

HEALTH AND GENDER

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Abstract: *Why is it necessary to talk about gender and health? Are there differences between men and women in health? Does gender affect health? This article offers evidence which reveals a close association between health and gender. Biological and biomedical models neither explain why the distribution of the diseases in the population follows the contours of poverty (pattern associated with economic and social structure of society), nor they explain health differences between women and men. There is a clear association between health and gender: Gender is one of the determinants of health.*

Keywords: *health in the view of gender; bio-psycho-social model of health, mortality and illness according to the gender; inequality of approaches to the health*

Why do we need to talk about gender and health? Are there differences in health between men and women? Does gender influence health? We shall see whether we are able to answer this question. Let us look through the information available to us. For example, let us mention a news item which appeared recently in a European newspaper (El País, 2007).

“A professor claims that having a wife at home prevents heart attacks”. The Director of The Chair of Cardiovascular Risk in the Universidad Católica San Antonio, Murcia, José Abellán, claimed at a press conference that the best protection against cardiovascular risks is to be married to a woman with money, a certain educational level and one not working outside the home. Abellán explained-in a press conference held to introduce a lecture on cardiovascular risk- that this datum appears in a study to be read in the near future in the UCAM.

There is a specialist, who holds a university chair in a private university, of “Cardiovascular Risk”, who when presenting a study, which we assume is a study carried out by people related to this chair, centres on men. It is a study evaluating cardiovascular risk in men. It is true that women appear in the text, not in relation to a possible evaluation of their own cardiovascular risk but as people making men’s cardiovascular health better or worse. So, we can assume that this is due to the fact that cardiovascular risk is to be found in men, and therefore, study of this topic centres on them. In order to check this, let us review the statistical data we have and which are accessible for everyone to see if this is really the case. To avoid making this explanation too complicated we centre upon data stemming from real life in Spain, while being fully aware that they are similar to those of any other developed European country. For example, we have a work by R. Boix, S. Cañellas, J.Almazán, E Cerrato, C.M. Meseguer, M.J. Medrano, of the Cardio-

vascular Epidemiology Service (Centro Nacional de Epidemiología, Instituto de Salud Carlos III), published in 2003. The text quotation is rather long, but it is worthwhile reproducing it in its entirety, although we will comment on each section.

“Death rates from cardiovascular diseases. The group of illnesses occurring in the cardiovascular system was the number one cause of death in 2000 among the Spanish population. Of the nearly 360,000 deaths recorded in our country, 124,610 were a result of cardiovascular diseases with 35 % of all deaths (30 % in men and 40 % in women). The relative weight, however, has shown a marked fall since 1980, when the figures were 40.9 % and 51.3 %, respectively” (p 242). That is, if we consider the death rate from cardiovascular diseases as a whole, in 2000 more women than men died from this cause. Though the death rate has fallen on the whole, in 1980 there were also more female than male deaths from this cause. We continue with the quotation:

“The accumulated decline has led to a situation in which, from 1999 onwards, death rates from diseases of the circulatory system have become the second cause of death behind the group of tumours” (p 242).

But in women it remains the primary cause of death in 2000.

And, with regard to the relative importance of cardiovascular diseases as a cause of death within each of the two groups, men and women: “Due to their frequency the main cardiovascular diseases are ischemic cardiopathy, cerebrovascular disease and cardiac insufficiency. The first two are fundamentally artereosclerotic in origin, and lead to 20 % of deaths among men and 25 % in women. Thus, they are the main cause of death in our country” (p. 242).

That is, as a whole, both because of their relative importance when men are compared with women and their relative importance as a cause of death in the group of women, cardiovascular diseases are also, unfortunately, found mainly in women.

Similar data appear in statistics for other years. For example, in 2002 (Table 1).

Table 1 Death rate from cardiovascular disease according to age and sex. Spain 2002

AGE	MEN		WOMEN	
	DEATH	RATE	DEATH	RATE
0-4	14	1,38	15	1,58
5-9	5	0,50	8	0,86
10-14	19	1,85	7	0,72
15-19	28	2,37	19	1,69
20-24	59	3,97	29	2,04
25-29	89	5,29	49	3,01
30-34	197	11,90	68	4,23
35-39	376	23,63	132	8,41
40-44	646	44,31	172	11,78
45-49	993	77,76	279	21,58
50-54	1447	122,92	382	31,64
55-59	2000	185,70	627	55,28
60-64	2691	304,03	933	95,93
65-69	5064	558,51	2311	217,41
70-74	7657	954,13	4766	468,35

75-79	10243	1749,65	8863	1052,87
80-84	10201	3117,18	13969	2427,09
85+	14573	7194,48	35775	7546,07
TOTAL	56302	291,35	68404	338,02

DEATH: Number of deaths by Cardiovascular RATE. Specific rates by age and sex per 100,000. Taken from the Centro Nacional de Epidemiología, Instituto de Salud Carlos III, Spain. http://www.iscii.es/centros/epidemiologia/epi_encfcardio_tabla.isp

Or in 1996 (Table 2):

Table 2 Mortality rates in total and by different causes per 100,000 inhabitants. Spain 1996.

	Males	Females
	All ages ¹	All ages ¹
All causes	973	820
Circulatory system	316	363
Ischemic Cardiopathy	116	83
Acute myocardial infarction (heart attack)	82	51
Other ischemic heart diseases	34	32
Cerebrovascular disease	83	114
Rest of circulatory system	116	166
Hypertensive disease	7	15

1 Gross rate

Taken from Sans, S & Paluzie, G. (2000). Evolution of morbidity-mortality by Cardiovascular Rate in Spain 1970-1996. Cuadernos latinoamericanos de hipertensión, 5 13-23

Similar data to the above appear systematically in statistics for different years, in different countries: and based on them, TIME magazine put on its front cover and devoted an edition to cardiovascular diseases in women. The front cover is reproduced in Figure 1.

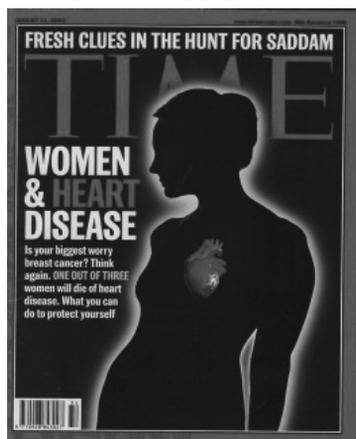


Figure 1: The front cover of Time magazine's edition for August 11, 2003, in which it warns women that they are more likely to die of cardiovascular diseases than they are of cancer.

Why, therefore, are cardiovascular risks still all too often only related to men, as was the case in the study with which we began this chapter?

But let us move another step forward. If, as already appears patently clear, women are more frequently victims of the whole group of cardiovascular diseases, they could be expected to be more often hospitalised for this reason. Let us put it to the test. Let us take a year at random, for example 2002.

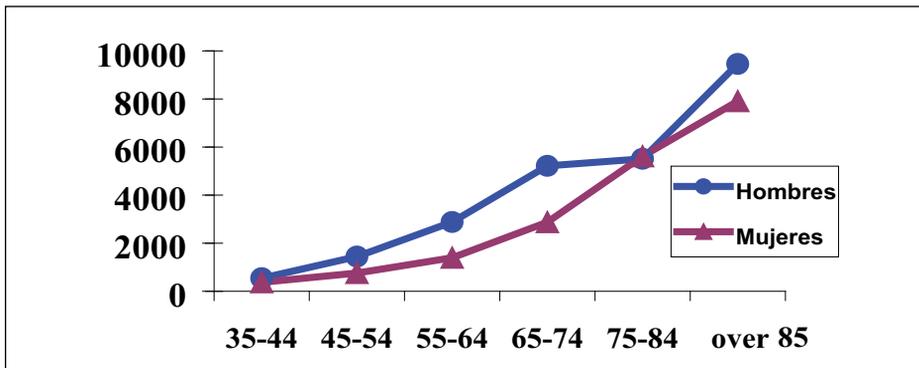


Figure 2: Rates of hospital admission for cardiovascular diseases. Spain, 2002
Source: INE (National Institute of Statistics. Spain)

In fact, this is not the case, women are not the ones most often admitted to hospital for cardiovascular disease.

We began to suspect that something was afoot...And to give substance to this suspicion, based on the example of data relating to cardiovascular diseases, we raised three general questions concerning health, which we shall attempt to answer in the rest of the chapter. They are as follows:

- Are men's and women's health the same?
- Are women's and men's health given equal treatment? Or do biases exist?
- If there are differences, when we refer to men's and women's health, are we merely talking of differences between the sexes or are we also talking of gender differences?

Before trying to answer these questions, in order to begin to find an answer to the question we started this chapter with, it is necessary to remember that the definition of what constitutes health and illness is not necessarily the same at different times throughout history or in different cultures. Therefore, we must choose a definition as a common reference point for the questions we are going to pose. Since 1948, the definition presented by the WHO (World Health Organisation) is usually accepted as a basic reference. "Health is a state of complete physical, mental and social welfare, and not merely the absence of afflictions or illnesses." (<http://www.who.int/es/>). The quotation comes from the Preface to the Constitution of the World Health Organisation, adopted by the International Health Conference, and signed on July 22, 1946 by

the representatives of 61 States (Official Records of the World Health Organisation, N° 2, p.100). This came into force on April 7, 1948, and since that time has not been substantially modified.

So, within this reference framework, generally accepted by every group dealing with topics of health, let us attempt to answer the first question raised above.

Are men’s and women’s health the same?

To deal with this question some more statistics will have to be studied again, for example, those referring to Death Rate/Life Expectancy. These appear in a highly visible form in Figure 3.

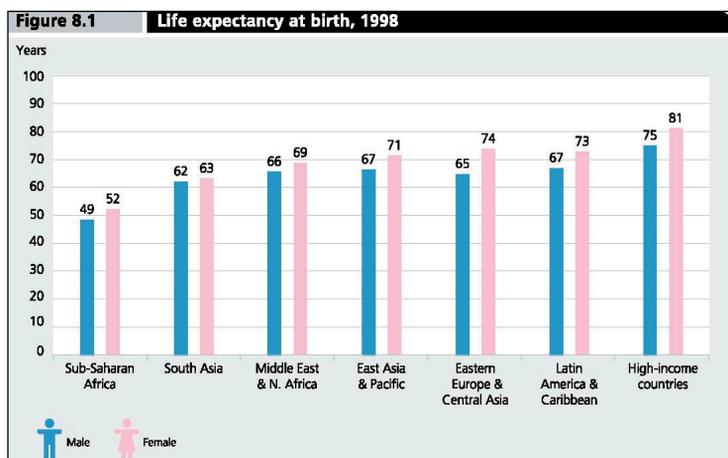


Figure 3. Life expectancy at birth 1995

Taken from Soubbotina, T. P. (2004). Beyond Economic Growth to Sustainable Development. Second Edition World Bank

In more recent years the position is similar. In all cases, women’s life expectancy is greater than men’s, though the distance in average years between the two groups varies in accordance with social conditions. In those countries and areas where in general health conditions are worse and especially those related to women’s death rates when giving birth, the differences between men and women show a decrease.

There is, therefore an initial difference with regard to mortality. What happens with regard to morbidity? That is, do women become ill as much as men? Let us consult any report, for example, that of health worldwide, by the WHO in 2003 (Table 3).

Table 3. Main causes of the percentage of morbidity (AVAD) for men and women (older than 15), throughout the world, in 2002.

MEN		% AVAD	WOMEN		% AVAD
1)	VIH/SIDA	7,4	1.	Unipolar depressive problems	8,4
2)	Ischemic cardiopathy	6,8	2.	VIH/SIDA	7,2
3)	Cerebrovascular illnesses	5,0	3.	Ischemic Cardiopathy	5,3
4)	Unipolar depressive problems	4,8	4.	Cerebrovascular illnesses	5,2
5)	Traumatisms from traffic accidents	4,3	5.	Cataracts	3,1
6)	Tuberculosis	4,2	6.	Loss of hearing	2,8
7)	Problems from alcohol consumption	3,4	7.	EPOC	2,7
8)	Violence	3,3	8.	Tuberculosis	2,6
9)	EPOC	3,1	9.	Osteoarthritis	2,0
10)	Loss of hearing	2,7	10.	Mellitus diabetes	1,9

Taken from the Report on health worldwide, 2003. Let us build the future. WHO.

Or this other one (Figure 4).

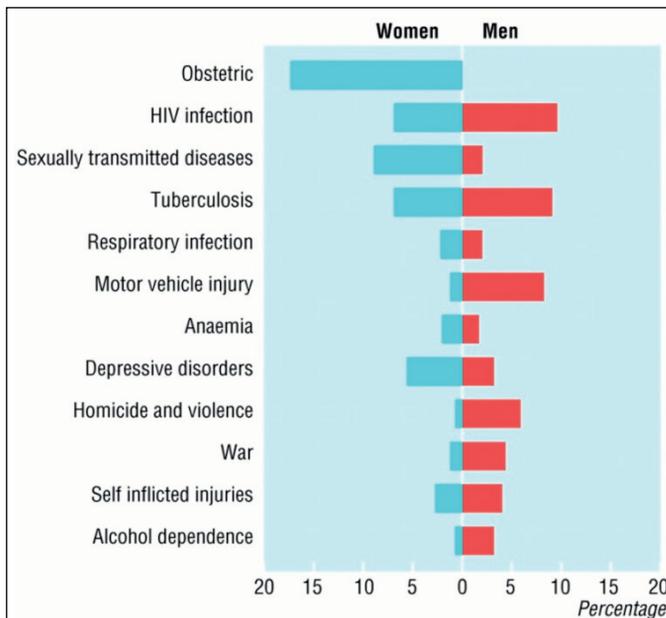


Figure 4. Percentage of type of illness in adult men and women aged 15-44 in developing countries, 2000

Adapted from World Development Report, 2004, p282.

We can also use more refined indexes, but the table remains the same, that is, there are differences in morbidity between men and women. From this starting point, we can make the comment that, in reality, the increasing lifespan in developed countries

does not necessarily translate into an increase in the number of years lived in a good state of health. The Spanish Ministry of Health, from 2002 onwards, had already put forward the idea that in order to evaluate a population's state of health it becomes essential to measure, not just mortality and morbidity, but also the consequences of illness. With this end in mind, other useful indicators have begun to be used to evaluate quality of life or state of health among those living an increased lifespan.

Life expectancy without disabilities (MSC, 2000) .This indicates the average number of disability-free years that a person of a particular age has in front of him/her. It is calculated by means of death and disability rates and presents information not only on how long the life will be but also on its quality. In Spain, at birth it is 69 years for men and 72.4 for women, and on a rising curve, while in both cases being above average for European Union countries (Health and Gender Report, 2005).

Life Expectancy without Chronic Illness (MSC, 2002). This indicates the number of years with no chronic illness that remain for a particular individual at that age until he/she dies. In Spain, at birth, men have 41 years compared to 38 for women. (Health and Gender Report, 2005).

Life Expectancy while Enjoying Good Health (MSC, 2002). It indicates the average number of years a person has to live in good health from a particular age till death. The years of life are weighted by the subjective perception of people's health. In Spain in 2002, at birth it is 56.3 years for men and 53.9 years for women. (Health and Gender Report, 2005).

The analysis of all the above leads us to the conclusion that, in fact there is differential mortality and morbidity for women and men, if differential morbidity is understood as the group of pathologies, risk factors and reasons for medical consultation which require specific or different attention in the cases of women and men.

It also shows the existence of what has been called **the mortality/morbidity paradox: women live longer, but have worse health** (see, for example, Sánchez-López, M.P., 2004), which we will do no more than mention here to avoid making this chapter excessively long, although a large amount of ink has been spilt in texts concerning the introduction of the gender approach in health.

Just as an example, and using the text of an international body, we can indicate some examples of differential morbidity (Table 4).

Table 4. Examples of Differential morbidity

WOMEN	
They live longer	Larger number of medical problems
More depression	Higher hospitalisation rates
Greater stress overload (family/work)	They use more prescribed medicines
More chronic conditions such as arthritis and osteoporosis	They report worse health
More injuries and deaths from domestic violence	They have more days of restricted activity

Taken from the Annual Report, 2005 of the International Women's Health Coalition

This is a rapid table of differences prepared in a rough fashion. A lot of nuances would have to be introduced with regard to some of the differences appearing here. For

example, on the higher rates of depression appearing for women, (see, for example, Valls, 2003).

Naturally, even if it may appear that we are talking of women as though they made up a monolithic group, we must never lose sight of the fact that there are intragroup differences which may be greater than intergroup ones. That is, there are differences among women (and of course among men), with regard to race, ethnic group, socio-economic level, education, geographical habitat, sexual orientation... and a long etc.

Likewise, neither must it be forgotten that when comparing men with women, if we do not match both groups through other basic variables (e.g., age, employment situation, etc...) we are not making a correct evaluation of possible differences between them. This is a basic principle of any intergroup comparison which, mysteriously, is forgotten quite often when the two groups we are comparing are those of men and those of women. The basic general principle is that there is always interaction between the fact of being a woman/man and other variables. These are for example, age, culture and a long etc.

Let us deal with the next question.

Is there equal (and fair) treatment of the health of men and women? Or are there biases?

If we return to the newspaper article we started with and compare it with the reality of the importance of cardiovascular illness in women, we are tempted to come to the conclusion that, at least in this respect, women seem to be invisible. As Valentín Fuster, an internationally renowned cardiologist, director of the Centro Nacional de Investigaciones Cardiovasculares, in Spain and the Cardiovascular Institute of the Mount Sinai Medical Center, in New York, said this year, when presenting his foundation for health education: “The foundation is called **She**- initials of science, health and education in English-because women have not been regarded with the importance that they should have been in terms of cardiovascular health; much remains to be done in this field”: And in many others: reviewing several health-related aspects leads us to the conclusion that quite often women have been invisible (Compare. for example, Valls, 2006). Only very recently have the differences between the sexes with regard to being ill and dying begun to be looked at and even till a short time ago and still today, health statistics did not so much as give information divided according to sex. Traditionally, women’s invisibility has been most seen in:

- a) Health research; for example, in clinical tests, where the absence of women has been and still is notorious, albeit on many occasions it was assumed that the findings could be extrapolated both to men and women. As late as 1977, the American Food and Drug Administration published a guide which specifically excluded tests on women of childbearing age. This has led to a gap existing in knowledge of how women are affected by many medicines and treatments. Since 1993, legislation in the United States compels clinical studies financed by the National Institutes of Health (NIH) to include in populations studied both men and women (as well as people from different ethnic minorities). The NIH has published a guide to studying and evaluating differences in trials on the basis of sex, promoting the inclusion of women in order to detect possible clinically

significant differences in responses to pharmaceutical products, and applying a gender approach in planning the studies.

- b) The training of health professionals, who suffer from the almost total dearth of specific training from the gender viewpoint in a central, regulated way. (compare Colmer Revuelta and Sánchez-López , 2007).
- c) Medical care. Sometimes medical care is not the same, as in illnesses. Later on we will return to the example of cardiovascular diseases.

Thus, it does not appear that there is any real equity between sexes in questions of health. Rather it seems we can talk of the existence of bias. But, to make things more complicated, with just a cursory examination of the subject, we shall see that there are different ways in which this biased view of health is shown. Traditionally, three different manifestations of this biased view are to be seen.

- Equality between the sexes is assumed when it is non-existent. The classic example normally cited in this respect is that of aspirin. Very often, until quite recently and even today, patients are advised to take acetylsalicylic acid to avoid heart attacks. The problem is that the studies on which this recommendation is based, for the most part have only used men for their clinical trials. We quote the results of the study by Ridker et al. (2005) as an example of how little is known from the basis of the few works which have researched the topic with women. The summary of the results is as follows:
 - Acetylsalicylic acid (100 grams every other day) has no effect on the prevention of heart attacks in women.
 - It has no effect in preventing cardiovascular accidents.
 - Gastrointestinal bleeding is more common among women
 - Preventive effects in women >65

At the very least, these findings lead us to use caution when giving widespread recommendations to men and women to take a dose of aspirin, at least, until there are more specific results stemming from research carried out on women.

- Differences are assumed when there is equality. A paradigmatic example is the treatment given for cardiovascular disease. They were deemed to be “men’s diseases” no more than 30 years ago, but, since then of course present day experience indicates that this assumption is false or incomplete. Not only do they affect both women and men, they affect women in a different way. There are differences in symptomatology, diagnosis, treatment and rehabilitation. Bias is shown when it is not appreciated that the latter disease is the primary cause of death among women. Moreover, national and international studies show that with equal cases of coronary pathology women do not receive the same medical and surgical treatment (for example, Ayanian and Epstein) 1991) and data indicate that mortality after an attack is noticeably higher among women (68 % against 33 %, for example, Marrugat et al, 1998. For an overview, Sans, 2007).
- Limitation to an area; that of reproduction. As pointed out by Barbara Rahder and Rebecca Peterson (2006), researching only on differences between sexes cannot be the cornerstone. If it were, we would reach the point (it has happened) of stressing needs of women merely as a result of biology: that is, those related to reproduction, by identifying Women’s Health exclusively with sexual and re-

productive health. This limits the interest in women's health to a period of her life, that linked to maternity, and this is dangerous in the sense of what it means in identifying a woman as simply a reproducer/carer. And, to end, the third question.

When we talk of men and women (in this case with regard to health), are we talking merely of differences between the sexes or also of gender?

It becomes increasingly clear with data from the research works in our hands, that there is a need to introduce analysis of sex and gender as variables in health-related research and practice. If under the term "sex" biological differences between men and women are included and under the term "gender, social and cultural differences experienced by women and men, the data show us that both realities profoundly impact on determination of health status. In fact, sex may determine a differential propensity to certain conditions of health or illness, varying risk factors and different treatment needs. What is more, gender may determine different exposure to certain risks, different patterns of seeking treatment or differential impacts of the social and economic determinants of health (see, for example, Sánchez-López, 2003). The idea which is becoming more and more prevalent is that the complex Gender construct, interacting with sexual, biological or immunological differences creates health-related conditions, situations and problems which are different for women and for men, as individuals and as groups.

There is, therefore a close association between Health and Gender. Just as biological and biomedical models cannot explain the way illness is distributed among the population in accordance with the poverty contours (a pattern associated with the economic and social structure of society), nor are they able to explain differences in health between men and women. What is true is that there is an association between health and gender, insofar as gender is one of the determinants of health.

Naturally, not every difference in health in women and men involves gender inequality. This concept is reserved for those differences considered to be unnecessary, avoidable and, also unfair. Therefore, achieving full equity in health would not lead, necessarily, to equal mortality and morbidity rates in women and men, but, rather, to the elimination of preventable differences in opportunities of enjoying health and not being ill, suffering disability or dying of diseases which can be dealt with. Nor should it inevitably lead to equal quotas of resources and services for men and women, but instead, there should be differential allocation and reception of the resources, according to the particular needs of each person and each socioeconomic context.

Having briefly seen what we have hitherto seen, it seems in no way outlandish to insist that we have to talk of gender and health (or health with a gender perspective).

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ZDRAVÍ A GENDER

Abstrakt: Proč je nezbytné hovořit o genderu zdraví? Existuje rozdíl mezi muži a ženami a jejich zdravím? Má gender vliv na zdravotní stránku člověka? V uvedeném článku je názorně vysvětlena zjevná závislost mezi zdravím a genderem. Stejně tak jako biologické a biomedicínské přístupy ke zdraví nevysvětlují, proč rozdělení nemocí v populaci kopíruje hranici chudoby (model spojený s ekonomickou a společenskou strukturou společnosti), taktéž nevysvětlují rozdíly ve zdravotním stavu mezi muži a ženami. Existuje však zcela zřejmá souvislost mezi zdravím a genderem: gender je jednou z determinant zdraví.

Klíčová slova: zdraví, gender, bio-psycho-sociální model zdraví, úmrtnost a nemocnost v závislosti na pohlaví, genderová nerovnost v přístupu ke zdraví