Making the link: Gender and health equity

The World Health Organization's **Commission on the Social Determinants of Health** (CSDH) has identified principles and recommendations to tackle health inequities: the factors responsible for avoidable health inequalities, which persist globally and in the European Union. This series of summaries, updated and expanded online at **www.equitychannel.net**, introduces how those and other recommendations, as part of evidence based health promoting approaches, could be applied to a range of European Union legislations, policies and programmes. The aim is to improve international, national and local policies and practices within and beyond health systems, in order to promote better health and well-being for all.

Equity Channel
Connecting People for Fair Health

Why making the link matters

Gender inequity cannot solely be attributed to innate biological differences as it is influenced by the environment we live in and the social conditions and cultural differences that exist between and within countries [i, ii].

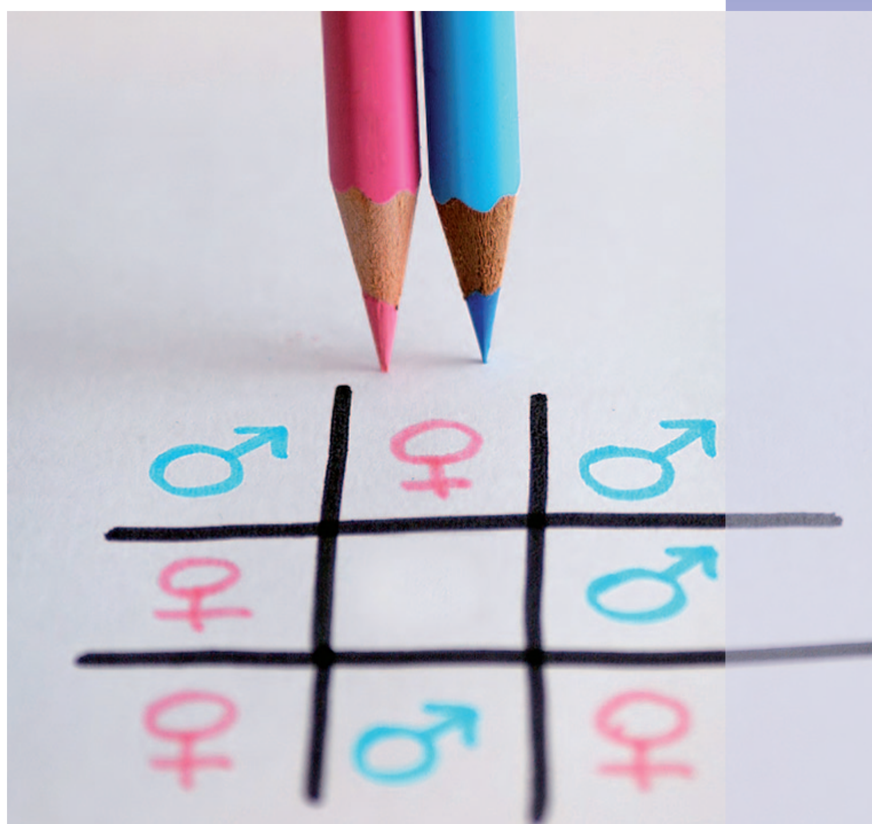
Discriminatory gender roles still influence crucial individual decisions on issues such as education, career paths, working arrangements, family and fertility. Gender inequalities result in underutilisation of talent and impose a heavy toll on the economy. Important benefits could therefore be gained if genuine choices were equally offered for men and women throughout different stages of life [iii].

Gender-related biological differences and socially constructed inequalities or gender differences between males and females play a central role in determining whether individuals are able to realise their potential for a long and healthy life. These translate into differences in life expectancy, mortality and morbidity risks, healthy life years, health behaviours and the use of and access to health care services [iv].

Similarly, health inequalities hinder labour productivity and also have a substantial economic impact. While the estimates of yearly inequalities-related losses to health as a 'capital good' seem to be modest in relative terms (1.4% of GDP), they are large in absolute terms (€141 billion per year).

Strengthening the gender perspective in all policies and mainstreaming gender in measures and actions therefore needs to be at the top of the EU policy agenda in order to ensure unnecessary, avoidable and unjust inequalities between women and men are eliminated and a positive impact is made on the health status of EU citizens.

The EU has committed itself to strive for equality between men and women (Art 2 and 3 TEU/ Art 8 TFEU) and equality is one of the five values on which the European Union is founded.



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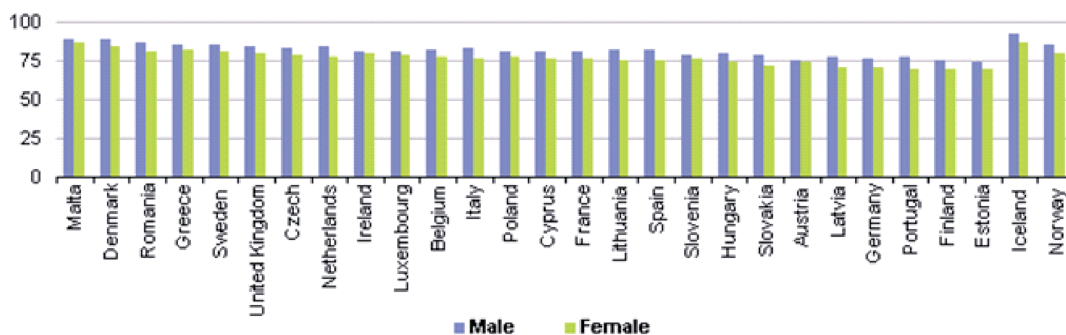
The situation

The average life expectancy at birth in the EU is 75.8 years for men and 82.1 years for women but gaps exist between and within countries. In Lithuania, the difference between male and female life expectancy is 12.3 years, while in Iceland, women only live 3.8 years longer than men.[vi] In the wealthiest part of London, a man can expect to live 88 years while a few kilometres away, in one of the capital's poorer wards, male life expectancy is 71.[vii] Social factors are therefore of primary importance in gender and health inequalities.

Women and men are susceptible to sex-specific diseases such as breast cancer and cancer of the cervix for women and cancer of the prostate for men. In addition, women and men present different symptoms and consequences of common diseases, such as cardiovascular and sexually transmitted diseases[v]. 47% of all deaths in women are the result of cardiovascular diseases and 22% are the result of cancer while the comparable figures for men are 39% and 28%. While women generally live longer than men, they are more likely to perceive their health as bad or very bad and they spend more years experiencing worse health[iv]. Although they are less likely to engage in risky health behaviour, women more often suffer from 'invisible' illnesses and disabilities – e.g. depression, eating disorders, disabilities related to home accidents and (sexual) violence as well as diseases related to old age. Within the 27 EU Member States, around 29% of men (aged 18 or more) have a long-standing illness or health problem, compared to 33.4% of women. These differences in health status and survival between men and women are unnecessary, unjust and avoidable.

It has consistently been found that role conflicts, total workload and unpaid work have adverse effects on women's well-being and long-term health as well as on opportunities for professional careers[ii]. The reasons for this include their reproductive role, their prevalence among the older population but also their role as caregivers for dependants (children, older or disabled people). As a result, women are more aware of their health status and are greater users of healthcare services than men. A just social distribution of responsibilities, power and rewards between men and women would ensure fairer health outcomes. This implies placing value on non-remunerated work.

Figure: Healthy life years at birth, 2007 ([1]) (% of total life expectancy)



([1]) **Bulgaria**, not available; the figure is ranked on the average of male and female. - *Source*: Eurostat (tsdph100 and tps00025)

Since women are more likely to perform repetitive tasks and have less opportunity to rest and recuperate off work, muscular disorders are more prevalent among women[ii]. Men on the other hand are considerably more likely to have an accident or to die at work since a higher proportion of them work in 'higher risk' sectors and occupations. Men are also more likely to work on a full-time basis[vi]. Moreover, gender stereotypes play an important part as men usually do not consider it normal to complain about their health and to visit physicians.

The increasing role of private health insurance and out-of-pocket payments may increase gender (and health) inequalities. Women usually have a lower income and do not benefit from the same kind of firm-based private insurance coverage as men do. In addition, private insurance schemes are less attractive to women since they usually consider age and gender-specific risks in defining contributions. Women who bear the 'risk' of pregnancy and birth and have a longer life expectancy risk paying higher total contributions than men of the same age group.[v]

Finally, cultural barriers also strongly define gender and health inequalities. Gender stereotypes, social status and level of education, cultural differences inherent in ethnic and migration issues, religious practices, prejudices concerning sexual orientation and working culture can translate into fewer opportunities for women to play an active role in society and to enjoy a healthy life. For example, due to the language barrier, immigrant women and women of ethnic origin have more difficult access to health facilities and information on sexual health. Nevertheless, men also have to face stereotypes in accessing healthcare and prevention programmes as some medical conditions (osteoporosis, for example) are more commonly associated with women. Education and health prevention programmes are also targeted mostly at women and only address men occasionally[v].

Setting an example

The Men's Health and Wellbeing Programme – ENGENDER database

The Men's Health and Wellbeing Programme (MHWP) was established by The Larkin Unemployment Centre in partnership with the Glasgow Celtic Football Club, in Dublin's North inner city, a socially disadvantaged area.

The MHWP objectives include: assisting men to develop skills and knowledge to take control of their own health, providing information in an accessible and gender sensitive way, acting as a catalyst for men to effect positive change through purposeful activity, providing new opportunities for men to engage in sporting activities, developing appropriate learning strategies, building capacity in the community, promoting alternative social and recreational spaces for men to meet, and creating a context that locates learning as part of community life and not fixed to a particular place or time.

The programme was effective in improving participant's health in areas such as blood cholesterol, BMI, blood pressure and fitness levels. The programme was also effective in increasing men's awareness of health, improving personal development and empowering and building social capital in the community.

Pathways to progress

A large number of European legislative texts are dedicated to Gender Equity. As from 1 January 2011 the issue falls under the portfolio of Justice, Fundamental rights and Citizenship.

The Strategy for equality between women and men (2010-2015), adopted in 2010, commits the Commission to promote gender mainstreaming as a contribution to economic growth and sustainable development. The Strategy spells out actions under five thematic priorities and one cross-cutting theme: (1) equal economic independence for women and men; (2) equal pay for work of equal value; (3) equality in decision-making; (4) dignity, integrity and ending gender violence; (5) promoting gender equality beyond the EU; and (6) horizontal issues including gender roles, legislation and governance tools. For each priority area, key actions and detailed proposals for change and progress are described [iii].

The new Strategy aims at strengthening cooperation between relevant actors and improving governance. To tackle the gender gap, effective implementation of gender mainstreaming in all EU policies is needed and legislation has to accompany societal change iii. Besides biological differences, economic, environmental, social and cultural factors have to be taken into account when adopting a gender perspective in policies and programmes, so that men and women will benefit equally, and inequality is not perpetuated iv. Both the PROGRESS programme (2007-2013) and the European Social Fund provide financial support to promote equality between women and men at local, national and European level.

The Commission's proposal for a single anti-discrimination directive covering protection against discrimination based on sexual orientation, age, disability, religion and belief with regard to access to social protection, goods and services, health care and education (2008) set the basis for gender mainstreaming.[viii] The Communication on the review of the working time directive and the Report on its implementation (both adopted in December 2010) also offer some opportunities for progress as work-life balance and flexible working time arrangements would contribute to both gender and health equity.[ix]

Additional Information

- **Closing the gap in a generation.**
  Report of the World Health Organization Commission on the Social Determinants of Health.
- **DETERMINE** - www.health-inequalities.eu
- **Beijing + 15: The platform from Action and the European Union**
- **EC Strategy for equality between women and men (2010 – 2015)**
- **The Engender Project - www.engender.eurohealth.ie**
- **Directorate General for Employment, Social Affairs and Inclusion**
- **Europe 2020: A European strategy for smart, sustainable and inclusive growth**
- **Directorate for Justice, Fundamental Rights and Citizenship**

Contacts

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Sources

i. **Closing the Gap in a Generation**. Report of the WHO Health Organization Commission on Social Determinants of Health, Geneva, 2008. ISBN 978-92-4-156370-3

ii. **Gender and Social Inequities in Health – A Public Health Issue**. Sarah P. Wamala & John Lynch (Eds.), Studentlitteratur and Statens folkhälsoinstitut 2002. ISBN 91-44-02202-6

iii. **Strategy for equality between women and men (2010-2015)**. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, COM(2010)491

iv. **How can gender equity be addressed through health systems?** Sarah Payne, WHO Regional Office for Europe and European Observatory on Health Systems and Policies, 2009. ISSN 1997-8065

v. **Access to healthcare and long-term care. Equal for women and men?** Chiara Crepaldi, Manuela Samek Lodovici, Marcella Corsi, Expert Group on Gender Equality and Social Inclusion, Health and Long-Term Care Issues (EGGSI), European Commission, DG EMPL, 2010. ISBN 978-92-79-14854-5

vi. **Europe in figures. Eurostat yearbook 2010**. Eurostat, European Commission, 2010. ISBN 978-92-79-14884-2

vii. **Fair Society, Healthy lives**. The Marmot Review, 2010. ISBN 978-0-9564870-0-1

viii. **Equal treatment: implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation**.

ix. **Reviewing the Working Time Directive**. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, SEC(2010) 1610 final.

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