Development in the context of health and equity between the genders

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1. Introduction

Firstly, whereas there are models of development that focus solely on efficiency, let us aspire to models of development that promote equity (as well). Secondly, it seems natural to assume that in an equitable world, different population subgroups will on average enjoy the same level of health. Thirdly, currently, men have poorer lifetime health prospects than women in many countries, as for example is indicated by lower life expectancy at birth. Pulling all this together, the question of interest is: what does equitable development imply for the health of men and women?

There are a few things that need to be clarified before going any further. First, are all inequalities automatically inequitable? In this paper we will treat equality/inequality as a matter of description, and equity/inequity as a matter of norms. So it is not impossible for two groups to have equal health, and for this to be regarded as inequitable. Second, where equity in health calls for equality in health, does equity in health across two population groups require that they have the same level of health? Sen (1992) distinguishes between attainment equity and shortfall equity. Briefly, attainment equity looks at what the two groups achieve, and for instance if they have the same level of life expectancy at birth, then attainment equity is achieved. On the other hand, shortfall equity looks at what is achieved with respect to the maximal achievable potential. If the potentials for the two groups are the same, then the implication of shortfall equity and attainment equity will be the same. But if the potentials for the two groups are not the same, then implications may be different. Let us leave this as an open issue for now. Third, what is the measure of health used? In this paper, we use Expected Lifetime QALYs (Quality Adjusted Life Years), or ELQ, as the concept representing the measure of health, over which equity is the issue. This is an improvement over using life expectancy at birth, because it incorporates health

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\(^1\) Justice and equity are core concepts in the sustainable development literature; see for example Pearce (1993); Campbell (1996); Haughton (1999).

\(^2\) Public health initiatives are typically concerned over different levels of lifetime health across populations. For a theoretical approach, see for example Williams (1997).

\(^3\) Suppose two individuals are in equally poor health, because the Driver was driving irresponsibly and caused a traffic accident involving the Pedestrian. Both are critically injured to the same extent. Thus, they are in equal health. But there is nothing that makes this equality equitable.

\(^4\) Suppose one individual has the potential to achieve 100 (of whatever good), whereas the second individual has the potential to achieve 200. Then, if both individuals achieved 50, this will be equal and thus equitable in terms of attainment, but not equal or equitable in terms of shortfall (which is much larger for the second individual).

\(^5\) This is the number of years a person has so far lived (ie. their current age) adjusted for the level of health related quality of life associated with each time period, plus the number of years a person is expected to live (ie. their life expectancy at birth).
related quality of life. It is also an improvement over using incidence or prevalence of ill health and morbidity alone because it reflects the duration of the ill health. Based on globally available estimates of quality adjusted life expectancy, disability free life expectancy, and the like, men tend to have poorer ELQ than women from the same country, especially in the developed world (Cambois and Robine, 1996; Kaplan and Erickson, 2000; WHO, 2002).

Tsuchiya and Williams (2004) examined six possible arguments on why the inequality in lifetime health between the sexes may not be an inequity:

(1) to challenge the data, and argue there is no inequality, by indicating that women have a higher morbidity rate, and therefore they may live longer but may have a lower lifetime health prospects overall;
(2) to deny that men and women should be regarded as members of the same community, so that the existing inequality is not an inequity;
(3) to assert that the differences are largely due to biology and beyond our control, and are therefore not an equity issue;
(4) to claim that men are themselves the main cause of, and thus responsible for, their shorter life expectancy, and therefore the inequality is acceptable;
(5) to point out that changing life styles of women are making them live more stressful lives and die earlier, so that before long there will be no more inequality in health between the sexes and therefore this discussion is unnecessary; and
(6) to question having health considered separately from all other sources of well-being, and to argue that better health is to be weighed against poorer socio-economic status when assessing the well-being of each sex.

The paper regarded the last point as an issue, and in effect, dismissed all the others. The reasoning used to discard the 5th point was that so long as there are current inequalities that are inequitable, claiming that it will eventually go away is not a good enough argument to make the inequality not inequitable. However, the paper did not examine the factual basis of the argument, or its implications should they be found to be the case. This paper aims to do that. It will also involve taking another look at some of the other points.

2. Background

If we are going to look at sex differences in lifetime health, a crucial concept is that of the gender system, or in short gender, which refers to the societal structure organising human activities based on sex (Harding, 1986). The gender system involves two dimensions. First, structures that facilitate keeping women’s and men’s work, characteristics, and behaviours separate (dichotomy), and second, structures that divide the relationship between the sexes unequally into a male superiority and a female subordination (asymmetry). This means, when combined with a capitalist system, that men’s primary role in life becomes working in the labour market to generate cash income, while women’s primary role in life becomes staying at home to look after the family. The continuation of the division of labour by sex is assisted by two other dimensions of the gender system; the symbolic division between femininity (as private, passive, dependent, tainted, etc.) and masculinity (as public, active, independent, pure, etc.), and by the fact that expectancy) adjusted for the level of health related quality of life associated with each time period (see for example Williams, 1997). We are fully aware empirical data are not always available in terms of ELQ.
human identity is formed by collective opinions about what is judged appropriate for men and women respectively (Månsdotter et al., 2004).

One implication of the gender system is that it implies different lifetime health for women and men. Gender may be seen as primarily counteracting men’s health since many health-damaging attitudes and behaviours are means for demonstrating a particular kind of masculinity (Courtenay, 2000; also see Segal 1990; Francome, 2000; Clare, 2001). It has, for instance, been shown that an essential part of men’s excess mortality is due to behaviours which are more encouraged in males than in females, e.g. working in hazardous jobs, drinking alcohol, and being seen as fearless (Waldron, 1976). A common view is also that gender primarily counteracts female health because of the vast evidence that a low socioeconomic position connects to poor health: women have less choice and control, and therefore their health must be at a disadvantage.

However, as Johansson (1991) points out, women’s subordinated position in wealthy settings has probably protected them, relative to men, from non-infectious death causes.

The well-established relationship between the gender system and differences in women’s and men’s health patterns leads to the view that it seems reasonable to assume that equitable development towards a “genderless” society/culture will result in a much smaller difference in ELQ. To examine this view, we first need to clarify what we mean by “genderless”. For instance, if, in order to “correct” for some residual social/cultural inequity, policy treated the two genders differently (e.g. people received different social benefits and privileges depending on their biological sex), would that still count as “genderless”?

Let us first assume that when the gender system is abolished, women and men will participate in more or less equal numbers in every sphere of life (“from infant care to high-level politics”, Okin 1987), and social privileges and burdens (not necessarily health) will be distributed independent of one’s sex. Since once the gender system is abolished, not only the asymmetric distinction but also the dichotomous distinction will no longer exist, the above assumption of equal participation across different spheres of life seems reasonable. However, during the transition towards the genderless society, we are likely to see interventions that are not themselves genderless, e.g. if it is found that men demand higher wages to work in some traditionally “female” jobs such as childcare, then decision makers may decide that wage inequalities are acceptable for the purpose of equalising the numbers of female and male employees in such jobs. With time, people will get used to seeing men working in childcare, so that higher wages will start to attract excess male applicants, and that will be the time when the wage differential should be withdrawn, and genderlessness can be regarded as having being achieved (at least, in this market).

Differences that arise from individual preferences and choices can thus be lead by appropriate motivations and incentives, but what about differences that arise from biologically determined factors as well? In other words, females and males might have different potential for ELQ, which are biologically determined. There are three possibilities, each relating to the debate on attainment equity and shortfall equity:

1) if an inequality in ELQ remains due to biological factors, and health is seen as a primary sphere that should be equally divided between the sexes, the genderless society will require

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6 On the other hand, the asymmetry between the genders means that there will be relatively fewer cases where women will require higher wages to take up traditionally “male” occupations.
different health-related resources, treatments, privileges, etc. to women and men --- since the recognition that health is a primary sphere of human life will then imply that everybody should have equal access to it, this case requires the use of the attainment approach to equity; (2) if an inequality in ELQ remains due to biological factors, and health is seen as a secondary sphere of interest, the genderless society will expose, and accept as fair, the health difference between women and men (as long as it is in line with the extent of the biological gap) --- since the recognition of health as a secondary sphere will allow for certain differential attainment to be equitable, this case supports the use of differential potential under the shortfall approach to equity; or (3) if the genderless society exposes no difference in biological ELQ between women and men, a genderless distribution of both health and health-related resources is possible --- in this case the issue of attainment equity versus differentiated shortfall equity disappears.

Regarding the facts, Waldron (1983) has reviewed evidence concerning biological causes to the female/male gap in mortality, e.g. the hypothesis that males have higher foetal mortality was rejected, the hypothesis that X-linked genes contribute to greater female resistance to infections was supported, and the idea that male sex hormones may affect differences between the sexes in behaviours like accidents and other violent causes was accepted. She concludes women may have an inherent advantage in life span; but, that it is impossible at present to make even a preliminary quantitative estimate of the biological contribution to the mortality gap at present. Although more than 20 years old, let us assume that the conclusion of the above study still holds. That is, we are not able to pin down the exact magnitude, but it seems reasonable to suppose females do have some biological advantage in terms of longevity, and ELQ. Thus, let us assume a positive health gap remained in the genderless society, should we regard this as inequitable, and aim to diminish this? Tsuchiya and Williams (2004) have argued that biological inequality can still be an inequity. A biologically caused disadvantage need not be an unavoidable disadvantage, and even an unavoidable disadvantage does not mean the disadvantage itself does not command special attention towards compensating it. If so, as is pointed out above, a crucial point would be whether or not the disadvantage is regarded as one in a primary sphere in life.

When one hears the argument that sex inequality in ELQ is not an inequity because it is biologically determined and there is nothing we can do about it, it is at curious odds with the fact that the whole enterprise of medicine is about trying to change the course of things that are initially set by biology. It is tempting to ask what would be the case if it were established that it was actually the males that had the biological advantage in longevity, which they currently waste on culturally and/or individually motivated risk behaviour. And, suppose the genderless society, in which men lived longer than women (thanks to their biological longevity) became true. Would there still be support for the argument that biological inequalities are equitable, and therefore it is equitable for women to die earlier than men as long as this is due to biology? Or is the idea of

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For an example of differentiated potential by sex, see for example UNDP (1995) or World Bank (1993).

Imagine an individual born with an incurable permanent disability with no known cause (viz. the disability is caused by nature). If this disadvantage is regarded as a matter of equity, then this individual can then be given priority and privileges in other areas of life to compensate for their lower ELQ. If this lower ELQ was not regarded as inequitable because it was caused by nature, then it is not obvious how such compensations and support will be justified. The argument that everybody is entitled to some basic level of functioning that is “normal” for humans will not work, since it implies that disadvantage caused by nature should not be left unsupported.

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biological inequality being equitable somehow implicitly linked to the fact that females are currently, undoubtedly, disadvantaged in socio-economic status?

3. The facts

This section reviews some of the evidence on the relationship between increased gender equality and the health of women and men. In a well-known study based on US data, Kawachi et al. (1999) report that women experience higher mortality and morbidity in states where they have lower levels of political participation and economic autonomy; moreover, living in such states damage men’s health as well. Further, a more recent cross-country study has demonstrated that patriarchy, measured by female homicide rates, is bad for men’s life expectancy; and, though more implicitly stated, also for women’s (Stanistreet, Bambra and Scott-Samuel, 2005). The implications seem to be that the initial steps towards a genderless society, in terms of improved female rights regarding reproduction, nutrition, education, resources, and influence, involve health gains amongst both sexes.

Although not in terms of ELQ, or QALYs, an interesting study on self reported health problems (headache, back pains, feeling low, sleeping difficulties, etc) amongst adolescents in European and North American countries found that, whereas girls report higher levels of subjective health problems than boys, the difference between the sexes was larger in countries with low scores on the Gender Development Index (viz. countries where the status of women is lower compared to that of men). In other words, steps towards the genderless society seem also to be associated with convergence of the sexes’ health in this age group (Torsheim et al., 2006).

However, these studies explore the associations between peoples’ health and community level indicators of gender equality; and as such, they can only investigate diverse degrees of inequality between the sexes. In a more recent project, Månsdotter and colleagues have performed two empirical studies where the impact of a changing gender system was captured at the individual level. The differences between women’s and men’s health were assumed to be mainly caused by the gender system, and hence, the overall hypothesis was that a genderless society will imply a convergence of life expectancy, or life time QALYs, between the sexes. The population consisted of all Swedish couples who had their first child together in 1978 (98,240 individuals). Aspects of gender (in)equality were measured during 1978-1980, while data on mortality was obtained from 1981 to 2001 and sickness leave from 1986 to 2000. The analysis used logistic regression adjusting for age and socio-economic factors, with odds ratios as estimates of relative health risks.

The first study aimed at examining if “traditional couples”, i.e. where the man dominates in the public sphere (income and occupational position) and the woman in the domestic sphere (parental leave and temporary child care), have different health risks compared with “equal couples” (Månsdotter et al, 2006a); Table 1 presents a summary of these results. It was demonstrated that, in the public sphere, traditional women (parental leave and temporary care) have lower health risks compared to equal women, while traditional men (occupation) have higher health risks compared to equal men. Regarding the domestic sphere, it was indicated that both women and men (temporary care) run higher risks of death and sickness when being traditional as opposed to equal.
The second, not yet published, study acknowledged that the prime motive behind the 1974 reform that granted Swedish fathers parental leave was to achieve greater gender equality in both domestic and public spheres of life (Månsdotter et al., 2006b). The analysis suggests that this reform may have benefited men's health as well, through the development of less health-damaging lifestyles. Hence, one aim of the study was to examine the relationship between paternity leave and male mortality. The results demonstrated that men who took paternity leave ran statistically significant decreased death risks over the period 1980-2001 compared with men who were not on paternity leave.

It is tempting to look at this result with a causality-based interpretation: viz. fathers who took paternity leave experience a situation of childcare, usually experienced by mothers, which actually makes them develop a less traditional (i.e. less health-damaging in terms of alcohol drinking, risk-preferences, etc.) male role than other fathers, and hence, lower mortality. However, although the analyses controlled for age and socio-economic factors, it is important to note that the design does not give opportunities to rule out the possibility that the results are due to self-selection; that is, men who took paternity leave in the late 1970th were perhaps more health-aware than other men with the same age and socio-economic status but who did not take paternity leave, and this may have exposed the former men to lower mortality risk over the following decades than the latter. Månsdotter and colleagues propose that the causality interpretation and the self-selection interpretation may both be valid. The studies do not, of course, expose what would be the remaining biologically caused health gap between women and men in the genderless society, but they indicate directions of health trends. One conclusion that should be undisputed is that men seem to have gained more lifetime health than women from increased gender equality during the late 20th century in Sweden; in fact, women may have had restricted opportunities to maximise their health. Another indication is that the process towards the genderless society is likely to involve a convergence of life expectancy, and ELQ, between the sexes.

4. Discussion: What to make of all this?

Equitable development towards the abolition of gender will most likely involve two moves. The first is the one where women move into spheres that have traditionally been regarded as male, and as a result, expose themselves to higher levels of health risks. The second is one where men move into spheres that have traditionally been regarded as female. If men are to benefit from the lower health risks traditionally enjoyed by women, they will also have to reduce their labour market activities at the same time9. In this respect, a re-assessment of what constitutes

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9 If more men/fathers looked after the family and more women/mothers participated in the labour market, then this may lead to a shift from the current gender system based on biological sex to a parenthood system, which treats people differently depending on whether or not one is a parent (i.e. women with children will be grouped with men with children, rather than with women without children). The new system should devise a way that treated parents and non-parents differently, but without advantaging one group systematically over the other. For instance, all part time work should be paid pro-rata to full time work, and appointments and promotions will be a function of expected performance, not a function of absolute amount of past contribution or experience per se. This will not only make career prospects fairer between parents and non-parents, but also for instance between those with and without disabilities. Or, people who simply do not want to work 8 hours a day for 5 days a week, or those who choose to
“masculinity” would be good for men’s health, and, to the extent that this is in line with what women want, it will be good for women’s well-being as well, if not their health.

The above seems to imply that if we are to achieve equality in ELQ between the sexes any time soon, this may well involve reductions in female ELQ, at least in the developed world. In the developing world, it may be possible to “soft land” to a point with minimal sex gap in ELQ without going through a phase where female ELQ needs to diminish. But even then, the process will probably involve harnessing in the growth in female ELQ so that it does not grow faster than male ELQ.

Regarding the issue of female advantage in longevity over males, and whether or not this should be reduced by policy interventions, for example, that restricted women’s access to health care, Sen (2002) makes the point that trying to reduce such differences in longevity may reduce health inequality but increase health inequity. This is because achievement of equal health is not the only issue in health equity, but also the processes by which this is achieved: if health equality is achieved by denying access to health care for whole population groups, this violates other considerations of equity. If so, would the genderless society with reduced inequality in ELQ between the sexes suffer from increased health inequity? Note that the process discussed here does not involve restricting women’s access to health care that are available to men: the process involves shifts in informed and free choices that people make in their daily life, where more women take more risks than women traditionally used to, and where more men take less risks than men traditionally used to. The reduction in health inequality will be a “side-effect” of these shifts.

Why would there be such a shift? If gender barriers were removed, both in the private and public domains, we expect more women would participate in the labour market and/or work less at home, and more men would participate in taking care of the family and/or work less at work\(^\text{10}\). Or rather, it is only when these changes actually take place that we will acknowledge that gender barriers have indeed been removed.

For men, the issue is relatively straightforward: they get to engage more with their children, they get to work less, they bear less responsibility for generating cash income, and as a result they get better health. The fact that more men do not currently make choices along these lines (“because the man should put the bread on the table”) is indirect proof that the genderless society is yet to come. On the other hand, for women, the picture is more complicated: they see less of their children, they get to work harder, they bear more responsibility for financing the family, and as a result their health will be worse. So, why would women want to do it? What does “development” mean to women in this context?

It is crucial to note that it has been predominantly women, not men, who have struggled for changes in the traditional gender system. Women have wanted to escape an exclusive occupancy...
in the domestic sphere because it is lonely, repetitive and boring, involving hard work, associated with low nor no social status, under-rewarded and un-paid, etc., whereas men have not valued the prospect of entering closer relationships with their children for the very same reasons. With more information regarding the health consequences for men, there may be some increased interest amongst men towards gender abolition. However, unless the current conceptualisation of masculinity changes, this is unlikely to lead to a major movement, since the very essence of conventional masculinity is that “real” men should not be affected by concerns over their own health and safety. Furthermore, the public sphere of resources, independence, and politics has traditionally been valued more highly than the domestic, private sphere of caring. The asymmetric power dimension of the gender system, which links the male with the public (and therefore to superiority) and the female with the private (and therefore to subordination), is highly relevant in this context.

In gendered societies, women and men have been subjected to different behavioural and aspirational norms, which seem to have long term health effects. We have pointed out that equitable development towards a genderless society will probably have a negative impact on women’s ELQ relative to men’s. An interesting question is, if health and longevity are key elements of well-being, then what does it mean, when improving well-being beyond a certain point by removing an asymmetric and inequitable social system seems to result in their reduction? It is possible that certain forms of the patriarch gender system have in effect allowed women to exploit men so that they do not have to shoulder the fair share of the health risks associated with human/social life. The breaking up of the gender system will mean women giving up the undue advantages regarding life time health they have so far enjoyed.

All this may sound ridiculous, especially when one looks at some parts of the world where women are subjugated to patriarch control, with limited choices and freedoms over their own life, given lower priority in terms of nutrition and health care compared to the men in the same family, and at the same time carrying out most of the physical labour around the house and possibly also in the lower-paid end of the labour market, and/or by tending commercial crop, to raise cash income for the family. However, we are not trying to argue that the patriarch gender system is inherently to the benefit of female longevity. The point we are trying to make is that to assume that the patriarch gender system is inherently to the disadvantage of female longevity seems wanting.

Insofar as the current gender system works to the advantage of female ELQ, equitable development towards abolishing this will imply women having to give up the excess health advantage, just like men having to give up their excess socio-economic advantages. Assuming full information and rational choice, if a significant proportion of women do make choices that imply reducing their own ELQ, it will mean these women do not regard mere ELQ as an absolute good: they will be better off with less health and more choices/control. Sen (2002) argues “health is among the most important conditions of human life and a critically significant constituent of human capabilities” (p660 l). We agree, but we will also like to point out that health alone is no good if there are no socio-economic opportunities to pursue. Health and longevity are not absolute, but is something that can be traded off with other opportunities in life.
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References


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Source: Månsdotter et al. (2006a)