2017) [7, 33].
3. **Caregiving roles are socially negotiated:** Gendered expectations influence who provides care and how it is performed. Men engaging in caregiving often negotiate their masculinity, while women may face undervaluation of their labor. These dynamics affect both patient support and health outcomes (Giesbrecht *et al*., 2016; Cottingham, 2017) [5, 14].

4. **Biomedical models often neglect social determinants:** Traditional healthcare approaches focus on biological or clinical aspects while ignoring structural and social factors that shape health. Feminist critiques emphasize that social, cultural, and economic conditions are crucial in understanding health inequalities (Annandale *et al*., 2018; Trevillion *et al*., 2014) [2, 38].

5. **Power dynamics shape professional identities:** Healthcare providers operate within hierarchies influenced by gender. Female nurses often face subordination in relation to physicians, while male nurses navigate masculinity in a feminized profession. These dynamics influence care delivery, workplace equity, and professional development (Lotan, 2019; Cottingham, 2017) [5, 22].

6. **Global health interventions can reinforce inequities:** International programs and NGOs may unintentionally perpetuate hierarchies or marginalize local voices if gender and social power are not explicitly considered. Effective interventions require context-sensitive, participatory, and reflexive approaches (Yassi *et al*., 2014; Storeng *et al*., 2019) [35, 41].

7. **Inclusive and intersectional frameworks improve health outcomes:** Approaches that incorporate feminist theory, intersectionality, and participatory pedagogy provide more equitable and responsive healthcare systems. Inclusive representation, trauma-informed care, and recognition of diverse identities can reduce disparities and enhance patient empowerment (Rice *et al*., 2015, 2018; Wiklund *et al*., 2018) [28, 29, 40].

These findings collectively emphasize that healthcare inequalities are not merely clinical issues but are embedded in social, cultural, and institutional power structures.

Conclusion

This study underscores that healthcare is inherently shaped by gendered power dynamics, social hierarchies, and institutional structures. Feminist perspectives provide critical insights into how inequalities are produced and perpetuated within healthcare systems, revealing that access, quality, and outcomes are deeply influenced by socially constructed roles, norms, and expectations. The review demonstrates that men and women, along with marginalized groups such as disabled individuals or ethnic minorities, experience healthcare differently due to intersecting social determinants. For example, men navigating caregiving roles negotiate their masculinity in ways that influence both their engagement with health services and the support they provide, while women often face undervaluation of care work and systemic barriers in professional healthcare environments (Abbott *et al*., 2019; Giesbrecht *et al*., 2016; Lotan, 2019) [1, 14, 22]. Furthermore, feminist critiques reveal that biomedical and policy frameworks frequently neglect social and structural determinants of health, reinforcing inequities instead of addressing them (Annandale *et al*., 2018; Trevillion *et al*., 2014) [2, 38].

The study highlights that inclusive, intersectional, and context-sensitive approaches can improve health outcomes. Approaches grounded in feminist theory encourage recognition of diverse identities, participatory care models, and reflexive practices that challenge normative assumptions about bodies, gender, and professional hierarchies (Rice *et al*., 2015, 2018; Shannon *et al*., 2017) [28, 29, 33]. Global health interventions and policy-making must actively consider power relations and social marginalization to avoid reinforcing inequities (Yassi *et al*., 2014; Storeng *et al*., 2019) [35, 41].

For future research, empirical studies can build on these theoretical insights by examining how feminist-informed interventions impact health outcomes across different cultural and institutional contexts. Longitudinal research could explore the effects of gender-sensitive policies on patient experiences and professional equity. Additionally, integrating intersectional approaches into health program design, clinical training, and community health initiatives can further enhance inclusivity and responsiveness. Overall, feminist perspectives provide a crucial foundation for transforming healthcare systems into spaces that not only deliver medical care but also actively address structural inequalities and empower all individuals, regardless of gender, ability, or social position.

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