Handbook of Clinical Gender Medicine

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Gender Effects on Health and Healthcare

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Abstract

With the advent of gender medicine there is the recognition that differences exist between and among men and women in relation to their health due to the interplay of biologically determined and socially derived elements. This has an impact on preventive, curative, and rehabilitative aspects of health and most body systems. The intent is to explore gender-based differences as well as disparities and their effect on health and health care.

Defining Terms and Measurement

Gender-based medicine encompasses sex differences (genetic, biological, and phenotypic) but goes beyond these to include the broader social, cultural, and normative factors that affect health. Its roots are partly embedded in the women's health movement of the 1970s, since through the recognition of women's health came the acknowledgement of gender differences. However, gender medicine is not women's health and it is it not binary. It extends past the health of women to create new prototypes of male health, as well as to encompass the biological and social aspects of lesbian, gay, bisexual, transgender, and intersex (LGBT) people.

As with gender medicine, the working definition of disparities extends past a simple one that only accounts for an identified difference between two groups to subsume the idea of social justice. The term is used in keeping with the World Health Organization's perspective that notes that disparities include a difference between two groups that is viewed as being unfair and unjust, as well as being both unnecessary and avoidable. Further, when determining disparities, equity and not equality needs to be considered through the assessment of need as well as of outcomes, since equal treatment may in fact perpetuate a disparity.

The Research Void

As noted by Marianne Legato, a leader in gender medicine, women are not little men, and all men are not alike. In fact, there is growing recognition that biomedical and clinical research has focused on males as a relatively heterogonous group. It has, in large measure, ignored women with the exception of reproduction, ignored LGBT populations with the exception of sexually transmitted diseases, and ignored other minorities and largely concentrated research efforts within high-income countries.

In the 1990s, in response to the paucity of research on women, a number of jurisdictions established requirements that sex be considered in study designs in order for grant requests to be eligible for governmental funding. Requirements along these lines can be found in diverse counties such as the USA, South Africa, and Australia. However, no requirement or incentive exists that promotes research for other key groups such as LGBT populations or that requires sex and gender to be considered in the composition of ethic committees or in the review of research proposals. This oversight points to a potential root cause for certain health disparities that undoubtedly have health and healthcare system equity implications.

Healthcare Utilization

Across the healthcare landscape we see different utilization rates, as well as different barriers and enablers to healthcare access. For example, women in high-income countries are more likely to engage in preventative health activities than are men. They are also more likely to seek treatment for most diseases and to do so early in the course of an illness [1]. In contrast, women within emerging economies, such as those of Ghana and India, have been shown to utilize health systems less than men during their lifespan due to restrictive barriers such as childcare duties and care giving obligations, as well as service cost [2, 3]. Irrespective of country of origin, women in general are less likely to perceive their overall cardiac risk level and therefore are less likely to attribute their symptoms to a possible cardiac related health issue [4].

Men's lower healthcare utilization rates in high-income countries are linked to the trend that they are fulltime workers, work longer hours, and have less flexible schedules than women do [1, 5]. Additionally, the presence of long wait times (more than 1 week) for a routine care appointment is a strong negative predictor of men accessing the health system within the USA [1]. Although variation may exist across countries, a study conducted in Denmark shows that working-age men have higher rates of hospitalization and mortality than their female counterparts [6]. This is attributed to lower rates of healthcare practitioner contact [6].

Available information from both the USA and Canada provides insights with respect to the LGBT population's utilization of healthcare systems. Lesbians and gay men are less likely to seek preventive care, such as cancer-screening services, and to

have poorer health maintenance behaviors than the general population [1, 7, 8]. This disparity is thought to be attributable to stigma, healthcare professionals' perceived biases, lack of clinical and cultural knowledge, and lack of gender-sensitive care [1, 7, 8].

Lesbians are also less likely to have health insurance, to see a healthcare practitioner, or to have a consistent source of care [1, 7, 8]. This population is believed to underutilize health systems and delay health seeking [1, 7, 8]. In contrast, gay men living with a partner are as likely as a male living with a female partner to have a consistent source of care and to have significantly elevated chances of having seen a clinician within the last year [1, 7].

Transgender, bisexual, and intersex people are less likely to utilize the healthcare system than is the population as a whole [7, 8], while research demonstrates that transgender people are less likely to be insured than the general population. The underutilization of the healthcare system by bisexuals and intersex people is reported as being due to their perception that healthcare professionals lack the requisite knowledge to support their unique needs [7, 8].

The Morbidity and Mortality Paradox

When we look at health status in terms of mortality rates, we see that men's life expectancy at all ages is less than that of women in most countries around the world (on average around 6–8 years less). This mortality gap is wider in the former Soviet Union countries. In fact, Russia reached an unprecedented 13-year difference between male and female life expectancies in the 1990s; this is primarily attributed to high rates of circulatory disease among the men [9]. Meanwhile, in the USA and other high-income countries the gap is narrowing. The US 2010 census shows that the gender mortality gap is getting smaller, most significantly in the above 65 year range.

In general, the shorter life expectancy in men is thought to be the result of male behaviors including greater risk taking in relation to tobacco and alcohol use [1, 10]. It is also attributed to masculine attitudes towards health, such as not expressing pain or discomfort or acknowledging emotions [1, 10]. In some low- and middle-income countries in Asia, a deviation from this trend is seen; women's life expectancy at birth is actually lower than or equal to men's [11]. This is thought to be due to socially mediated causes including maternal mortality, disparities in access to care, female infanticide, and lack of female empowerment [11]. It is worth noting that, irrespective of the gender mortality trends, about 350,000 women die each year, predominantly in low- and middle-income countries, due to pregnancy and childbirth. Neither of these conditions in isolation constitutes an illness or disorder.

While men in most instances are more likely to die earlier than women, epidemiological information points to greater morbidity in women, based on rates of self-reporting and provider reporting [1, 12]. This finding is further supported by research

in the USA that reveals that on a per capita basis women's spending on health care services exceeds that of males [13]. Another study provides additional cultural insights in that women in Canada were shown to be more likely than men to report unmet health needs; this is within a country that provides universal basic care [14]. Women's spending rates and their likelihood to report unmet health needs may be either a consequence of or a causative factor in the higher rates of morbidity in women.

Although the medical literature overwhelmingly points to a gender difference, there has been some questioning of the existence and the extent of any gender difference in morbidity. It has been proposed that when lifespan and disease area variation is accounted for, any noted difference in morbidity rates is attenuated [1]. Others reports suggest that the variation is an artifact due to factors such as higher rates of hospitalization due to childbirth in women, women's increased tendency toward seeking out health services resulting in higher diagnosis rates as well as higher rates of medication usage, and women's greater inclination to identify complaints believed to be health related [1].

Morbidity in Lesbian, Bisexual, Gay, Transgender, and Intersex Populations

Disparities within LGBT populations as well as differences among them exist in relation to disease patterns and behaviors affecting health. A consistent disparity across LGBT populations is that they are at a higher risk for violence than the general population, with one third to one fourth of this population in the USA having experienced a violent act. Mental health is also an area of special concern, notably depression and anxiety [7, 8]. LGBT people are more than four times as likely to have attempted suicide as the general US population. Eating and body image disorders have a higher prevalence in gay and bisexual men compared to their heterosexual peers [7, 8]. It is believed that all of these mental health conditions are manifested as the result of being marginalized within society, coupled with a history of emotional or physical abuse [7, 8].

Additionally, higher rates of recreational drug use among gay men, higher rates of obesity among lesbians, and overall higher rates of tobacco use in LGBT populations have been reported in the USA and Canada and may result in increased morbidity [7, 8]. The use of tobacco puts this population at a higher risk for lung cancer and chronic obstructive pulmonary disease, obesity increases the risk of a number of noncommunicable diseases, and finally recreational drug use can lead to an increased risk of sexually transmitted diseases due to an increase in high-risk sexual behaviors [7].

When we look at other areas of increased disease prevalence we see that lesbians are at a greater risk for morbidity and mortality due to gynecological cancers, especially ovarian cancers [7, 8]. This risk is thought to be compounded by the tendency to delay routine healthcare [7, 8]. Higher cancer risk is also seen in men who have sex

with men. They have a higher prevalence of anal human papilloma virus which can result in anal cancer [7, 8].

There is little research on transgender morbidity but, due to exposure to hormone therapy over extended periods of time, transgender people may be at increased risk of hormone-related cancers [7, 8]. Special concern also exists regarding the self-administration of high-dose hormone regimens, without medical supervision, within the transgender population [15]. This practice poses an obvious and significant health risk.

Aging

Healthy aging is a shared goal between sexes and across the gender continuum, yet as the numbers of aging people grow, our knowledge on the topic does not keep pace and our health systems remain largely focused on curative rather than preventive care.

Interestingly, in some high-income countries the higher rates of morbidity in women compared to men are either somewhat diminished or absent as women age [1]. In contrast, a study within India demonstrated that women over the age of 60 continue to report a higher prevalence of disabilities, worse self-rated health, and marginally lower chronic conditions compared to same-aged men [3]. However, when controlled for a number of socioeconomic conditions, the study shows that financially empowered women have equal or better health than similarly aged men [3]. Another study conducted in Africa and Asia shows conflicting information in that women have significantly worse self-reported health than do men even when differences in demographic and socioeconomic factors are adjusted for [16]. These last findings are of particular interest since the majority of women 60 years of age or older reside in low- and middle-income countries and the overall proportion of older people within these countries is rising [11].

In light of LGBT populations' tendency toward having delayed, avoided, or been the recipient of mismanaged care over their lifespan, they are at a greater risk for increased health issues as they age. They are also disadvantaged by the lack of targeted governmental services available and the potential lack of social networks established to help provide them assistance in navigating healthcare systems as they age [7, 8]. Older LGBT people may also have significant concerns about the need for institutional support in residential facilities for the aged due to inherent social prejudices [7].

Allocation of Resources, Empowerment, and Equity

Any discussion of sex and gender requires acknowledgement of the unequal distribution of assets and power as well the existence of harmful gender norms. The differential distribution of, access to, and control over resources has an effect on health.

Health is positively associated with gender equity and lack of equity has a distinctly negative impact on health [1, 17].

A key predisposing factor for an individual's health is their level of education, which is also a driver of health literacy. Women in a number of low- and some middle-income countries, particularly in Africa and Asia, are disadvantaged due to having lower literacy rates and significantly lower rates of access to primary and/or secondary schooling in contrast to their male counterparts [11]. Moreover, it has been established that a person's level of education is positively correlated with their use of healthcare services such as preventive services, intake of fewer prescription medicines, and a lower likelihood of inpatient hospital stays [1]. The social practice of restricting women's attendance in school has a distinct and long-lasting influence not only on the women's health but also on the health of their children [11]. There is a growing body of evidence that points to the importance of women's education for child survival rates.

Although the exact numbers are not known, we know women are particularly vulnerable to poverty and in general earn less than men. Women are also subject to higher rates of unemployment, with the unemployment gap in relation to men ranging from 15% higher in countries with developed economies to 40% higher in countries with developing economies [11]. Women are also more likely than men to be in nonformal employment for which they do not receive a salary [11]. Also, in most societies men continue to hold more political power and with it have greater rein over social and economic controls. The data is very clear with regard to the socioeconomic gradient; higher levels of wealth translate into better health, and women's financial status within most societies is less than males.

However, we have yet to gain adequate insights into how gender equity is affected within a socioeconomic level. We do not know if there is any difference between women and men in terms of their access to health or in their health outcomes within the same impoverished household.

With respect to LGBT populations, for the most part they are excluded from mainstream health policy which by nature remains largely hetero-centric. These populations are rarely considered within healthcare systems outside of the domain of HIV/AIDS and other related diseases. Moreover, the LGBT population is largely missing from inclusion in the health disparity and diversity discussions occurring within countries such as the USA and Canada [7, 8]. The focus is limited to more 'visible' groups such as racial and ethnic minorities. Since LGBT populations are not readily identifiable, they are usually absent from national data sets such as health surveys, censuses, and epidemiological studies. There are either limited or inadequate measures used to identify these populations. If present they are often limited to a single question related to 'sexual preference' which provides minimal and possibly slanted information. Finally, the structural barriers faced by LGBT populations are significant and include the limited knowledge of health care professionals, healthcare professionals' bias which may be largely unintended, and the lack of legal status which

can prevent a partner from being able to participate in health consultations or decision making in most countries [7].

The Final Word

The effects of gender inequities on global health are clear and far reaching. Their magnitude is a potent driver and catalyst for change. In an attempt to address these disparities, gender mainstreaming has evolved as a process in which issues related to gender inequities are given attention when making policies, designing programs, and providing services. This is included within both the legislative and the financial domains. While gender mainstreaming goes beyond the health sector, it is a critical element within it. In theory it should be framed by human rights, be inclusive of men, women, and LGBT people, and span preventive, curative, and rehabilitative healthcare services. While gender mainstreaming as a concept has great merit, it remains more of a promise than a widespread practice.

Another strategy aimed at addressing sex-based differences is the intentional increase in women within the healthcare professionals, within leadership positions in healthcare institutions, and within key political roles. While this intervention is admirable, it will by itself do little to affect equity within health systems since it is not a panacea for creating gender-sensitive health systems. The issue is far more complex and the interventions need to address inequity in broader terms.

Further, while the call for universal healthcare is well intentioned, it may have little or no impact on the gender-related disparities inherent in health systems unless we also address empowerment, access to education, gender-based violence, and heterocentricity; these societal factors are prerequisites for the desired sea change and without them there will be little movement in terms of improving the overall health of society at large.

At the core of health systems is the tenet 'to put people first'. To do this we must put sex and gender front and center. Although gender medicine is not a new therapeutic area, it is a new dimension for healthcare professionals and healthcare systems. Since healthcare systems are shaped by the society in which they operate, the change which needs to occur must permeate how these systems operate and how people relate as well as how people operate within these systems.

Ultimately, the success of a sex- and gender-based approach to health will be dependent on healthcare professionals who, among other actions, will need to play a leadership role as advocates in order to break the cycle of gender-based neglect. Advocacy and action must occur in a number of domains including policy, research, healthcare professional education, and clinical practice guidelines. Available and additional evidence needs to be generated and then put into practice across all of these domains. Additionally, education of patients must be coupled with broad awareness of all healthcare consumers.

Men, women, and LGBT people are waiting for healthcare systems that minimize inequities in health status, disease distribution, and access to services. They are also waiting for gender-sensitive approaches to their care. Let us not keep these patients waiting.

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