

Men and women: together in sickness and health?

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Educational aims

- To discuss some examples of gender differences in Malta in terms of lifestyle choices
- To explore gender differences in the utilization of health care
- To examine disparities in activity limitation between elderly men and women in the Maltese population and appreciate their implication

Key words

Gender, awareness, lifestyle, consumption of health care services, elderly

Abstract

One of the highest ranked works of non-fiction of the twentieth century is titled 'Men are from Mars and Women are from Venus'. While most of us may actually agree with such a statement in a generic setting, one would question whether this should hold true in terms of health outcomes and practices. This review attempts to pose this question within the context of the Maltese population and reflects on some reported differences in health behaviour and status between the two genders. Indeed, differences noted in terms of lifestyle practices in other countries and cultures, particularly in the Western world are noted in Malta as well. Maltese women appear to make better lifestyle choices in general; however, there is a lower perceived risk or awareness compared to men for a number of conditions, such as diabetes or obesity. It is unclear whether such behaviour is likely to arise from lack of awareness or simply denial. Nevertheless, Maltese women also exhibit higher rates for utilization of healthcare services, and are more likely to utilize certain types of medications, just like their counterparts elsewhere. Of particular concern is the degree of disability and activity limitation that women are likely to face in their elderly years. Such disparity has serious implications for an ageing population and call for gender-targeted investment along the life course to help reduce such disparity.

Introduction

"To call woman the weaker sex is a libel; it is man's injustice to woman." Mahatma Gandhi.¹

Our literature across different cultures is peppered with references to women as 'the fairer sex' or simply 'the weaker sex'. These gratuitous labels have always been met with a variety of reactions ranging from acceptance to sneers, if not anger. While the statement above clearly does not refer directly to health, or at least, not only, it certainly brings up the question whether hard data supports or refutes these labels. This review will be attempting to start scratching the surface of this eternal question, with a particular focus on Malta and its population. This article can never explore all the gender differences reported in Malta over the years but attempts to illustrate some concepts with some local epidemiological findings.

Gender differences and inequalities

The World Health Organisation (WHO) defines gender differences and inequalities. Indeed, gender differences are defined as differences between men and women arising mainly due to a specific culture's gender norms and values.² A number of these differences may not in themselves be considered inequalities, as, typically this causes no specific discomfort for any of the two genders, such as choice of clothing. Nevertheless there are other differences that, for a variety of reasons, result in different health outcomes. One can call these health inequalities. The term health inequalities can be taken as referring to differences, variations, and disparities in the health achievements of individuals and groups – in our case, of different gender.³ Such inequalities are not always reflecting an injustice (thereby implying an inequity rather than just inequality).³ Nevertheless, once such differences do occur, whatever the possible cause, such differences should be managed pro-actively and care targeted to address those who are most in need.

Two main such differences that are also highlighted by WHO as particularly prevalent even in developed countries are gender differences in ageing and mental health. Indeed, in the grand majority of countries, female life expectancy typically exceeds male life expectancy.⁴ In effect, according to the United Nations, the global average life expectancy for men is estimated to be 66 years, as compared to 71 years in women.⁵ Nevertheless, women appear to spend more time in disability, with the resultant effect that the gap may be much less when

considering healthy life expectancy, or life expectancy adjusted for disability.⁶ One can speculate that this is likely to generate a number of subsidiary health inequalities. Another noted difference refers to the fact that, as from adolescence, women tend to be more at risk of affective disorders (depression and anxiety) which happen to be the commonest mental disorders and therefore the major contributors to the burden of mental illness.⁷ On a positive note, women have been known to make more frequent use of health care services. Such a difference has been particularly noted in preventive health care services.⁸

Local scenario and data sources

Malta should be no different to the international scene but certain specific peculiarities may affect a culturally sensitive area such as health behavior. This paper will be highlighting gender differences identified in Malta, referring mainly to existing publications based on local epidemiological work.

The article will be concentrating mainly on health behaviour, including aspects of lifestyle, utilization of health care resources and medication, and activity limitation. These are best assessed using survey data rather than administrative sources. One main source which is referred to here is the European Health Interview Survey (EHIS) of 2008 which is the latest edition available. This rather comprehensive health survey explores all the above areas together with sociodemographic variables. Being a harmonized European tool which was applied across a number of European Union (EU) member states in the same time period, it also allows a degree of comparison to other countries. Another related dataset that is only available for Malta is that for the pilot European Health Examination Survey (EHES) which was conducted as part of a European feasibility project in 2010. One more harmonized survey dataset is the Survey on Income and Living Conditions (SILC) which is also carried out across the EU. Another local survey that permits insight into activity limitation among the Maltese elderly was the Elderly Needs Assessment Survey carried out in 2012.

Consumption of healthcare services

The European Health Interview Survey 2008 analysed among other variables, utilisation of health care services in Malta – both in the public and private sector.⁹ There are indeed variations in both consultation rates and use of other services between men and women.

In effect, utilization of family doctors or specialists in an ambulatory setting in the public sector varies very little by gender, unlike care in the private sector where women appear to lead – with as many as 77% who report having been to a family doctor in the previous 12 months, compared to 71.5% of males. This also applies to specialist outpatient visits in the private sector where only 27% of women admitted they have been never been to a specialist as opposed to 34% of men. Even when analyzing the above differences among persons affected by a specific group of diseases, using asthma and chronic obstructive pulmonary disease as an example, the same trends were observed.¹⁰ Dental consultations were also more in demand among females than males. A similar increased pattern of health care seeking behaviour among women has been observed in a number of studies in various Western cultures.^{11,12}

This increased engagement with health services among women is also reflected in medicinal consumption. A generally higher consumption of prescription medicines was noted among females in general, whilst this trend seems to be reversed amongst those over 75 years of age. Nevertheless, when considering specific therapeutic areas, a higher proportion of men reported use of medication across age groups, particularly in cardiovascular disease, diabetes and for blood cholesterol lowering agents. This would have also been true for hypertension had it not been for the rise of antihypertensive treatment among women overtaking that of men in the 55-64 age group with the disparity increasing substantially by age after then. Comparative data in other EU member states is only available for diabetes and hypertension. While the higher reported rate of use of anti-hypertensive treatment among women is

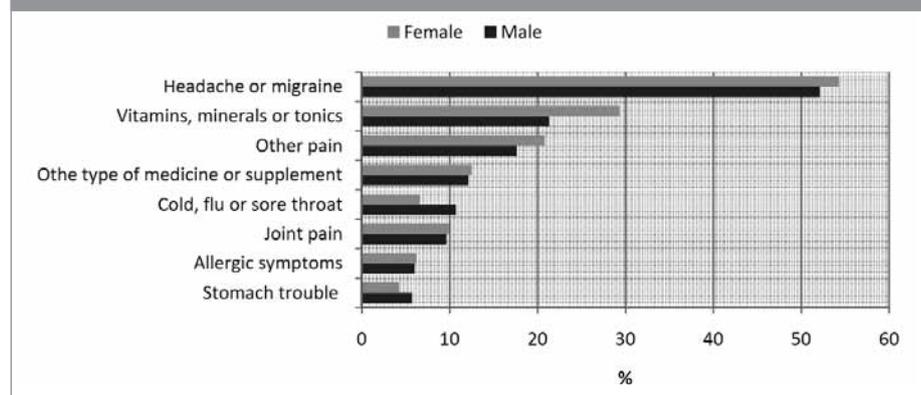
consistent across all countries participating in EHIS, only Malta and Cyprus reported a lower rate of consumption of diabetic medication among females than males.¹³ This is likely to be related to the decreased awareness of the presence of diabetes among Maltese women reported later as one of the findings of the pilot EHES. Sleeping tablets are also reportedly used more by females over 55 years of age. Indeed, poorer sleep quality has been described in elderly females in the Netherlands as well.¹³ As for over the counter medication, little if any difference has been noted, apart from vitamins, minerals or tonics, and analgesia (including headaches and migraine), as noted in Figure 1. Comparable statistics for non-prescription items from EHIS across EU member states are not available by drug type but only as an aggregate, however there is a consistent substantial higher rate of consumption among females in all participating countries.¹³

One may wonder about what could give rise to such behavior. One landmark sociological study goes as far as asserting that health care seeking behaviour is also an expression of masculinity and femininity in a number of cultures. The study underlines that a major feature of masculinity is a degree of risk-taking, which tends to equate to unhealthy behaviour or outright reduced utilization of health care when this is needed. It argues also that the current medical model has singled out women as in need of special professional attention, and, as a result, women have been trained in defining life problems in medical terms and seek help for them more than men.¹⁴

Lifestyle and awareness

One may equate a higher contact rate with the health services with a sicker cohort. Therefore, it is worth reflecting on any gender differences in lifestyle.

Figure 1: Rate of consumption of over the counter medication in Malta by gender (Reproduced with permission from EHIS 2008).⁹



Utilising data reported in the same survey as above, one notes that smoking is clearly a commoner practice among males than amongst females. However, the uptake of smoking presents another interesting insight. While in men, daily smoking rates are noted to peak around 30% between the ages of 25 and 55, females present a consistently rising trend by age, which peaks in the 45-54 year age group, fueling speculation that uptake of this habit may be occurring later in life among women.¹⁵

On the other hand, most other lifestyle characteristics appear to be better in women. Alcohol consumption is clearly still lower among females, even though the difference is much less pronounced in the 15-24 age group. Fruit and vegetable consumption is also higher among females. The exception is physical activity, with a higher proportion of women reporting low or no physical activity.¹⁵

As for weight management, one expects better weight management amongst women. In effect, when analyzing self-reported data dating back to 2008, the majority of women reported their weight and height as effectively being within the normal body mass index (BMI) range (40%) as opposed to the peak category in men being the overweight range (45%). However, in a pilot Health Examination Survey conducted in 2010, one noted that the prevalence of obesity was actually slightly higher in women above the age of 18 (32%) that it was in corresponding men (28%). In fact, a tendency to underestimate BMI was noted amongst women, which was practically not present among males (Figure 2). The higher rate of obesity among women was further corroborated by waist circumference measurement with a markedly higher proportion qualified as having substantial health risk (Figure 3).¹⁶ While underestimation of one's own weight and overestimation of one's own height is a known phenomenon in health surveys, this misclassification is known to occur to a larger extent among women.¹⁷

This decreased awareness or potential denial amongst women persists also in terms of other conditions. One such example is the presence of impaired glucose metabolism. There was practically perfect correspondence between self-reported diabetes and elevated blood glucose on examination amongst men, but diabetes was definitely under-reported amongst women, with a slightly higher prevalence of elevated blood glucose noted among women on examination. On the contrary, hypertension was substantially but similarly under-reported amongst the two genders. An unusual finding was that more

Figure 2: Differences between self-reported BMI (2008) and examined BMI (2010) in Malta, by gender (Reproduced with permission from EHES 2010).¹⁵

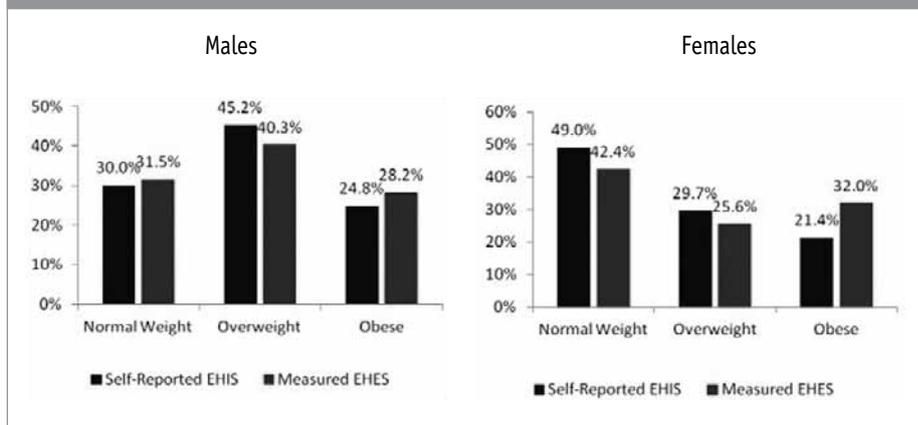
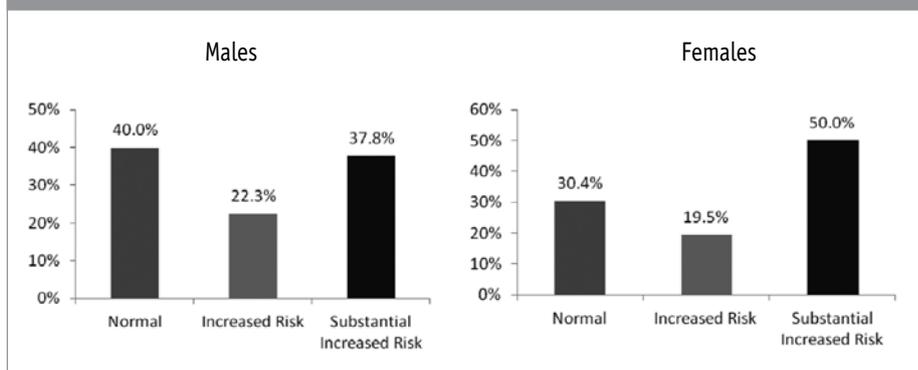


Figure 3: Gender differences in waist circumference in Malta (Reproduced with permission from EHES 2010).¹⁵



women were opting to live with near-normal vision (as opposed to normal) than men, with lower visual acuity being recorded among the female study participants, even when corrected with glasses, if they typically use them in their normal daily activities. Reluctance to wear glasses among young people is known, typically for aesthetic reasons.¹⁸ Interestingly such a cultural barrier towards corrective glasses has been described in another Mediterranean country: Lebanon.¹⁹

The same argument of the medical model defining lifestyle and health-seeking behaviour could apply here in a reverse manner. The higher prevalence of cardiovascular disease and related conditions among men may have been emphasized so much in the past that, while femininity may be characterized by better health awareness, women may fail to appreciate their risk for conditions such as diabetes.¹⁴

Focus on the elderly

Most of the above findings have been corroborated further in the Needs Assessment of the Elderly Survey conducted in 2012.²⁰ This survey investigated the needs among the elderly aged 75 and over still living in a private

household. Indeed elderly females reported a higher rate (13.9%) of making regular use of medical home visits than their male counterparts (11.7%). Higher dependency is also noted among Maltese elderly females. It may be enough to note that 6% of interviewed females were on a waiting list for entry into a long-term care institution as compared to 3% of males. In fact, while 89% of men reported low or no dependency, only 85% of women reported the same. Similar findings were noted in Spain in a different survey – with higher utilization of home visits and other medical services.²¹

This phenomenon is likely to be linked to the increased morbidity known to affect elderly women in Western society. In fact, across all European countries, the number of years expected to be lived without chronic disease after the age of 65 is practically identical, with differences not exceeding one year. Nevertheless, the life expectancy of women at that age is always higher than that of their male counterparts by more than that – typically three to five years longer.²²

Increased chronic morbidity and disease brings about increased limitation and lower

perceived health. Indeed, a similar phenomenon to the one described above also occurs when estimating the number of years expected to be lived without activity limitation and also in self-perceived good health – the difference between men and women is slight, suggesting that elderly women spend a lower percentage of their remaining years in good health and without activity limitation.²²

On deeper analysis of the Maltese Needs Assessment survey data, one notes that, across all activities of daily living, a significantly higher proportion of women reported difficulties, with the exception of eating and continence, where the difference is not significant. A different pattern shows up when analyzing the more complex instrumental activities of daily living (IADLs). There is clear evidence that these difficulties arise mostly from one life experiences rather than any age-related disability itself, with men expressing more difficulty with meal preparation, laundry and other light household work, including cleaning. Women, on the other hand, express significantly higher difficulty with managing money and medication. One exception to the rule is probably grocery shopping whereby women express most difficulty. This is more likely to be related to physical limitations more than life experience. This is also reflected in the reported use of community care services with women reporting higher usage of all services with the exception of meals on wheels. Heavy housework is also worth singling out since, apart from women being more susceptible to difficulties in this area, this is further pronounced among those reporting respiratory disease, with very high reported rates among elderly females afflicted by such conditions of difficulty to cope with house cleaning duties and grocery shopping (73%). Reflecting on these differences, there may be room for more gender targeted active ageing strategies. More research should be invested internationally into exploring the root causes of these differences and whether prevention earlier in the life-course could help to reduce such disparities.

Conclusion

As was highlighted earlier, this gender profile should enable health care providers to engage better with members of the two sexes. This becomes particularly of relevance when putting it in the context of ever-increasing financial pressure on the health system to engage in more cost-effective interventions. Targeted practices are known to result in better individual gains than blanket, whole-population type of interventions.

It is also worth bearing in mind the cumulative nature of health inequalities along

Key points

- Differences between men and women imposed by cultural norms and values may sometimes result in health inequalities.
- Maltese women tend to engage more in a healthy lifestyle than men, in line with other populations.
- In a number of areas, particularly obesity and diabetes, Maltese women tend to be less aware of any existing problems than men. In the case of obesity, this is a known phenomenon among women in the Western world.
- Higher utilization of health care services and medication and supplements occurs amongst Maltese women.
- European elderly women, including the Maltese, tend to face more years with activity limitation or with a chronic condition in their latter years than men.

the life course. Indeed, any differences in lifestyle and preventive care are likely to accumulate as wider inequalities in later years in terms of health outcomes, or, in a more tangible manner, the proportion of the older population requiring medical and social care.

Finally, the same cumulative nature of inequalities is likely to apply to a different extent across generations rather than just along one's life course. Lifestyle practices are likely to pass from parents to child, particularly so from mother to child.²³ In this light, this short review can be concluded with the words of Italian Minister Beatrice Lorenzin during her inaugural speech for the General States in Health national conference in Rome in April 2014:

"Treating a woman is treating the entire family. The wellbeing of the entire society is dependent on women's health."

References

1. Gandhi M. To the Women of India. Young India. 1930 October 4. Quotes about Gandhi. <http://www.goodreads.com/quotes/tag/gandhi>. accessed 16th June 2014.
2. WHO. Gender, women and health. [Online].; 2014. Available from: <http://www.who.int/gender/genderandhealth/en/>. Accessed 16th June 2014.
3. Kawachi I, Subramanian SV, Almeida-Filho N. A glossary for health inequalities. J Epidemiol Community Health. 2002; 56(9): 647-652.
4. WHO. Gender, health and ageing. [Online].; 2003 [cited 2014. Available from: http://www.who.int/entity/gender/documents/en/Gender_Ageing.pdf?ua=1. Accessed 16th June 2014.
5. United Nations. The United Nations World Population Prospects: The 2012 Revision New York: United Nations; 2013.
6. EHEMU. Country Report Healthy life expectancy in the EU15. France.; 2005.
7. WHO. Gender and mental health. [Online].: WHO; 2002 [cited 2014. Available from: http://www.who.int/entity/gender/other_health/en/genderMH.pdf?ua=1. Accessed 16th June 2014.
8. Vaidya V, Partha G, Karmakar M. Gender differences in utilization of preventive care

services in the United States. J Womens Health (Larchmt). 2012; 21(2):140-145.

9. DHIR. European Health Interview Survey 2008: Utilisation of health care services. [Online].; 2009. Available from: <http://www.healthsurveys.gov.mt>. Accessed 16th June 2014.
10. DHIR. Health care service usage and needs in chronic illness: Diabetes, heart disease and respiratory disease.. [Online].; 2011. Available from: <https://ehealth.gov.mt/download.aspx?id=6150>. Accessed 16th June 2014
11. Bertakis KD, Azari R, Helms LJ, Callahan EJ, Robbins JA. Gender differences in the utilization of health care services. J Fam Pract. 2000;49(2):147-152.
12. Gerritsen AA, Deville WL. Gender differences in health and health care utilisation in various ethnic groups in the Netherlands: a cross-sectional study. BMC Public Health. 2009; 9(1):109.
13. EUROSTAT. Statistics Database. 2014. Available from: http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database. Accessed 16th June 2014.
14. Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Social Science & Medicine. 2000; 50(10): p. 1385-1401.
15. DHIR. European Health Interview Survey 2008: Lifestyle. [Online].; 2010. Available from: <http://www.healthsurveys.gov.mt>. Accessed 16th June 2014.
16. DHIR. Pilot European Health Examination Survey 2010. [Online].; 2012. Available from: <http://www.healthsurveys.gov.mt>. Accessed 16th June 2014.
17. Jeffery RW. Bias in reported body weight as a function of education, occupation, health and weight concern. Addict Behav. 1996;21(2):217-222.
18. Yawn BP, Kurland M, Butterfield L, Johnson B. Barriers to Seeking Care Following School Vision Screening in Rochester, Minnesota. Journal of School Health. 1998; 68(8):319-324.
19. Mansour A, Kassak K, Chaya M, Hourani T, Sibai A, Alameddine M. National survey of blindness and low vision in Lebanon. The British journal of ophthalmology. 1997; 81(10):905.
20. DHIR. Needs Assessment of the Elderly Survey: Phase 1. [Online].; 2012. Available from: <http://www.healthsurveys.gov.mt>. Accessed 16th June 2014.
21. Redondo-Sendino A, Guallar-Castillon P, Banegas JR, Rodriguez-Artalejo F. Gender differences in the utilization of health-care services among the older adult population of Spain. BMC Public Health. 2006; 6:155.
22. Robine JM CE. Healthy life expectancy in Europe. Population & Societies. 2013;(499).
23. Fisk CM, Crozier SR, Inskip HM, Godfrey KM, Cooper C, Robinson SM, et al. Influences on the quality of young children's diets: the importance of maternal food choices. Br J Nutr. 2011 105(2): 287-296.