

# Health and Gender 2006 Report

## Life Span's Central Ages





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# Health and Gender 2006 Report

## Life Span's Central Ages



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**The Observatory on Women's Health (OWH)** has been part of the Directorate General of the Ministry of Health and Consumers' Affairs' Quality Agency since 2004. It targets gender based health inequalities, aiming at promoting their progressive disappearance. It acts in a participative and cooperative manner in order to generate and disseminate the kind of knowledge that may enable analysis from a gender perspective and promote integration of both equity and a gender approach in health policies and systems.



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# Foreword

This report is in keeping with the Ministry of Health and Consumers' Affairs' line of action that targets the mainstreaming of gender central role in healthcare policies, a highlight featured for the last three years. Furthermore, it is one of the goals outlined in the Quality Plan for the National Health System.

This second report is also among the Spanish Government's main undertakings, specifically developing Organic Law 3/2007 of 22 March for the effective equality of women and men that in its Article 27 commits to the «integration of the principle of equality in health policies».

In order to guarantee the enforcement of the right to health in equal opportunities this Law among other purposes, compels to promote the sort of scientific research that may provide for differences in the health of women and men, encouraging as far as possible disaggregation by sex to enable study of all data contained in records, surveys, statistics or medical or healthcare information systems of any kind. as well as to promote a well-balanced presence of women and men in managerial and professional-responsibility-involving posts throughout the National Health System. On the other hand, it establishes that professional training of healthcare organizations' personnel be provided under the principle of equality.

It is thus for me a real pleasure to present this document that, though referring to 2006, advances some of the aspects of the Law passed in 2007.

Whereas the previous report focused on general aspects of the connections between health and gender, this year's highlights health in women and men's central ages of life.

The range of relevant situations to be discussed under the gender in health perspective undoubtedly stretches beyond what we here present. However and for reasons of usefulness and information availability, some aspects fail to get a mention but may well be dealt with in reports to come.

This report aims at analysing, from a gender perspective, the health of women and men in the central stages of their lives, which involves rendering visible situations of inequality never studied before. It also contributes fresh proposals for newly started research into the knowledge of health and

opens new ways of improvement in the healthcare field that may result in higher quality and equity in the health system as a whole and may better citizens' health.

The Report is organised in six chapters. The first one includes the conceptual framework on health, gender, life cycle and maturity. In second chapter biopsychosocial gender determinants with an impact on health are dealt with in depth.

Issues addressed in next chapters are demographic changes, perceived health, population health complaints, morbidity attended to in primary and hospital care and early mortality, medicalisation of middle-aged women's health and gender role impact on women's health when undertaking other people's care. Sex differences have been singled out for each of the issues to explain when applicable how they translate into gender inequalities.

The last chapter closely approaches women's role in the healthcare professional career, highlighting the fact that despite its feminisation, men's presence is still stronger as far as greater responsibility posts are concerned.

Some conclusions and proposals close the report, materialising in the Ministry's making specific commitments to continuing its endeavour to improve women and men's health and diminish inequalities in health arising from gender.

BERNAT SORIA ESCOMS  
Minister of Health and Consumers' Affairs

# Highlights

This report analyses the Spanish population's health in the central stages of life and its link with the healthcare system from a gender perspective. It aims at contributing to the description and understanding of inequalities with a view to promote equity in health and analyse the gender determinants that influence women and men's health outcomes.

It focuses on the central ages of life, regarding these as the period stretching from age 45 to 65. This is a segment of population that, as a result of the increase in life expectancy, is seeing its life cycle redefined which entails a necessary redefining of the relevant health approach. The situation of this age group that corresponds to the middle-age stage in the life cycle, needs thorough examining with the purpose of giving responses to these generations whose health needs are changing keeping pace with modern life transformations. All this will be better understood in the light of gender analysis as health pathways for women and men differ greatly at these ages. In this group, gender inequality combines with age arisen discrimination in a society that idealises youth, with which middle-aged women are given an even further underprivileged position in terms of health and quality of life.

Inequalities at these stages of life not only surface in quality of life and ways of falling ill of women and men but in their different link with healthcare resources. The health-disease process is conditioned on the one hand by socioeconomic and productive factors in such a way that the lower the level the worse the outcome in terms of health indicators. On the other, it is influenced by psychosocial factors arising from gender models and roles, which determine the different ways of life and duties, this giving rise, in turn, to different ways of falling ill for the sole fact of being man or woman.

For both women and men the dichotomic combination of socialising along modern and traditional lines in terms of gender entails important consequences for their health. For females, the overload brought about by care, reproductive and non-paid work, subordination, dependence, abuse, maltreatment and gender violence on top of doubled or tripled timetables, new family models, patterns of social and personal success, all revolving around competitiveness, exemplary body ideal and eternal youth, may explain their feeling worse and with lesser expectations of a healthy life. As for males, display of strength and retaining power-based relations on the one hand, and the ideal of success and competitiveness on the other also explain the ways they live and fall ill.

It stands as true that even though women live longer, their subjective perception of their own health is worse. Broadly speaking, men present more serious and fatal illnesses, while women get increasingly pestered by chronic ailments that have a negative repercussion on their assessment on their own health. According to preliminary data from 2006 National Health Survey, when it comes to assessing their own health, 46.1% of women find their health to be between poor and very poor, in contrast with 36.9% of men.

More men get admitted to hospital and die prematurely whereas both 60% of the chronically ill population and 56% of the limited for daily life are women. As a matter of fact disability rates in women outnumber those in men by 10 points.

Main causes of death among women and men are tumours —breast among women and lung among men— and cardiovascular diseases. Death rates by tumours in men tend to double occurrence among women and to triple that attributable to cardiovascular diseases.

The Report's main conclusions show that premature death is higher among men, especially mortality due to risk-conduct-associated diseases, as a consequence of gender-related socialising models. Men and women endure and manifest their ailments differently. Women live longer but have a worsened perception of their state of health and though the type of chronic complaints is similar for both sexes, frequency among women doubles and triples that of men in all main categories (osteoarthritis and rheumatoid trouble, bad circulation, headaches, migraines and depression). Also, possibilities of improvement have been identified in the care to women suffering cardiovascular diseases regarding both perception of the risk of suffering from one and healthcare professionals' attitudes in connection with early detection and optimisation of relevant treatment.

Climacteric is often viewed as decline and loss of femininity but most of its related ailments bear relation to gender socialising processes and not to biological changes. Most of the care burden falls on middle-aged people's shoulders and is unevenly distributed between men and women. Women's being overburdened with functions takes a toll on their health.

This stage of life often coincides also with professional maturity. On analysing the professional healthcare field it becomes apparent that despite its feminisation, presence of men in higher responsibility posts is stronger.

As regards proposals for action, we envisage: continuing the promoting of research in health and gender; contributing to encourage the gender approach in health care and in health programmes for middle-aged people; developing informative and educational material targeting the

elimination of gender bias and medicalisation of the healthcare provided to middle-aged women and men; developing and disseminating information for the general population; including the gender approach in the ischemic cardiopathy strategy; and studying distribution of men and women among healthcare personnel.



# 1. Conceptual framework

## 1.1. About health

Since its constitution in 1946, the World Health Organization (WHO) has conceived health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*. In accordance with this notion, safeguarding health not only involves attention to illness but mostly prevention and comprehensive care, as well as the need to address all factors that play a role when attaining the best possible quality of life is the aim. Commitment with the population health shall then have to see to the combination of a series of biological, psychological and subjective, social, cultural, demographic, political and economic factors, insofar as they act as determinants of this well-being.

There have thus been attempts at different levels to promote healthcare and research policies consistent with this approach. Such is the case of the European Union (EU) that along the lines of WHO, mainstreams research and prevention and develops community action programmes in the fields of public health, consumers' protection and environment, amongst others.

Now then: how is this well-being attained? «Health is the outcome of the process in which human life evolves, and where both biological conditions that materialise in the physiological body functioning as well as all impacts caused by conditions of the social context during interaction of the individual with their environment and the particular way in which each person lives their own experiences» (Velasco, 2005). It is a well-known fact that the frontier between health and disease is a social construction that depends on historically determined values about health, which translate into different conceptualisations of unwellness. It follows from the global definition of health that the state of health has to be established through standards arising, in broad terms, from the social context, this including not just variable conditions stemming from sex, age or ethnic group but also from culture, social class, education level, working or co-habitational situation, etc., as well as from vital processes each person goes through and their personal experiences and subjective perception.

A **theoretical framework of biopsychosocial health** (Engel, 1977 and 1980; Tizón, 1988 and 1995; Borrel i Carrió, 2002) enriched with such a wide and comprehensive conceptualisation of the concept of health proves essential, when health is intended to be addressed from a gender perspective (Velasco, 2006a) as gender is precisely a category that serves the

analysis of both social constructions on women and men and how social representations are interiorised by individuals as mandates over ideal models (Tubert, 2005; González de Chávez, 1998). What in gender affects health belongs to the field of sociocultural and psychological spheres and it is hence necessary to render them visible in order for their influence on women and men's health to be addressed.

In short it is a question of using a concept of health as the process determined by biological, socioeconomic and cultural factors as well as by psychical, subjective and gender-related ones that may be analysed using indicators suitable for describing all the said aspects that integrate it and that may be taken in consideration when developing strategies, in terms of health, for all individuals.

## 1.2. About the gender perspective

The intellectual concept of gender is attributable to Simone de Beauvoir in 1949 —according to Virginia Maquieria (2001) and many other authors when discussing the concept genealogy—, when she pronounced her famous statement «you are not born a woman you grow to be one» and not exactly through biological conditions that define sex but through an individual and social process. Feminist Anglo-Saxon academician women are the ones, in the seventies, to systematise the intellectual proposal of the French philosopher and concretize it in the notion of gender, which started to be used to refer to the sociocultural construction of men and women's behaviours, attitudes and feelings (Maquieria, 2001).

Accepted definitions of the gender concept and components applicable are those gathered by WHO (2002) which at present synthesize the majority of theoretical developments conceived from within the health field.

Thus, the **components of the gender perspective** intended to be made operational here are, on the one hand, identifying differences due to sex and gender inequalities (those differences deemed to be unfair and unavoidable) in general health condition. After, reflecting on and identifying as far as possible, underlying gender determining factors that may explain women and men's health condition. Finally, the way in which men and women seek attention and are cared for in the healthcare system will also have to be reflected on, trying to identify gender stereotypes which may bring about different outcomes and inequalities in services provided. In other words, it will not be a matter of informing on women and men's health, but on gender inequalities and inequities that may be occurring, and

also of identifying gender psychosocial components that are potentially explanatory of different aspects of the way of feeling, falling ill, seeking advice and being cared for in the healthcare system.

This way the gender perspective is being applied as conceptual framework for describing health condition, this including the following aspects (Velasco, 2006a): The first one derives from sex; the second one from the analysis of gender sociocultural constructions and of ideal models and socially constructed gender stereotypes, and the third one is the analysis of gender stereotypes individually interiorised and that bring about behaviours, experiences and the way to live health and disease and even the ways to consult at healthcare services and to provide care in the latter.

### 1.3. On life cycle and maturity

For the purposes of this Report, life's central ages have been established to span ages 45 to 65 years that in life cycle equal middle-age.

The concept of **life cycle** stems from evolutionary psychology and regards life as a continued process of potential growth and change. It means that even though each person has a particular life with a course of its own, in keeping with the chain of events that unfolds before them and shapes their own history, life is contemplated as a cycle made up of stages where inevitably one has to go through specific and unavoidable periods and crises (Erikson, 1988). For instance, childhood development, adolescence, youth, adulthood, middle-age and old age are stages likely to have a critical character. In such stages of the life cycle experiential changes occur due to both biological changes as well as expectedly new social functions, and personal and intimate changes one has to go through.

The vital cycle viewpoint involves considering not just age and biological aspects but all other facets of social functions and personal events that condition the way one is living and hence, inevitably the way one is falling ill.

Considering not just the age group but the moment of the life cycle, is in keeping with that concept of health that takes into account social and experiential context factors apart from mere biological factors. And, inversely, allows categorizing physiological changes that are undoubtedly experienced along subsequent moments of the life cycle —puberal changes in the course of adolescence or hormonal and physiological changes brought about by menopause at middle-age— as accompanying the process of personal and social change that may have an even greater weight than the aforementioned physical changes. Speaking about middle-age and

its context, about climacteric for instance —moment of the life cycle—, is a much farther-reaching approach than speaking about menopause —physiological fact—.

This vital cycle approach was incorporated when developing studies about gender on health because it permitted to make visible and to include lived experiences both social and everyday life, in health. It is thus, in tune with the gender approach because again, when it comes to speaking about sociocultural and psychical aspects that influence women and men (gender-related aspects) at certain ages, mention has to be made of which social rules, which functions they (women and men) are expected to take on, which experiences do they undergo as result not so much of age itself but of experiences you have to go through at that age and how such experiences are socially modelled and determined depending on one's being woman or man.

Study is made easier when analysing not just hormonal changes, for instance, that occur in women between 45 and 55, but what vital processes linked to life cycle maturity, do they undergo.

Middle-age is frequently assigned the midlife crisis, a crisis that according to Erickson may prove to be conducive to knowledge, social encounters, creativeness, or otherwise to a personal stagnation if such crisis is not overcome. Maturity is often believed to be an allegedly stressful period brought about by revision and reassessment of one's elapsed life. Towards the middle of this stage most targets and duties are supposed to be close to achievement and fulfilment and the peak of productivity and creativity should have been reached at the same time that recognition and appreciation are to be expected in the working and living environment. Most people are supposed to have created a family and brought up their children. A number of authors claim that what really looms up above the rest is death awareness.

A considerable part of maturity vulnerability factors, related to the vital process may stem from frustration arising of not been capable of achieving success ideals imposed by contemporary society.

Also and again, social perception of age and expectations about maturity are socially constructed and turn out to be very different for women and men, being as they are, conditioned by gender patterns that establish behaviours and alleged achievement each sex should reach at this stage. Same as social class, educational level, working activity and, in short, depending on what life has been devoted to so far, they are factors that give rise to different sorts of vulnerability.

Also in present-day western societies it emerges that the transformation of the population dynamics known as **demographic transition** acts as an important motor of change not just regarding the

distribution of the different ages but also that of traditional gender roles. Reassignment of generational and gender roles entails a series of closely related changes. The increasing weight of middle and older age people resulting from extended survival, has meant new possibilities of social and family organization, as well as new models of individual life cycle, and such reorganising has meant in turn a subsequent change of expectations linked to gender (Pérez Díaz, 2003).

**Life expectancy lengthening** and subsequent redefinition of men and women's life cycle has in turn given rise, within the sphere of health sciences, to a special consideration of the meaning of maturity and the process of aging, which traditionally and mostly from a biologicist approach has tended to be pathologised. Late middle-age in its closeness to old age has often been exclusively considered as a «progressive loss of faculties» disregarding the fact that the passing of time may also mean the «gain of new faculties» for the body (González de Chávez *et al.*, 1993-1999) this also being added to an idealization of youth as ideal model all of which has resulted in the pathologisation of the health of persons in older ages (Valls Llobet, 2006).

This process, in turn, adds up to the reinforcement of gender hierarchies: the gender axis intersects with the age axis. Indeed, when lengthening of life cycle prompted a reconsidering of the middle-age stage analyses were oriented towards redefining men's life cycle, in accordance with work relations (productivity, work recognition and early retirement) whereas women's life cycle's redefining has taken place as a function of family relations («the empty nest») only regarding their fertile cycle again granting validity to gender stereotypes hinging on work distribution based on sex and women's allegedly exclusive function of motherhood. Likewise, centrality awarded to menopause upon analysing middle-aged women's health serves to, again, reproduce the reduction of women to their reproductive functions. If at the previous stage their problems were reduced to motherhood, at this one all revolves around the alleged «loss» of «femininity» (Esteban, 2001; Valls Llobet, 2006, Freixas, 2005b, 2007), being the latter understood only through those reproductive functions and giving new connotations to women's subjection to this gender identity that in maturity disempowers them again.

Hence addressing **maturity** as a stage of the life cycle thus including the social, functional and experiential processes it entails, will serve as a third conceptual axis, intersecting on the one hand with the concept of **health-disease** as a biopsychosocial process, and on the other with the **gender approach** axis, giving an account on the state and health needs of men and women.



## 2. Determinants that from a Gender Perspective Influence Health in Central Ages of Life

In this chapter an analysis is presented, from a broader to a closer outlook, of all aspects that give an account of the conditioning factors in the lives of men and women and their repercussion on their health. It has been made bearing in mind that health is the outcome of the process along which human life evolves under the influence of biology, economic and social context and individual subjectivity. Equally, life habits linked to such conditions are explained also taking into account the gender socialisation pattern concerned.

### 2.1. Life Conditions According to Socioeconomic and Productive Determinants

Once economic, productive and social conditioning factors in men and women's lives conditions, are considered, the direct relation between how they differently affect each person's life and state of health becomes apparent. Hence, social class, binomial work-employment and educational level bear close relation with states of health.

As environmental conditions worsen in addition to power structures and lack of opportunities, health indicators turn more and more negative leaving, above all, women, in situations of greater vulnerability, poverty and social exclusion (Rohlf, 2006). In addition, whenever migration processes are taken into account, vulnerability or discrimination situations are patently clear especially among women.

Hence, when analysing from a gender perspective the intersection of the above determinants with the sex variable, earlier hidden gender inequalities become obvious.

Since women accessed the paid work market there has been a salary gap ever translating into economic income levels different from those of

men. Although in the last 10 years these differences have certainly decreased, it is worth mentioning that after analysis of **economic conditioning factors** men's gross salary per hour is still 17.3% higher than women's which can be explained by differences in education level, different composition of age groups, types of contract, professional qualifications or economic activity. However, a different range of causes having to do with qualitative elements exists and reflects on indirect discrimination arising in the framework of work relations in companies. On the other hand and when it comes to income level, women's situation depend greatly on the family overall situation and fact is that mono-parental, (marental more like) families' income is lower than the rest of typologies'. Likewise, the group presenting the highest rate of population under the poverty threshold is women over 65 (31.8%).

Incorporation of women to the **productive system** is linked to their access to education, and to the subsequent improvement of their life conditions. Nevertheless, access to education does by no means guarantee direct working integration and neither does it ensure recognition of their instruction level in the work market; also their assuming new gender roles in the productive area has not translated into withdrawal from traditional roles in the reproductive sphere. Finally and owing to gender socialisation models it remains a reality that many women entered the work market in conditions of previous inequality extending on the one hand gender mandates as far as selection of job opportunities is concerned and on the other, considering work as a second choice and not a priority which differs from men's approach. This series of conditioning factors reflect on their health, inside as well as outside the professional world.

Certainly for women, the higher the level of education the higher the activity rate, however, in proportion to occupation level, unemployment rate is lower among men than among women. Regarding this, there exist differences according to sex as far as occupation and education level are concerned, both factors having great influence when it comes to establishing state of health in this age group. There is also an inverse relation between men's activity rates and women's inactivity rates; in this sense and according to data from the Active Population Survey (English for «Encuesta de Población Activa (EPA)») for 2006 69.12% of total active population are men while 63.7% of women are considered to be inactive population namely outside the mercantile working sphere or work circuits. Going deeper into the analysis of this category for the age interval under study (ages 45-65) and upon examination of inactivity causes it follows that there is clearly a double approach and that data are inversely related; on the one hand a high percentage of women categorized as «*housewives*» (95%) and on the other, a high percentage of men categorised as «*retired or early*

*retired*» (76%). Therefore, it follows that most middle-aged women are devoted to the job of daily sustaining life and care.

Furthermore, being a long-term housewife is closely related to a lower education level. According to the Fertility and Values Survey in 21<sup>st</sup> Century Spain (CIS 2006), between ages 50 and 64, 75.2% of women are married, 11.2% are widows and 67.3% are housewives (they undergo non-paid housework, or are retired or pensioners). Of the total of this age group, 64.3% still have children living at home and follow the breadwinner man pattern, who contributes a higher income (66% of cases). It is also worth considering that in this age group, 74.2% have an education level equal to or below secondary education. Equally and for both men and women from less privileged classes, impact of health determining factors is higher according to prevalence of gender socialisation traditional model. On the contrary, availability of economic resources allows diverting and lessening the care burden and that arising from double working timetable, conflict solving, economic dependence effects and impact of lifestyle changes after breaking-off or loss. In other words, gender traditional model determining factors are unevenly distributed according to socioeconomic conditions so that social-class-derived inequalities deepen through gender-related ones.

As regards situation of women in the employment market, something to be pointed out is that horizontal segregation is commonplace occurrence, which entails their occupying productive spaces different from their male fellow workers'. Equally, hierarchic position of women in the work market comes conditioned by vertical segregation conducive to their holding posts of lesser responsibility than those of men. This together with de-regularisation of the work market and increased work flexibility worsens working conditions for women making them more precarious (Artazcoz *et al.*, 2004; Instituto de la Mujer, 2005) perpetuating survival of a man-centred model of employment and also rendering more difficult the redefining of health at work which should incorporate once and for all a standpoint that may contemplate with a far-reaching perspective the needs and situations of women be it to modify organizational guidelines in productive jobs or to redefine general terms concerning work risk prevention (Sánchez López, 2003). For instance, «double-tasking» which is highly debilitating for female workers is only envisaged in the way of work leaves. It should also be taken into account that working instability itself linked to women work precariousness is still a psychic burden (1) in contradiction with work health (Rosales Nava, 2002).

(1) The psychic burden «double-tasking involves: term attributed to the Italian Sociologist Laura Balbo, which expresses that while carrying out a task, for instance a paid job, you are at the same time, thinking, organising or taking steps relating to the reproductive role».

At present, women's giving up the employment market is still common practice. As per data from The Women's Institute for 2005, 40% of women that quit the work market did it because of birth of a child. This practice is widely spread among middle-aged women generations, socialised in the «sole breadwinner» model, based on sex division of work, which opens up a deep division between male and female roles, assigning men employment centrality and the earnings of their work, and women, occupation in the housework and reproductive tasks. Along these lines, another factor that casts light on this withdrawal from the work market is the difficulty to conciliate work, family and personal lives.

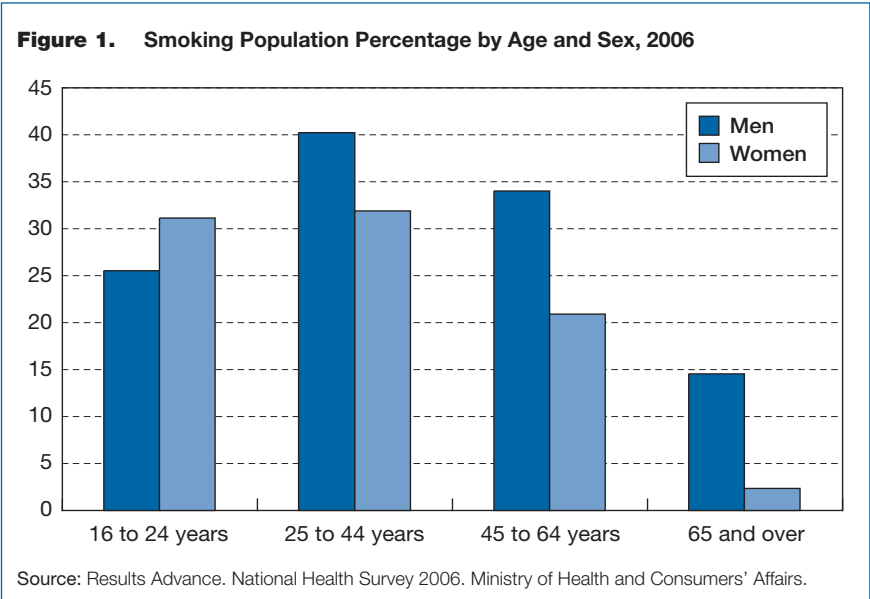
In short, this secondary rating of women's work helps in its being underestimated in socioeconomic terms, which translates in lower salaries, less professional development and career opportunities, etc. Therefore, strategies being adopted by women for remaining in the work market point at the persistence of values and norms that make them assume double-tasking in both mercantile production and in sustaining life reproduction (Pérez Orozco, 2006). A vicious circle is thus drawn by which work segregation and discrimination reinforce the feminine gender mandate of assuming reproductive responsibility. Difficulty to conciliate both sides of this double-tasking is put up with through the added effort of women, this taking a toll on their well-being and quality of life.

In addition to life conditions and different repercussion on the health of men and women as result of a men-centred model of society, under analysis here, there are other factors linked to life habits and that hence have a direct impact on health. That is why those related to tobacco and alcohol consumption, exercising and nutrition conducts, deserve special attention.

Regarding this, in spite of the fact that the number of deaths attributable to tobacco dependence has been decreasing in Spain since the beginning of the 90's, **tobacco consumption** is still the first cause of avoidable mortality (Ministry of Health and Consumers' Affairs, 2005). Between 45 and 65, the percentage of smokers is lower than among younger people. Also, men are smokers more frequently than women, at all ages; this difference increases with age and is very high in the 45-65 group (figure 1).

Upon analysis from a gender viewpoint, some issues should be highlighted as regards women's consumption of tobacco. The first one is that although tobacco dependence has been decreasing since 1993 among the whole of the population as well as among men, among women, in the period stretching from 1993 to 2006, prevalence hardly varied. This was mainly due to the age group 45-64, where the percentage of female smokers rose from 10% in 1993 to 21% in 2006. According to Rodríguez Sanz study (2005) women from more privileged classes, though with a low prevalence

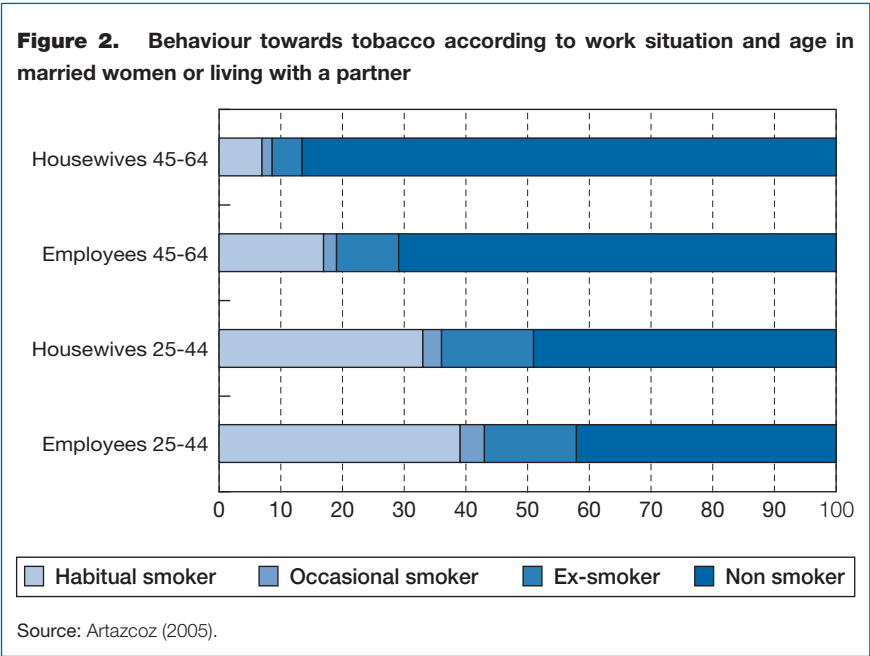
of tobacco dependence, are the only social group in which the frequency of consumers keeps on rising and more so for serious smokers (20 or more cigarettes a day). This fact was pointed out in the 2005 Health and Gender Report, for which motives are likely to arise from the pressure undergone by this age and class group, due both to stressing loads and to gender models in force that may still be validating smoking as an aesthetic means as well as a stress outlet. This should be paid further attention from a gender viewpoint to better ground preventive strategies.



As regards socioeconomic conditions such as occupation and co-habitation status, middle-aged women, married or with a partner are the lightest smokers of all (habitual, occasional smokers and those having given up, together, do not reach 20%) (figure 2). Same as what seems to be true for general population, the percentage of female habitual smokers increases among women with an occupation (Artazcoz *et al.*, 2005).

These differences in tobacco consumption between women who work for a salary or with a job and those who work without pay, or have no job is not related as much to work integration impact on tobacco consumption, as it is to association of this habit with socialisation public spaces. To this respect, some studies conclude that up to the middle of 20th Century this

was a exclusively male habit, partly because tobacco consumption was (and still is) an essentially social practice and because up until quite recently public spaces were almost exclusively masculine (Waldron, 1991). Moreover, it was linked to the traditional masculinity model but did not coincide with the traditional femininity model, whose stereotype dictated tobacco to be part of «manly vices» aesthetic and ethically allegedly inaccessible to women. At present, the turn taken by this stereotype may explain why part of middle-aged women from upper classes may get to be heavy smokers.



On top of this and linked to the contemporary ideal that imposes slimness on women’s bodies as an aesthetical requirement aimed even at reaching social success in many respects (Tubert, 2005) weight turns out to be a key motivation for a woman to smoke or getting less involved in trying to give up cigarettes. The fear of putting on weight after giving up smoking and the fact that sometimes it does happen, are issues that concern women smokers (Becoña Iglesias et al., 2000)

For all the above, the gender approach makes visible and brings into focus motivations for starting and staying in the dependence on tobacco,

which should be taken into account when devising programming and preventive actions, since for their proving to be effective in a person's change of conduct, they should contain replacement models for those gender attitudes which maintain conducts and perpetuate inequalities.

With regard to **alcohol consumption** and along the same guidelines as for tobacco, it must be emphasised that it is chiefly masculine. Teetotal population increased in the decade 1993-2003 in men (30.8%) as well as in women (54.8%). In the case of men, light consumers are among younger groups and heavy and hardened are concentrated in the age interval 45-65. Combining the social class variable and the analysis of alcohol consumption, it emerges that men from less privileged social classes are the ones to present a higher prevalence of alcohol risk consumption. On the contrary, women from privileged classes show higher percentages of risk drinkers (2005 Health and Gender Report, Rodríguez-Sanz, 2005). This social class-related pattern, in the case of women, correlates with the same pattern of tobacco consumption and might be the result of the influence of changes in expected traditional gender model in this social group of women. So, the adoption of conducts traditional and stereotypically manly may be identified as one of the factors responsible for rising prevalence of morbidity and mortality relating to causes typically more frequent among men.

As regards life habits linked to physical exercising, it is worth highlighting that according to National Health Surveys in Spain, **sedentary lifestyle** used to be more frequent among women than among men and had been progressively decreasing until the 80's, but in recent years a trend towards stabilisation has been surfacing and even a rise has occurred (Ministry of Health and Consumers' Affairs, 2005). According to an outcome pre-view of the 2006 National Health Survey, sedentary lifestyles are more frequent among women of all groups, exception made, precisely, of the 45-65 one.

Finally, nutrition conducts are a factor to be considered as long as disorders like obesity, anorexia, bulimia, etc., are closely related. Actually, obesity is believed to be second among known avoidable causes of death, after tobacco dependence. As discussed in 2005 Health and Gender Report, obesity is more frequent in less privileged social classes for both sexes, although class gradient is higher among women (Rodríguez-Sanz 2005). On the contrary underweight is more frequent among upper-class women and lower-class men due, among other socioeconomic factors to the influence in the former of a greater dependence on current stereotypes of slimness for women's ideal body or middle-aged women's eagerness to maximize body care, even more so the higher the class and the education level, contrasting with a penchant for passivity and neglect of themselves

which surface among women from less privileged classes probably arising from the gender overburdening they sustain (Rodríguez-Sanz, 2005). The impact of these last two contemporary factors may probably be higher in more privileged classes and higher education levels and may explain why overweight and lack of exercise during free time, by way of example, is less frequent among women of these sociocultural levels as an effect of their search of not just health but model beauty. They are all but hypothesis, that have to be studied, once again, to enable developing of preventive strategies with potential to influence factors and attitudes that sustain life habits.

## 2.2. Life Conditions as Resulting from Psychosocial Determinants

Psychosocial determinants are those that account for social contingencies and events in the lives of men and women and constitute each person's own biography (Breilh, 2001). By associating this definition to the gender approach, it may well be said then, that such determinants are related to the feminine and masculine gender socialisation models, this is to say, the process through which women and men acquire and interiorise behaviours, roles and ideals of femininity and masculinity as result of gender consensus in a given society, and also of norms and relation forms between males and females equally integrating in culture itself. Thus, the process of differentiated socialisation that follows the traditional model pattern, for women and men in the stretch of age under analysis, coexists with the contemporary model of society. Thus, where both models intersect vulnerability appears as result of the conflict between masculinity and femininity ideals and exercising of masculine and feminine identities. Below, are described some of the key features that characterise both models, for men as well as for women (2).

(2) These key features have been drawn up from Velasco studies (1999 and 2006a).

## Feminine Gender Socialisation Model

### Traditional

- **Reproductive and domestic spaces as only options for personal fulfilment**, in addition to care provided to the rest of persons (in charge or dependent), this adds up to vulnerability because of consequences it brings about like the lack of one's own life project, and communication, isolation and repetitive, invisible, devalued and non-paid work (Burín, 2005; Conde, 2000).
- Lack of socio-familiar support and help which generates **physical and emotional** overloading, situations of emotional abuse by family members, absence of time for oneself and self-care (Burín, 1991; González de Chávez, 1993).
- **Marriage** cohabitation model is in itself a risk factor for women, above all when there is no intimate communication with partner and no care or love reciprocity.
- Exposure to **situations** of affective and economic **subordination and dependence**, that are in themselves vulnerability factors, but are also the basis for **abuse, maltreatment and gender violence** (Nogueira *et al.*, 2001; Blanco, 2004).

### Transition

- **Innovation for the changing of socialisation** model entails accumulation of former and new femininity ideals generating role overloading (Arber, 1991): multi-tasking and doubled work timetables (and tripled when the care to dependants is added up).
- «Superwoman» or «slave grandmother»: The impact new ways of relating between sexes has for middle-aged women translates into new family structures, doubled working timetable with mono-parental load by oneself, in which women undergo overloading when it comes to paid work, professional progress, household sustaining, care of, and conflict with young and adolescent children, build up, and all of it in affective loneliness (Artazcoz, 2007). This picture is even more serious when their salary and resources are minimal.

### Contemporary

- **Search of personal and social success** (Conde, 2000; Moreno 2000; Velasco, 2005) characterised by endeavour to reach a model and eternally young body and by enjoyment of a well-off socioeconomic situation, comforts and material possessions; All based upon **competitiveness**. These factors affect men and women of all ages though, and materialise into suffering when there lack **valuation and personal and social recognition**.

- Tyranny of the **Body Ideal Model** (Benloch, 2001; Tubert, 2005), with a penchant, even compulsion, for remodelling surgery and restrictive diets, —that if in adolescence and youth shows the face of anorexia, at maturity appears as a constant preoccupation and also diet restriction and compulsive consumption of clothes and cosmetics and every product relating to appearance (Bernárdez, 2005) and in spite of it all, a permanent dissatisfaction with their body
- **Difficulties about fertility**, or problems with pregnancies, deliveries or miscarriages, may also represent subjective damage. So, the pressing need of becoming a mother and the request for assisted reproduction, for instance, may be indicative of a lesion in the integrity of feminine identity, culturally constructed as if being a mother were the only way, finally, of being a woman (Tubert, 1999 and 2000; González de Chávez, 1998 and 1999).
- The different moments of the life cycle in which both the body and the pillars of subjectivity are redefined and that in the case of maturity reach their peak at climacteric. Organic events that accompany **climacteric**, like menopause and some body changes frequent at this age, even when they are surgical like **hysterectomy** (Akiko Komura, 2007) or **mastectomy** (Sebastián, 2002), demand a redefinition of femininity when it has been sustained and symbolised only by reproductive possibilities, a process that appears as a source of vulnerability.

### **Masculine Gender Socialisation Model**

#### **Traditional**

- Public space as the only space for personal fulfilment and economic sustenance of the cohabitation unit.
- Marriage is a protective factor for men. Maintaining the masculinity ideal, supported on being the family breadwinner and a relation of ownership with the woman, provokes, when failing to fulfil these demands, a vulnerability that has a repercussion on health. Also, whenever loss of the dominance role occurs there is a fall into passivity and silence, or violence against the woman (Bonino, 2000 y 2002).
- Perception of own body as a machine.
- Need of maintaining positions aimed at **exhibition of strength** and hiding of weakness, which is conducive to engaging in risk conducts (Rohlf's, 2000; Bonino, 2000 and 2002; Stanistreet, 2005). Therefore, this translates into a later access to healthcare services and a lessened attention to messages promoting health.
- Less healthy lifestyles and adopting of conducts conducive to accidents.

### Transition and Contemporary

- Demand of **potency and sexual responsiveness** as an exhibition of manliness and meeting a body ideal of youth and strength difficult to attain for the majority.
- Performing of functions involving new **care roles shared** with the woman, that may be regarded by their environment as not being the done thing. Just as with women, new family ways involve new vulnerability processes, such as **loss of contact and daily life with estranged children**.
- The new ways in gender relations often entail relational and affective mix-up with differences in interests and compromise degree that lead to effort-consuming and affection-wearing conflicts within the couple.

There also exist common aspects in feminine and masculine socialisation models that affect vulnerability processes:

- **Losses**, and not just the loss of the beloved and needed, but the loss of love and cohabitation with the partner and other significant persons, and the loss of the job and life conditions. The consequences of the loss are intensified in the case of persons who live in material and affective dependence and that have pinned on the world of relations and affections their main sources of personal fulfilment. In this respect, women subjected to the traditional gender model, present in general a greater vulnerability.
- An outcome of **diseased children**, that endanger the ideal of a **good mother**, in the same way as for men the ideal of a **good father** (Tubert, 1996; González de Chávez, 1998). What results damaged is a very vulnerable aspect of the femininity or masculinity fulfilment: motherhood and fatherhood functions.
- The **impact of children's diseases or problems**, not just at childhood but at any age, even in adult age, although apparently this affects women more intensely because of the different significance that children have for them.

After describing the main keys to understanding vulnerability processes for women and men according to gender socialisation models that have an impact on health, it is interesting to detect those guidelines that have to do

with changes in gender models and translate into protection for health. This would entail removing traditional model constraints, evolving to active subjective positions, autonomy, independence, projects and own achievements. Also, creation of a support network, generating or participating with other people at meeting spaces avoiding falling passive victim to circumstances and social models. Sorting out overloads through sharing and conciliating, apart from not letting one's own life goals rest upon the care to other people. Recognise and abandon positions of victim (of circumstances, social models, of the partner, etc.) seeking the necessary support and connections for achieving it (Velasco, 2006b).

Finally, it becomes essential to act upon one's body care, promoting healthy habits (nutrition, restricting alcohol consumption, avoiding tobacco and other drugs, favouring exercise, good rest and enough sleep) and detection and liberation from exposure to environmental toxics (Valls, 2002 and 2006). Also, seeking equity and elimination of inequalities relating to socioeconomic factors and working sphere, are factors that promote health. To close this chapter it can be said that all these processes are consistently explanatory of differences in states of health and constitute qualitative indicators to continue research on their influence on population complaints and ailments as well as in morbidity and even avoidable mortality. They will be taken in this Report as an explanatory matrix when analysing the different aspects of health.

# 3. Population Health in Life Central Ages

## 3.1. Demographic Changes and Life Expectancy

Demographic transition in Spanish population is defined by low fertility rates that in addition to the increase in life expectancy cause population aging. In the last few decades increased immigration, chiefly young populations, is an added factor.

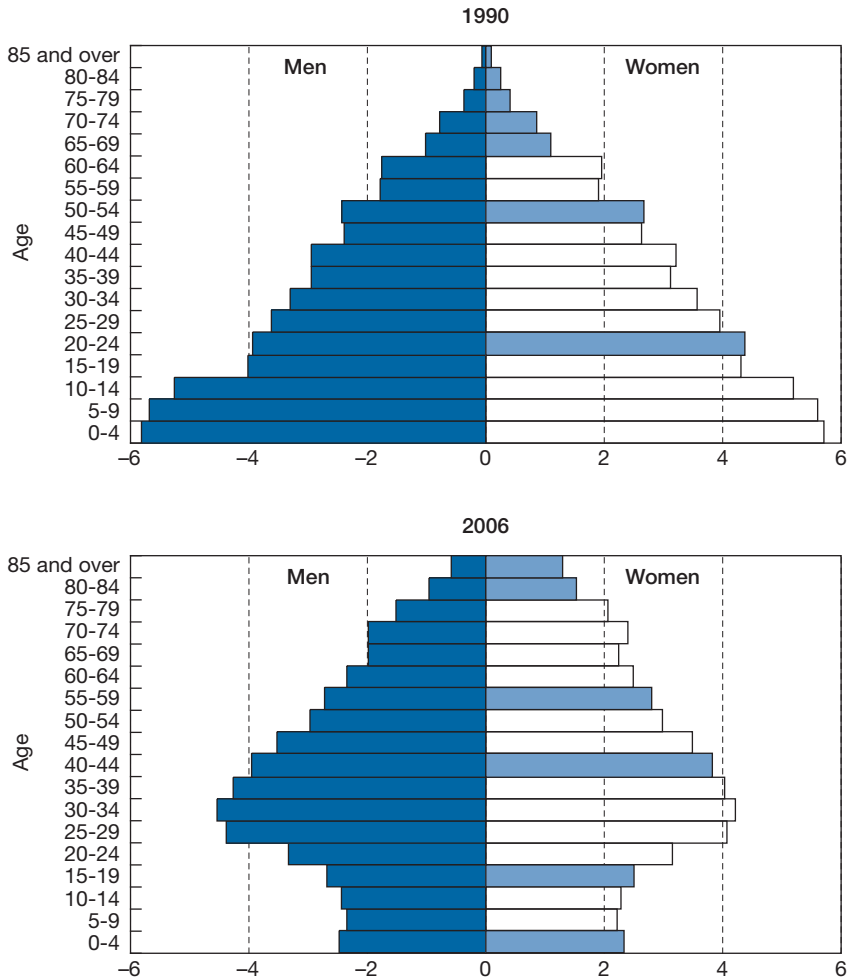
These **demographic changes**, already explained in the Ministry of Health and Consumers' Affairs' 2005 Health and Gender Report have in the first instance a different repercussion for men and women within different age groups, but at the same time occur owing to social, cultural and economic factors to which women and men contribute differently, this is to say they are factors that need to be analysed from a gender viewpoint.

Comparison of Spanish population by age groups between 1900 and 2006 (figure 3) shows how there has been a change from a young population to a marked decrease in children population (ages 0-14), a decrease in young population (ages 15-29), a considerable increase in adult and middle-aged population and above all, over 65 years of age.

Evolution by sex and age groups (figure 3) shows that if in 1900 there were more men than women up to 15 years of age; the proportion between sexes reversed at that age although it remained quite even until age 75. However, in 2006 men slightly outnumber women up to the 45-54 age group where the proportion by sexes gets evened. Reversal with most women occurs from 55 onwards and the proportion of women outnumbers that of men by 8% at 65 years and over, whereas in the population 75 years and over, more than 60% are women (figure 3). These figures outline the population aging profile and the feminisation of old age. As regards what happened to the, at present, middle-aged population, some thought should be given to which social, cultural, economic and gender factors have had an influence on the present demographic outcome.

Women born in the first half of the 20th century were the ones to limit the number of children, followed by the ones born in the 50's who featured high impact changes, such as solid incorporation to education and work and

**Figure 3. Evolution of the Population Pyramid, 1900-2006**

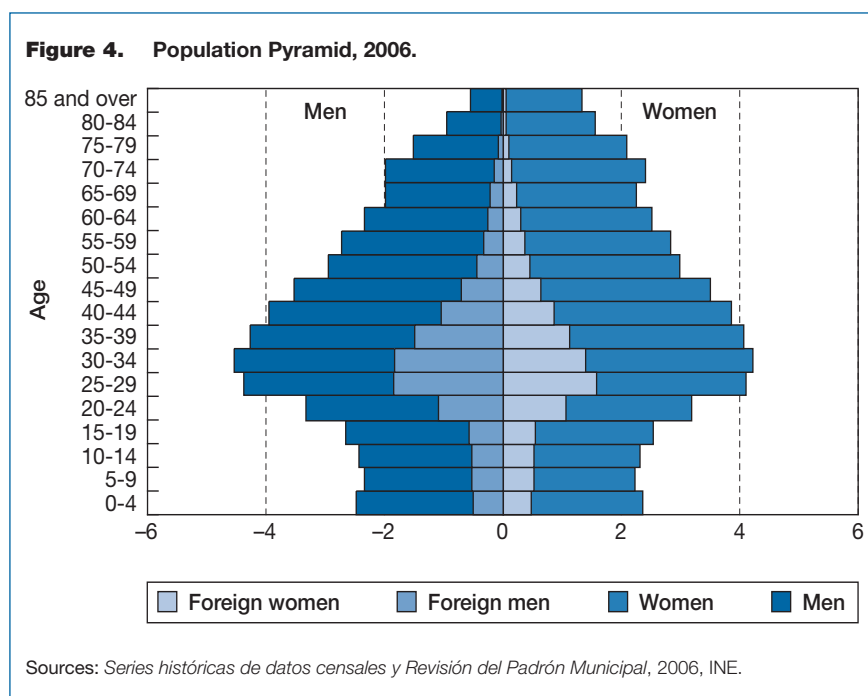


Sources: *Series históricas de datos censales y Revisión del Padrón Municipal, 2006*, INE.

participation in the public sphere keeping on limiting the number of children; those born in the 60's delayed emancipation, marriage and motherhood age (Bernardi, 2003; Solsona and Viciano 2004, 2005 Health and Gender Report).

As for extended **life expectancy**, the second component of aging, it is found to have been increasing in Spain all along the 20<sup>th</sup> Century, for both

sexes, just as in the rest of neighbouring countries. In 2006 women's life expectancy is gauged at 83.8 years of age and men's at 77.2, so that women live 6.6 years longer than men.

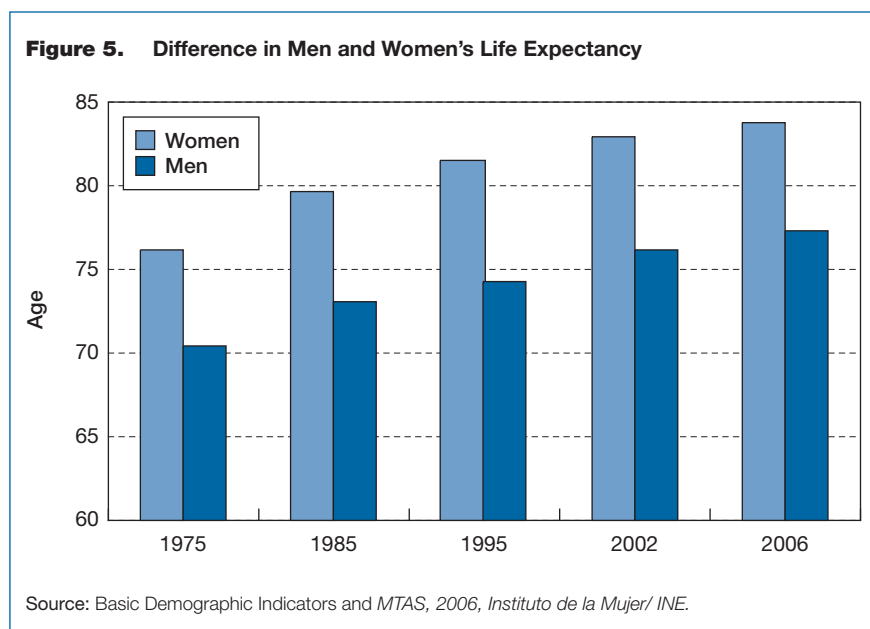


Nevertheless, the gain in life expectancy for both sexes has come about at the expense of age groups over 65 years. Or, in other words, what is being prolonged is old age (Gómez Redondo, 1995).

Inversely with causes are the **consequences of the demographic situation**, described here for the population in life's central ages. Aspects to be considered are demographic weight of people between 45 and 64 years of age, that amount to a fourth of the population, the noticeable increase of the population over 65 and the feminisation of old age.

An analysis of some **socioeconomic aspects** has to be added; aspects that among others count in the conditions in which the work market evolves and young people's extended dependence on their families due to socioeconomic hindrance to attain emancipation; young and adult women's difficulties to make work, career development and motherhood,

compatible, owing as much to social support deficiencies as to insufficient involvement of males in housework and daily care and support of children; dependence circumstances of old people, in constant rise, both in number as in seriousness of dependence, as a result of Alzheimer's disease and senile dementia progress and because old age reaches more and more advanced years and with a greater personal decline. These circumstances depict a scenario in which, although adult population (ages 35-44) should sustain the burden of supporting the rest of age groups, this **burden is shared with and has shifted to persons aged 45-65**. This period of the life cycle, maturity, used to be considered as practically within old age although at present it corresponds to people between 45 and 65. Lengthening of life cycle and better conditions of strength and health in which people reach these ages today enable them to maintain high productive and generative capacities. This together with the delay with which young people and adults attain full autonomy, is prompting the shifting onto the 45-65 population, of a considerable share of the load made up of society's support functions, productive as well as informal, of the rest of population stretches—childhood, youth and old age—. Fathers and mothers are supporting the addressing of their children needs, the care to grandchildren, as well as the support and care to the elderly and oldest people and disabled, making up for social shortcomings these generations encounter to achieve autonomy



or being provided care, so becoming the frustum of the population pyramid that withstands the pressure of the load shed from the upper as well as from the lower frustums.

In turn, this load is not evenly distributed among middle-aged man and women. Although in this age group the proportion of men equals that of women (24% of the population) there exist marked gender differences. The **dichotomic assignment of gender roles** that are far from equalitarian prevents both burden and opportunities from being distributed in equal way among males and females. This remark of Rosa Gómez Redondo (1995) about the emergence of the «granny boom», grandmothers often over 65 but also very frequently below, —middle-aged— who take on the daily support to their children, apart from their grand-children and at the same time their elders and, depending on which social stretches, they even work for a salary. The pressure of care is shared with another group of population of rising importance, this is to say: immigrant younger women. Further on in this Report we will refer to the consequences on health of this gender-related overload that is placed on middle-aged women's shoulders, relating to both the accumulation of roles and the effects of their functions as caregiver.

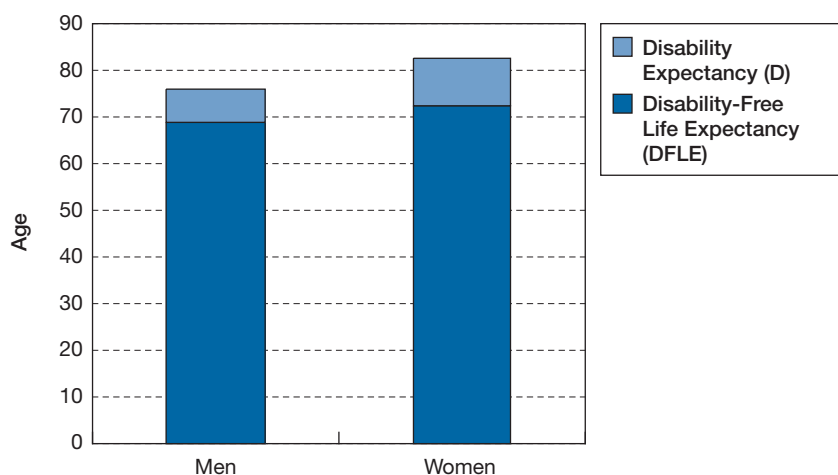
### 3.2. Quality of Years Lived. Disability-Free and Healthy Life Expectancy

The increase of chronic and mental illnesses characteristic of the situation of population aging in developed countries, forces us to qualify that the widely spread increase of life expectancy may imply that life might be lived with a lessened quality, with limitations and incapacity. **Disability-Free Life Expectancy** (DFLE) is an indicator that synthesises life duration and its quality. It measures, on average, the number of free of disability years left to live, to a person of a certain age until their passing away.

This indicator keeps an important distance with just life expectancy, going deeper into differences between men and women. It clearly shows that the gain in years of life expectancy in women as compared to men, is brought at the expense of years lived in disability (figure 6).

A second indicator to assess quality of years lived is **Life Expectancy in Good Health** (LEGH). The difference with the disability —free life expectancy is that years of life are measured according to subjective perception that individuals have of their state of health, based on responses

**Figure 6. Disability-Free Life Expectancy (DFLE) and Disability Expectancy (D), 2000**



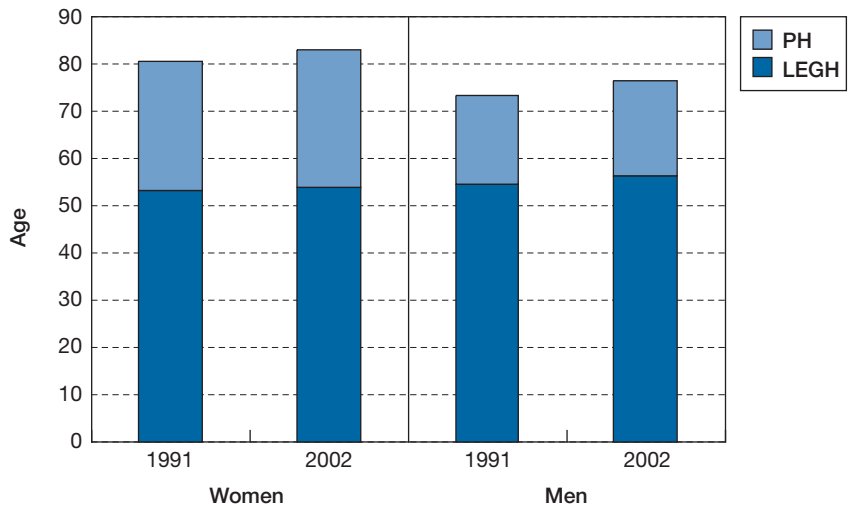
Source: Health Indicators, 2005. Ministry of Health and Consumers' Affairs.

to National Health Surveys, instead of measuring by disability. In this case the higher wellness of longevity in women is also inverted here, as expectancy of years lived in good health is higher for men than for women. According to the Ministry of Health and Consumers' Affairs's 2005 Report on Health Indicators in Spain: «In 2002, the number of years on average expected to be lived in poor health was 24.6 years —20 years for men and 29.1 for women—». As in the case of DFLE, LEGH shows that women live longer than men but live them with worse perceived health. Another relevant fact is that LEGH between 1991 and 1992 (figure 7) increased further in men (2.3 years) than in women (0.5 years). There was even a decrease of LEGH in women aged 65 in that period whereas in men it increased by 1 year.

To this respect, what happened in the decade 1991-2002 does not allow visualising if this may be due to a trend to improvement in the lengthening of healthy life of men, or on the contrary to a possible stagnation in women, at least from 65 onwards.

Profiles for two other indicators allow further qualifying the quality of years lived and are permanent and temporary disability prevalences. **Permanent disability**, understood as serious and lasting more than one year, estimated from last available data from the 1999 Survey on Disabilities,

**Figure 7. Life Expectancy in Good Health (LEGH) and Subjective Poor Health Expectancy (PH), 1991-2002**



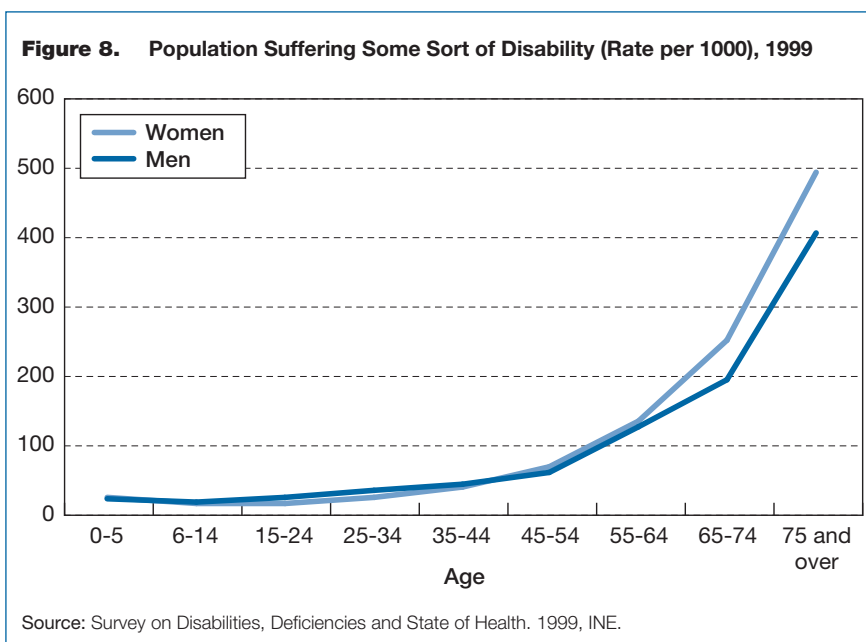
Source: Health Indicators, 2005. Ministry of Health and Consumers' Affairs.

Deficiencies and State of Health, also shows a higher prevalence in women (10.3%) than in men (7.7%) logically increasing with age. By age it emerges that from 45 onwards women turn to experience a higher frequency of disability than men (figure 8).

In this case also, the lower the level of education the higher the frequency of disability for both sexes.

According to data from the latest available survey (1999) and with respect to **temporary disability** expressed in number of days of incapacity per person and year, seriousness degrees are understood insofar as the person may have seen some daily activities restricted; most activities (including main activity) or constrained to stay in bed all day or most of it. The outcome of this measure as per National Health Surveys is that again women exhibit a higher average of days of incapacity per year (22.4) than men (15.4). Within the 45-64 population group it goes beyond average with 27 days a year.

According to the Outcome Preview of 2006 National Health Survey, 56% of the population with restrictions for daily life turns out to be women. Likewise it is a fact that women disability rates are roughly 10 point higher than men's.



Once again, as happens with practically all health indicators the lower the education level the more frequent the incapacity, either temporary or permanent (Ministry of Health and Consumers' Affairs, 2005).

### 3.3. Perceived Health. Middle-Aged Women Feel Worse

Subjective perception of health is an indicator that provides relevant information for building health strategies on solid foundations; it is usually well correlated with morbidity and even mortality, and besides it allows tracing the needs felt by the population.

**Perceived health** speaks about each person's subjective perception, about how they feel. It has been concluded that perceived health is worse when there are physical symptoms and pain, chronic illnesses –among those which worst influence perceived health are osteoarthritis, depression, bronchitis and high blood pressure (Perula, 1995), serious or longstanding diseases, or restricted functional capacity, or having to stay in bed and prescription drugs consumption. We also know that unhealthy lifestyles, as

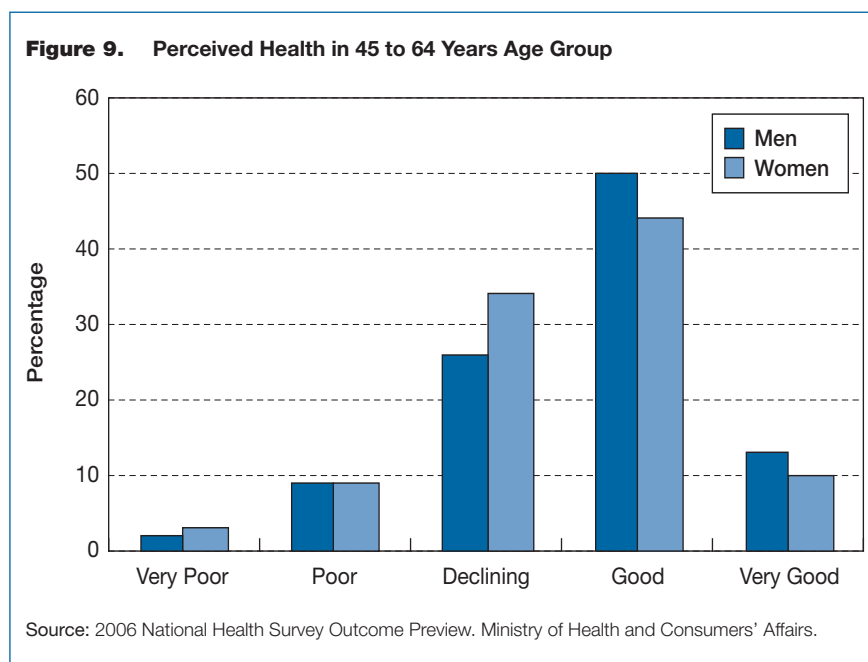
well as concerns, psychological ailments and somatisations, worsen perceived health (Martín Moreno, 2001). This leads to factors that underlie worse health perceptions.

It is also rather frequent in studies about the subject, that social classes with lower standards of general education and income, have a worse perceived health, and women always worse than men (Martín Moreno, 2001; Borrell and Benach, 2005; Rodríguez Sanz, 2005). Thus, perceived health, apart from its being a state of health guiding indicator, is sensitive to cultural —environmental conditions— this including gender conditioning factors, as it is influenced by health and well being meanings for each social and cultural condition and lifestyle (Jylhä, 1998).

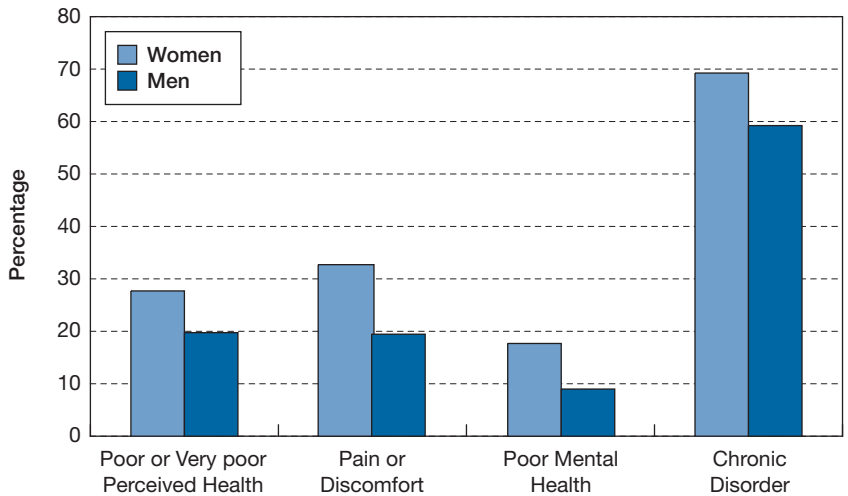
In Spain, just as in other industrialised countries, men and women have a different self-perception of their own health and illnesses (Fernández, Schiafino and García, 2005).

As per the Outcome Preview of the Health National Survey, 2006, 46% of women and 37% of men find their health to be poor or very poor.

Fernández, Schiafino and García (2005) from whose work figure 10 has been drawn point at a certain paradox in the lack of direct relation between perceived health and morbidity.



**Figure 10. Perceived Health, Pain, Mental Health and Chronic Disorders As Manifested by Men and Women**



Source: Borrell and Benach, 2005. Graphic drawn by Velasco, 2006b.

It gathers percentages of women and men who perceive their health as declining or poor, it having been observed that they are lower than those of people who answer they suffer from some chronic disorder (3); in other words: many people with chronic disorders, even when most of these entail upsets and require treatment, feel they are in good health. However, this same figure 10 shows how there exists a greater correlation between poor health perceived and pain categories, discomfort and poor mental health, aspects of great importance in health during maturity, especially in women.

Perception varies in accordance with education level and social class, with a constant correlation in that the higher the education level and the more privileged the social class, the better the perception of one's own health, both for men and for women (Rodríguez Sanz, 2005). The ones declaring the worst health are women with non-qualified jobs, and within women of same social class, employees declare better health than those dedicated to non-paid housework. This difference, also, gets broader with

(3) Chronic disorders that group hypertension, heart diseases, high cholesterol, asthma, bronchitis, diabetes and urinary tract complaints, more frequent in men, and varicose veins, constipation, depression, cataracts and skin problems more frequent among women.

older age, so that taking social class transversely, elderly women never having worked but at home would account for the worst health of all (2005 Report on Health and Gender).

### 3.4. Health Complaints and Morbidity-Musculoskeletal Pain and Psychic Discomfort

After epidemiological transition in advanced societies, the importance of indicators, when appraising state of health, shifts the importance of mortality as predominant force, in favour of complaints, morbidity and its sequelae and disabilities.

Health National Surveys contribute information on health complaints the way they are experienced by general population. Observing, in the first instance, what people complain about enables clarifying what ailments integrate perceived poor health and getting closer to the causes of morbidity. In the case of more or less middle-aged women it has special importance, as even though they die later, we know them to live in worse condition than men, so, it is interesting to know which sufferings determine their feeling worse and their worsened quality of life.

The Health Study on Women in Spain, conducted by Mercedes Onís (1993), summarises chronic disorders of women aged 45-65, highlighting that 46% of women suffer from **musculo-skeletal pain** followed by headaches, **varicose veins and psychological disorders** (4).

When asked, as per acute pathology—defined in the National Survey as any sort of disorder or disease having affected the interviewed person within the two previous weeks— this presents a pattern similar to chronic illnesses'. **Bone, spine and joint pain**, in the first place, in 25% of women; **headaches and migraines**, in 19%; **insomnia and sleeping disturbances** in

(4) The Women's Institute (*Instituto de la Mujer*) study conducted by Mercedes de Onís (1992), uses data from 1987 National Health Survey (*Encuesta Nacional de Salud, 1987*). Subsequently and in consecutive national surveys same complaints and symptoms were inquired about, up until 1995'. We have used those initial complaints because in subsequent surveys, questions asked were not just subjective complaints but clinical signs, clinical manifestation symptoms and diagnoses, and hence original complaint layouts were not as clear as in that first one that had not been interfered with diagnosis processes of any kind.

12%; **nervous trouble and depression** in 11%; and **tiredness for no apparent reason** in 11%.

This pattern has remained similarly for subsequent Spanish National Health Surveys. They feature the same complaints frequency profiles, although with intermediate categories of clinical signs as part of diagnoses, that cannot however be strictly considered as complaints, as they frequently fail to produce symptoms and are not referred to as such by population, but as diagnoses received.

**Table 1. Chronic or Long-Term Diseases. Diagnosed by a Physician**

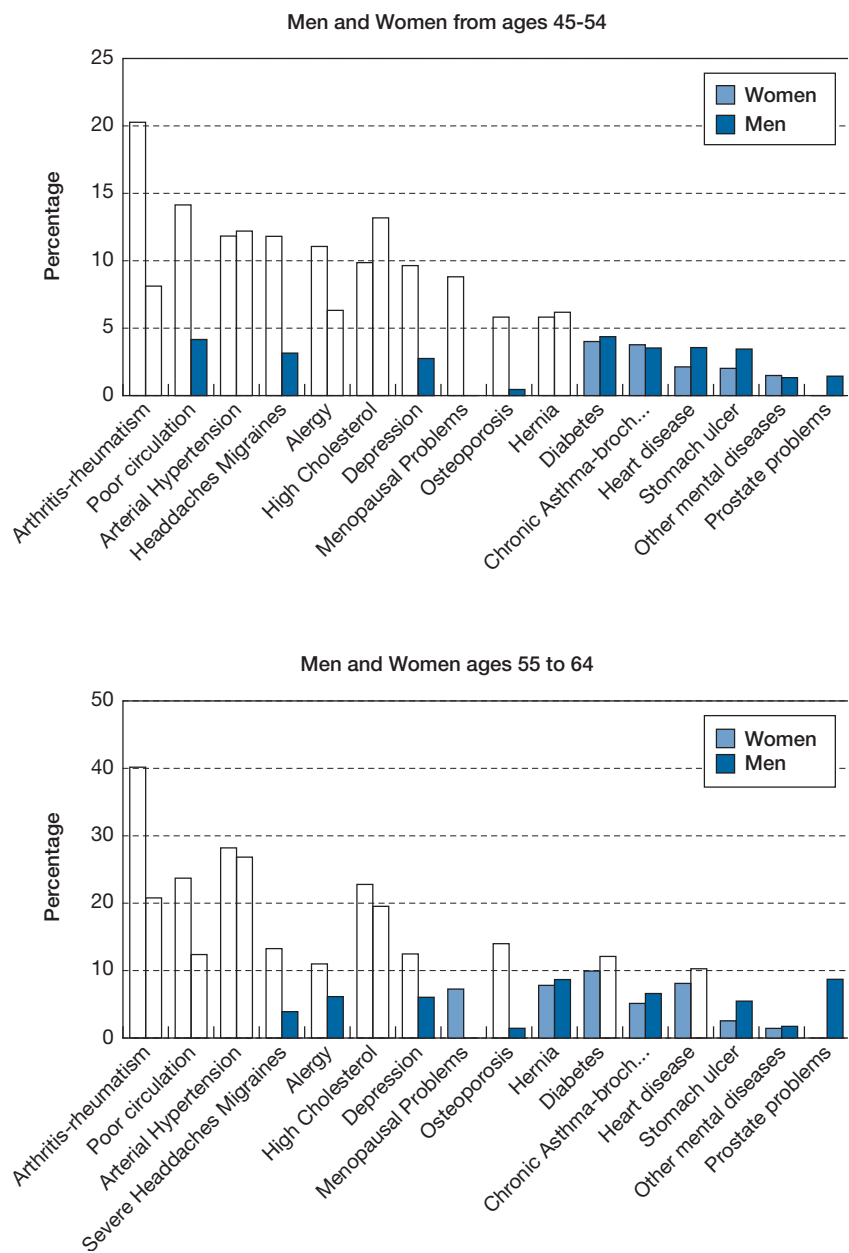
	Age 45 to 54		Age 55 to 64	
	Women	Men	Women	Men
Osteoarthritis and Rheumatic Disorders	<b>20.27</b>	<b>8.12</b>	<b>40.17</b>	<b>20.78</b>
Bad Circulation	<b>14.14</b>	<b>4.16</b>	<b>23.71</b>	<b>12.38</b>
Arterial Hypertension	11.83	12.2	28.2	26.83
Migraines. Headaches	<b>11.81</b>	<b>3.15</b>	<b>13.26</b>	<b>3.91</b>
Allergy	<b>11.06</b>	<b>6.32</b>	<b>10.99</b>	<b>6.14</b>
High Cholesterol	9.86	13.18	22.78	19.53
Depression	<b>9.64</b>	<b>2.75</b>	<b>12.47</b>	<b>6.04</b>
Menopausal Onset related problems	<b>8.81</b>	<b>0</b>	<b>7.26</b>	<b>0</b>
Osteoporosis	5.82	0.37	13.99	1.44
Hernias	5.82	6.18	7.81	8.67
Diabetes	4.01	4.37	9.93	12.1
Asthma, chronic bronchitis and emphysema	3.77	3.53	5.13	6.6
Heart Diseases	2.13	3.56	8.1	10.27
Stomach Ulcer	2.02	3.45	2.54	5.47
Prostate problems	0	1.44	0	8.71

Source: National Health Survey, 2003. Ministry of Health and Consumers' Affairs.

Excluding these clinical conditions (high cholesterol, hypertension, osteoporosis...) the frequency order of these chronic complaints still presents the same profile as in previous surveys, in similar order for both sexes, although frequency in women is a double or triple fold in all main categories (osteoarthritis, and rheumatic problems, poor circulation, migraines, headaches and depression (table 1, figure 11).

The «**Menopausal-period-related problems**» category, of considerable frequency, appears as a «diagnosed chronic illness» and deserves special discussion. Since such an illness or diagnosis does not exist, misconstrued complaints and symptoms may be being categorised under this section and attributed to menopause as if it were a hotchpotch for middle-aged women

**Figure 11. Chronic or Long Term Diseases by Age Groups, 45 to 54 and 55 to 64 Years of Age**



Source: Encuesta Nacional de Salud, 2003. Ministry of Health and Consumers' Affairs.

ailments. It would be advisable to revise this concept which is being discussed as an example of the pathologisation stages of women's life cycle under whose umbrella dim complaints that are most probably due to discomfort arising from psychosocial circumstances experienced during maturity, and not necessarily due to the physical and hormone changes that converge at this age (Freixas, 2007; Valls-Llobet, 2006).

As regards ailments and complaints evolution in time, Rohlf, Valls y Pérez (2005) in their study in Catalonia, have compared data from 1994 to 2002 and found that perceived health has improved for both sexes although **pain, discomfort, mental health perception and depression** have worsened, the latter being the chronic suffering that has increased the most.

About how complaints are presented at primary care, it is known that pain is the first cause for seeking medical advice at primary care (Valls Llobet, 2002). As regards registered morbidity, **respiratory diseases**, are the first motive followed by **circulatory and osteo-myo-articular troubles and misconstrued morbid states** (Aguilar *et al.*, 2001). Although for women they have a greater influence at more advanced years, together with **musculo-skeletal, mental pathologies (common ones like depression, anxiety and somatisations) and endocrine metabolic ones**, they occur in practically all adult ages (Gervás, 1992; Instituto de la Mujer, 2007).

Consultations for **musculo-skeletal pain, somatic symptoms for no organic reason and depressive and anxiety states**, double in frequency men's reasons for consultation. So that, of total consultations for these clinic manifestations, between 73 and 80% are made by women (Airza, 2002; Velasco, López Dóriga, Tourné, 2006c). There exists a certain distribution pattern by age group although all these ailments appear anytime during one's lifetime. Between 45 and 65 chronic musculo-skeletal pain, depression and somatic symptoms are a little more frequent. The latter in the line of vertigo, dizziness, tingling are in turn related to long term psychosocial processes, such as being a long term caregiver, undergoing maltreatment by partner, or housewife work in isolation and dependence. At younger ages, headaches, anxiety disorders and somatic symptoms related to stress are more frequent; an example of the latter being tachycardia, more closely related to acutely stressing psychosocial processes based on competitiveness and success models challenges (Velasco, 2005 and 2006b).

Processing of requests for attention related to diverse symptoms and pain, in primary care (and also in specialised care) is also giving rise to an increase in diagnoses of emerging functional syndromes (fibromyalgia, chronic fatigue, irritable bowel syndrome and others). At the same time a

considerable proportion of these symptoms, pains and complaints for no obvious organic reason, cared for in primary care are recorded as misconstrued signs and symptoms.

This outstanding difference by sex seems to be caused partly by the different way to fall ill according to sex (Wool, 1994; Piccinelli, 1997) due to the different influence of gender psychosocial factors (WHO, 2002; Velasco 2006c); also by the particular way to complain that depends on sex, together with the greater tendency of women to resort to the health system and hence make symptoms recordable (Kroenke, 1998; Campbell, 2001); in addition there is a different way of both female and male doctors of listening to and diagnose according to the sex of their patients (Malterud, 1998; Bensing, 1999; Delgado, 2001; Ruiz Cantero, 2001 and 2004).

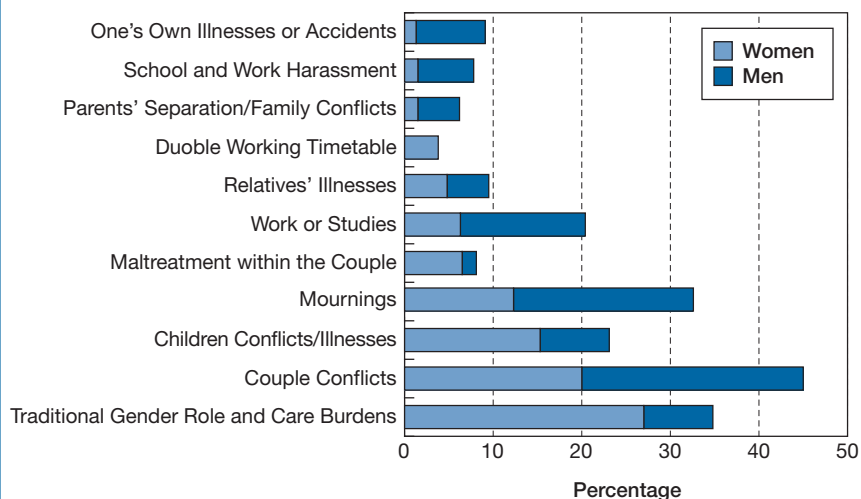
All these ailments for which there are yet no effective therapeutic resources —end up being treated with prescription psycho-drugs— and in keeping with what many female authors suggest may be considered as present-day manifestations of **women's biopsychosocial uneasiness** (Tubert, 1988; Burín, 1991; Rodríguez, 1990; Mosquera Tenreiro *et al.*, 2005; Velasco, 2006b and 2006c; Valls Llobet, 2002 and 2006) —although also men's who sustain them in a lesser proportion. Probably for women they may well be the most relevant subjective complaints, chronic ailments and cared for morbidity in this age group. They must be taken as consequences on health of the causes listed as follows: In the biological sphere, exposure to environmental toxics of increased bodily effects in women and the occurring infra-diagnosis of physiological-pathological factors that are rendered invisible and underestimated by medical practice stereotypes (Valls Llobet, 2006). A good example of this is that evaluation that takes low figures of serumal ferritin in women as normal even for those presenting a symptomatology of ferropenia.

The lesser frequency of unwellness in men may be explained by the less demanding gender loads they sustain, insofar as they are not under as much pressure as women endure in daily life, with an increased demand on both physical and mental commitment and even on ideal conflicts located in the subjective area as is the case of gender related factors in women. In this respect, men's daily life wellness seems to be less affected resulting in a better perceived state of health and less complaints and morbidity concerning those forms of pain and psychosocial uneasiness, reflecting more on risk conducts and habits as the abusive consumption of toxic substances may be.

Distribution of the association between psychosocial factors and the diverse diagnoses —considered jointly as psychosocial uneasiness— is shown in the outcome of an appraisal on action conducted in Primary

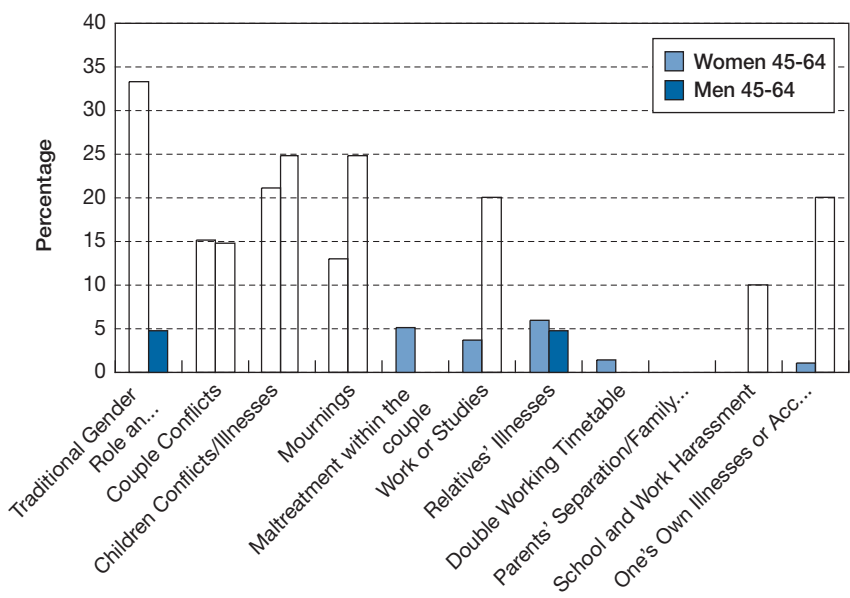
Care, for detection and treatment of psychosocial factors associated to the diagnoses of unwellness listed above, and states approximate results on distribution by sex of such associated factors (Velasco, López-Dóriga and Tourné, 2006c) (figures 12a and 12b).

**Figure 12a. Psychosocial Factors Associated to Pain and Common Mental Disorders as per Sex**



Source: Data on Assessment of Biopsychosocial Healthcare Action in Primary Care Services of the Murcia Region *Instituto de la Mujer*. Velasco, López Dóriga and Tourné, 2006c.

**Figure 12b. Psychosocial Factors Associated to Pain and Common Mental Disorders as per Sex and Age**



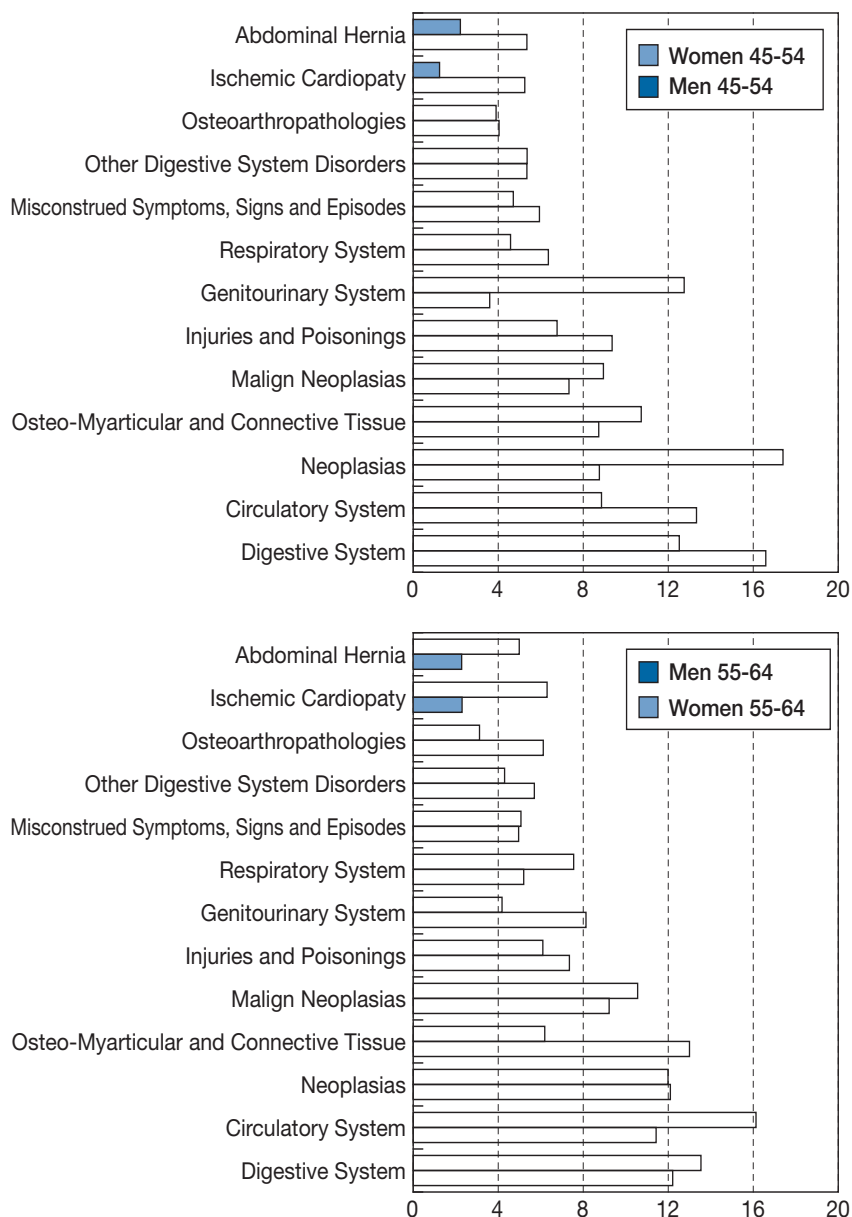
Source: Data on Assessment of Biopsychosocial Healthcare Action in Primary Care Services of the Murcia Region *Instituto de la Mujer*. Velasco, López Dóriga and Tourné, 2006c.

### 3.5. Hospital Morbidity

According to data from the Hospital Morbidity Survey (INE, 2005) within the population aged 45 to 65 years, men have been the ones in greater need of hospital attention (figure 13). This might be due to various reasons, among others the fact that pathologies men develop require admission to hospital with higher frequency. It might also stem from men's more frequently resorting to hospital attention or being redirected there, while women tend to resort firstly to primary care services (OSM, 2005). Traditional gender conditioning factors in men might be hampering their identifying symptoms and pain, resulting in their turning to hospital when the disease is already in an advanced stage.

So far, traditional manliness has featured rational and mental orientation, denial of one's one bodily dimension, the privilege of strength and the prejudice towards vulnerability (Bonino Méndez, 2000; Pastor

**Figure 13. Hospital Discharges by Age and Sex (figures in Thousands of Inhabitants)**



Source: *Encuesta de Morbilidad Hospitalaria* (Hospital Morbidity Survey, 2005. Ministry of Health and Consumers' Affairs).

Carballo, 2000; Barberá and Martínez Benlloch, 2004). Such traits are conducive to regarding illness as a sign of weakness. At the same time these same stereotypes influence healthcare providers when it comes to assessing the seriousness of a man or a woman's health complaint, all of which introduces a gender bias resulting in a higher redirecting of men to hospital care (Ruiz Cantero, 2001 and 2004). Likewise, differences in hospital morbidity causes (respiratory and some digestive diseases like cirrhosis and external causes and accidents) may be caused by lifestyles relating to traditional gender values.

As regards hospital admission causes for both sexes, **circulatory and digestive disorders** account for the highest rates. **Tumours** rank third for women and so do **respiratory tract diseases** in the case of men.

Among men aged 55 and over, circulatory disorders take the lead followed by digestive system diseases and benign and malignant tumours. Meanwhile, tumours and genitourinary trouble would be the cause for most hospital morbidity cases among women of up to 55 years of age. From age 55 onwards, osteo-myoarticular disorders would be the most common occurrence.

Diseases causing feminine overmorbidity are mostly **osteomuscular** in keeping with pain complaints, endocrine, nutrition and metabolic disorders conducive to **obesity and diabetes**, probably in relation with sedentary lifestyle social factors and unbalanced diets, **drug, medicament and biological substance poisoning**, considerably more frequent among age groups 25-44 years. From 45 years onwards, women admitted to hospital outnumber men, while in earlier ages the number of men admitted for these causes was higher than that of women. And finally, **misconstrued symptoms, signs and morbid states** which account for a considerable proportion, constant at all ages.

**Table 2. Hospital Discharges by Sex and Main Diagnosis. Absolute Values**

	Ages 45 to 54		Ages 55 to 64	
	Women	Men	Women	Men
Digestive System Disorders 520-579 IX	<b>26,681</b>	<b>45,088</b>	<b>31,922</b>	<b>52,238</b>
Circulatory System Diseases 390-459 VII	<b>18,891</b>	<b>36,223</b>	<b>29,890</b>	<b>62,211</b>
Neoplasias 140-239 II	<b>37,078</b>	<b>23,817</b>	<b>31,640</b>	46,241
Osteo-Myoarticular System and Connective Tissue 710-739 XIII	22,859	23,731	<b>33,978</b>	<b>23,863</b>
Malign Neoplasias 140-208 II.1	19,080	<b>19,916</b>	<b>24,103</b>	<b>40,728</b>
Lesions and Poisonings 800-999 XVII	14,433	25,432	19,217	23,541
Genitourinary System Diseases 580-629 X	<b>27,177</b>	<b>9,785</b>	<b>21,255</b>	16,133
Respiratory System Diseases 460-519 VIII	9,769	17,289	<b>13,603</b>	<b>29,118</b>
Misconstrued Symptoms, Signs and States 780-799 XVI	10,041	16,154	12,961	19,541
Other Diseases Affect. Digestive System 570-579 IX.6	11,425	14,539	14,911	16,578
Osteoarthropathies and Related Disorders 710-719 XIII.1	8,319	10,987	15,989	12,033
Ischemic Heart Disease 410-414 VII.4	2,642	14,281	<b>6,008</b>	<b>24,309</b>
Abdominal Cavity Hernia 550-553 IX.4	4,725	14,543	5,955	19,245

Source: Hospital Morbidity Survey 2005. Ministry of Health and Consumers' Affairs.

### 3.6. Early Mortality. Breast Cancer and Cardiovascular Diseases

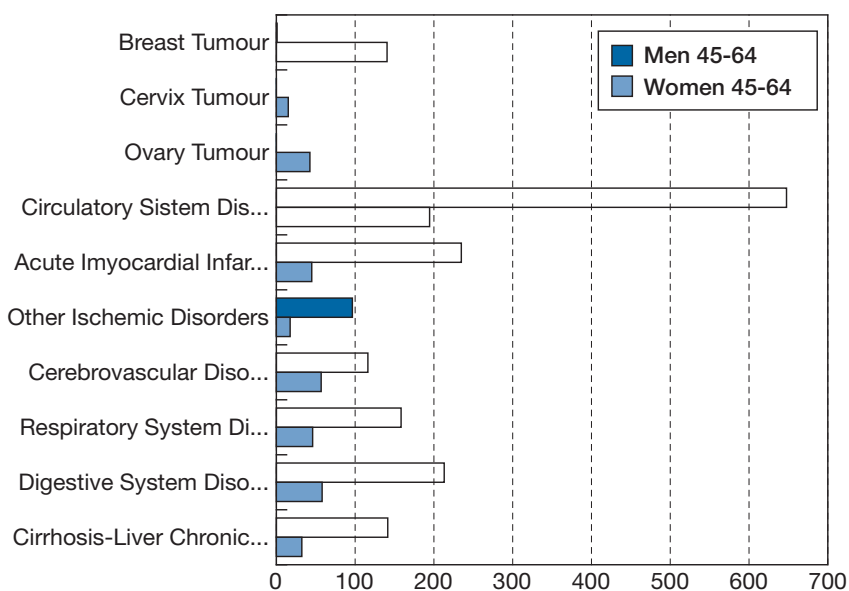
In keeping with life expectancy, mortality rates for the segment stretching between 45 and 64 years of age show that early mortality number of cases is significantly higher among men (table 3, figure 14). Also in keeping with the morbidity curve in this age group, male early overmortality is very sharp.

In women as well as in men, early mortality at these ages is caused by tumours (breast mainly in women and lung in men), and circulatory system diseases, these including cerebrovascular diseases, cardiac ischemia and acute myocardial infarction.

<b>Table 3. Mortality Rates by Causes, Sex and Age Group (per 100,000 inhabitants)</b>								
CAUSES	Ages 45 to 49		Ages 50 to 54		Ages 55 to 59		Ages 60 to 64	
	Men	Women	Men	Women	Men	Women	Men	Women
Tumours								
— Malign Breast Tumour	0.06	22.81	0.07	30.29	0.252	39.66	0.49	47.52
— Malign Tumour of the Cervix	—	3.30	—	4.47	—	3.20	—	4.12
— Malign Ovary Tumour	—	5.68	—	8.73	—	10.81	—	17.30
Circulatory System Diseases								
— Acute Myocardial Infarction	70.28	21.23	113.11	31.05	181.41	50.71	281.67	91.19
— Other Ischemic Heart Diseases	27.59	4.69	43.02	6.98	66.7	11.85	97.07	21.33
— Cerebrovascular Diseases	8.24	1.72	17.44	2.2	27.27	3.76	43.37	9.79
	13.03	7.01	17.59	9.94	31.38	15.3	53.99	24.53
Respiratory System Diseases	13.43	4.89	23.95	8.04	42.2	11.53	78.48	21.51
Digestive System Diseases	31.91	7.93	45.82	10.249	58.06	16.02	76.91	23.8
Cirrhosis and other liver chronic diseases	21.34	5.09	31.16	6.3	38.01	8.81	50.65	12.08

Source: Encuesta de Mortalidad, 2005, INE. Ministry of Health and Consumers' Affairs.

**Figure 14. Mortality Rates by Causes, Sex and Ages 45-64**



Source: *Encuesta de Mortalidad*, 2005 INE. Ministry of Health and Consumers' Affairs.

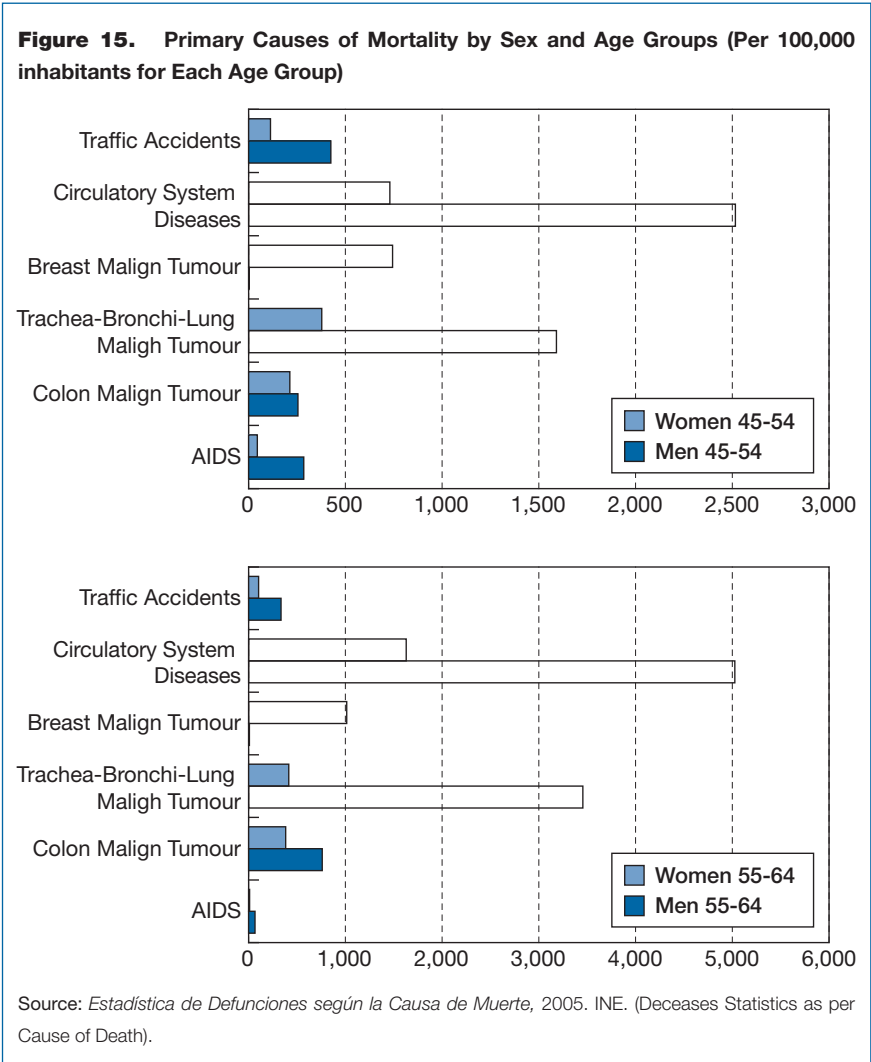
**Breast cancer** is the first cause of avoidable death among women aged 45 to 54. Although risk factors are not yet thoroughly known, causes are thought to relate to latest nutrition habits as an increased intake of fats common in industrialised countries, new reproduction patterns —reduced number of children and breastfeeding (Women's Institute, 2007)—. Among men, the same applies to **respiratory system diseases, cirrhosis and other liver pathologies**, all of them conditioned by alcohol and tobacco consumption with greater incidence in men due to gender factors.

**Tumours** account for the second cause of death among women although aged 40 to 54. **Malignant breast tumour** is the first cause of death among women. Bronchi and lung tumours, first in importance among men, have kept on rising, followed by Chronic Obstructive Pulmonary Disease (COPD) and injuries arising from traffic accidents.

Among **lesions**, apart from traffic accidents as first cause of death between ages 15-25, **suicides and deaths by self-inflicted injuries** are worth pointing out. Between 20 and 30 years of age they constitute the third cause of death, after traffic accidents and tumours, and, between 40 and 44 they

rank fifth, being this age stretch the one featuring the greatest number of suicides among women.

Finally and according to data from INE (Spanish Acronym for National Institute of Statistics) published in 2005, the four causes that presented **feminine overmortality**, were: heart failure, dementia, hypertension and Alzheimer disease.



## 3.7. Cardiovascular Diseases

According to the study conducted by the *Agencia de Investigación de la Sociedad Española de Cardiología* (5) (Research Agency of the Spanish Society of Cardiology) from data from their records, there exist important differences arising from gender in cardiovascular disease in Spain. Clinical and etiological features, cardiovascular risk factors profile, performing of diagnostic tests, therapeutic measures and prognosis are different between men and women in most of the pathologies and variables studied. Broadly speaking and above all in the field of acute coronary syndrome and heart failure, women prove underprivileged if compared to men in what concerns adoption of diagnostic measures and recommended therapies what may entail a worse prognosis.

The said study detects differences between men and women in clinical and demographic profiles and in use of therapeutic resources that partly explain differences in mortality and morbidity observed in women, which are even more obvious in more serious pathologies, like heart failure, and, above all, acute coronary syndrome. An increased prevalence of diabetes, arterial hypertension, obesity, related diseases and global risk profile in women might greatly influence those differences.

## 3.8. Mental Health

The mental health issue deserves special attention in this Report thanks to the aspects highlighted here: Significance of mental disorders; differences derived from sex, gender inequalities and social class, and gender determinants and gender vulnerability at maturity.

**Significance of Mental Disorders.** Arising from the epidemiological transition undergone in developed societies, mental disorders have a rising importance. WHO (2001) alerts on the fact that, if present trends consolidate, around 2020 mental disorders may rank as the health condition contributing the heaviest load of morbidity (6) in the developed world and for all ages. The most frequent and disabling are: use of psychoactive substances, schizophrenia, Alzheimer's disease, mental retardation and

(5) [http://www.secardiologia.es/pdf/LIBRO\\_ECV\\_FINAL.zip](http://www.secardiologia.es/pdf/LIBRO_ECV_FINAL.zip).

(6) Global Morbidity Load (GML) is a method for assessing morbidity and mortality by age, sex and region and lost years of life, that measures the loss of health, early death and disability impact and other non deadly health claims. World Bank. World Development Report 1993: Investing in Health. Washington D.C.: Banco Mundial; 1993.

childhood and adolescence disorders, and common mental disorders—depression, anxiety and somatic complaints—.

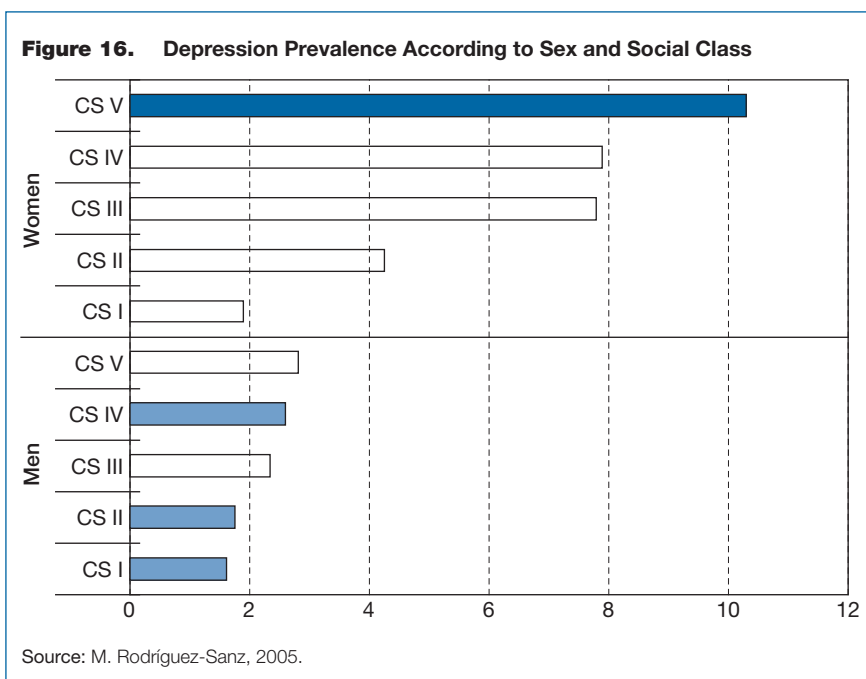
**Differences arising from sex.** Prevalence differs significantly for each sex, as far as some of the most relevant mental disorders are concerned: **clinical manifestation of depression**, that accounts for 41.9% of all mental disorders in women and 29.3% in men and that together with the rest of **common mental disorders —anxiety, and psychological and somatic complaints—** that afflict 30% of the population, show a double occurrence in women than in men (WHO, 2002). Also, evolution in women is worse; depressive episodes are longer, recurrence is more frequent and with a greater trend to chronicity than men (Usall, 2001; Montero, 2004). However, **addictive and personality disorders** exhibit a greater prevalence in men.

**Gender and Social Class Inequalities and Gender Determinants.** Mental disorders are greatly conditioned by **socioeconomic determinants —social class, occupation and educational level—**, by the kind of relation with work and by **gender determinants**, and hence are to a large extent susceptible to bio-psychosocial analysis and very sensitive to changes likely to be operated in the social and psycho-subjective spheres and the world of gender models. In Spain, the probability of presenting a mental disorder is estimated to be higher for women in all age groups, in lower social classes, in population groups with lower educational levels and in unemployed people of both sexes (Brugulat, Seculí and Fusté, 2001).

An association has been described between depression prevalence and social class, as well for men as for women (figure 16), so that prevalence is lower among more privileged classes and gender inequalities are greater in underprivileged classes.

**Gender vulnerability in maturity.** In life's central ages a **greater vulnerability to common mental disorders** is occurring, these ages being when the latter are more frequent which in turn owes to the socioeconomic and gender changes analysed all through this report. Likewise, for middle-aged men **addictive conducts to tobacco and alcohol**, also influenced by gender and class conditioning factors, are the main risk factors for their more significant causes of morbidity and early mortality (cardiovascular diseases, lung cancer and cirrhosis).

In Spain, between 45 and 54 years of age, women diagnosed with common mental disorders outnumber men by nearly twofold; between 55 and 64 the difference increases to largely double men's incidence. In addition in this last age segment the percentage of women diagnosed with psychiatric problems exceeds men's for all kinds of disorders (MHCA. *Encuesta de Morbilidad Hospitalaria, 2005* (Hospital Morbidity Survey, 2005).



In Primary Care services prevalence is found to be of 38% of patients suffering from anxiety, 25% from depression, 58% from somatisation, and they are always higher in women than in men (Rodríguez-Sanz, 2005).

Progression of common mental disorders in women is bound to be related to manifestations of women’s psychosocial uneasiness that were discussed in the section about general health complaints (Velasco, 2006b). To this respect, what seems to be necessary is to produce knowledge and strategies for attention to common mental disorders or psychosocial uneasiness of women in their maturity, that include psychosocial factors viewed from a gender approach.

### 3.9. Climacteric and Maturity: a Stage in Life Cycle

Criticism to the coupling of the feminine with the reproductive function is an issue largely debated within gender studies. It has been a privileged subject in the field of medical anthropology and gender (Stolke, 1987, 1998;

Esteban, 2001, Peña Othaitz, 2002), psychology (Sau, 1995; Moreno Rosset, 2000), in the sphere of health sciences (Bernis, 1995; Hubbard, 1995; Velasco, 2004; Valls Llobet, 2006) and bioethics (Corea, 1987; James, 1995; Donchin & Purdy, 1999; Warnock, 2003) to mention just a few relevant authors.

In terms of sexual and reproductive health this homologation entails a double turn: firstly, women's life experience is made to revolve around their fertile cycle (Peña Othaitz, 2002) and secondly, the fertile cycle itself is considered to be oriented exclusively to reproduction and motherhood. The outcome of this double interrelation has been the medicalisation of the feminine body and the subsequent pathologisation of the feminine biology (Martin, 1987; Franklin, 1997).

It is this «mother-centered» approach that explains for instance in gynecology and obstetrics, menstruation to be restrictively described as the outcome of a failed fecundation or pregnancy (Esteban, 2001).

In fact the reduction femininity-sexuality-fertility-reproduction —well synthesised in the customary remark «you are a woman now» when the first menses occurs which would logically imply that a woman stops being so when she stops menstruating— has resulted in viewing menopausal and postmenopausal periods as extremely trying (Valls Llobet, 2006; Coria, 2005). It is as if entering perimenopause meant not just loss of femininity in terms of procreation potential but also of personal appeal given youthful models of beauty and sexuality (Freixas, 2005a; 2007).

It should in turn be emphasised that this shifting of the sexual towards the reproductive approach (Vance, 1989) might partly explain why sexuality in middle-ages —above all in the case of women though the phenomenon occurs in both sexes— is somehow concealed and hardly given recognition or representation in the public sphere.

Traditional identification of women's sexuality with reproductive functions still pervades today's beliefs (Tubert, 1993; Juliano, 2003) where lingers the false notion that menopause puts an end to feminine sexuality (Santiso, 2005). Indeed the construction that sexual activity reaches an end at older ages still reflects persistence of certain stereotypes and taboos in persons' lives tantamount to prejudices that hamper person's behaviour and quality of life when it comes to leading a sexually fulfilled life.

Over recent years there has been intense debate around the medicalisation of the feminine life cycle process and in keeping with how debates around gestation and delivery medicalisation have unfolded, discussion has revolved around the reach medical intervention should have in a natural process as is the outcome of woman's reproductive capacity. And truth is that given the reproductivist approach to women's life and health this natural process that entails a diversity of conceptions and

experiences (Santiso, 2001) has tended to be depicted as disorder (menopausal syndrome) which has resulted in an over-dimensioning of menopause from the biomedical approach (Esteban, 2001; Freixas, 2002). This has been the framework that some years ago integrated debates over Hormone Replacement Therapy (HRT), establishment of a clear clinical manifestation outline or controversial relation between climacteric and psychological symptoms. Fact has it that research puts in question the alleged scientific evidence that would allow associating menopause with certain psychological symptoms that occur as well in other sectors of population, or that might well arise from certain specific social and gender conditioning factors in that crucial stage of life (Castaño and Martínez Benlloch, 1990; Velasco, 2006b).

It is true in this controversy that assumption of menopause as a medical issue prompts preventive action in what concerns physiological consequences of hormone evolution. But at the same time, it is noteworthy that the request of medical care for complaints allegedly menopausal does not come determined by hormonal change status itself but by an array of social and gender factors, among them the consequences of having been subjected for a lifetime to the traditional gender model in which social isolation, dependence and lack of one's own life project, different from just providing care to others (children leaving home), take their toll at the very moment of older age in the life cycle when one's cornerstones, resting on the partner or the family, change, giving way to a void of interest, of activity, of affective response, from the environment. The surfacing of possible dissatisfaction in the couple and in sexual relations the way they used to be (Montero y Ruiz, 1999).

The fact that maturity stage and menopause in women tend to be confused and overlap should not be disregarded and neither should that hence most of the ailments allotted to menopause actually arise from social and gender conditioning factors, which go deeper in the stigmatising of this period (Bernier, 2003).

The construction of a health ideal has significant impact on the health of women and men thanks to the influence of ideal models of manliness and femininity socially generated (González de Chávez, 1998; Tubert, 2000, 2005; Velasco, 2005). Idealisation of youth as a model of beauty and health for women has created discriminatory stereotypes that in combination with the medical approach, has promoted the viewing passing years almost exclusively as decline and loss (Freixas, 2001). This has translated into systematically pathologising older-age instead of assuming it as part of women's life cycle (Uría, 2007), of which negative stereotypes about menopause are one of the most meaningful examples.

## 4. Health Medicalisation of Middle-Aged Women

### 4.1. Pharmaceuticals and Psycho-Pharmaceuticals Consumption. «Prescribed Tranquility»

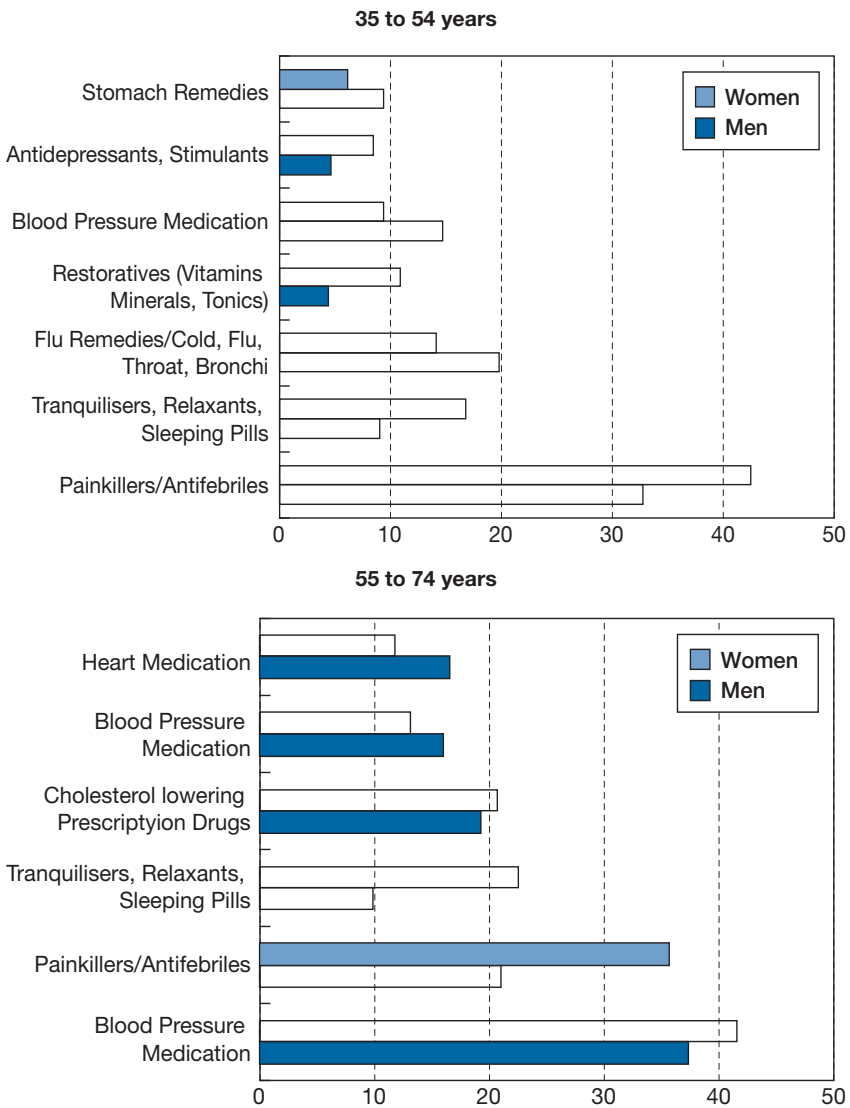
Women outnumber men in psychopharmaceuticals consumption (on medical prescription) and in self-medication (WHO, 2005). Broadly speaking, increased consumption of prescription drugs by women coincides with the worst perceived state of health. But these figures also suggest how gender conditioning factors impose on women and men, a different attitude towards their own health. To this respect, it could be said that in order to deal with uneasiness, most frequent in central ages of life, while men (who frequent healthcare providers to a lesser extent) drink and smoke, women get medicated or self-medicate themselves.

The percentage of middle-aged women consuming pharmaceuticals, that is shooting up and actually gone beyond 50%, tells us about the incidence of gender inequality, just as we saw when discussing mental health. But apart from this fact which is consistent with subjective perception of health the percentage of women consuming pharmaceuticals is, between ages 45 and 64 years of age, significantly higher among housewives, further abiding by the traditional gender model.

Some authors underline that after analysis of drugs consumption (legal or illegal) from a gender perspective it emerges that women's addictions appear to be related to legal drugs authorised by Medicine and Psychiatry and that therefore they perceive as safe (Romo Avilés, 2004 and 2006). Certainly, according to data from the study conducted by Romo, 75% of sleeping pills or tranquilisers' consumers are women and 70% of Spanish women have, at some moment consumed this kind of medication.

Particularities of this kind of healthcare approach may arise, partly, from the evidence in healthcare of a gender bias that somehow discredits female users' discourse when they recount their symptoms. Traditionally women's health problems have remained invisible for the Medical Science

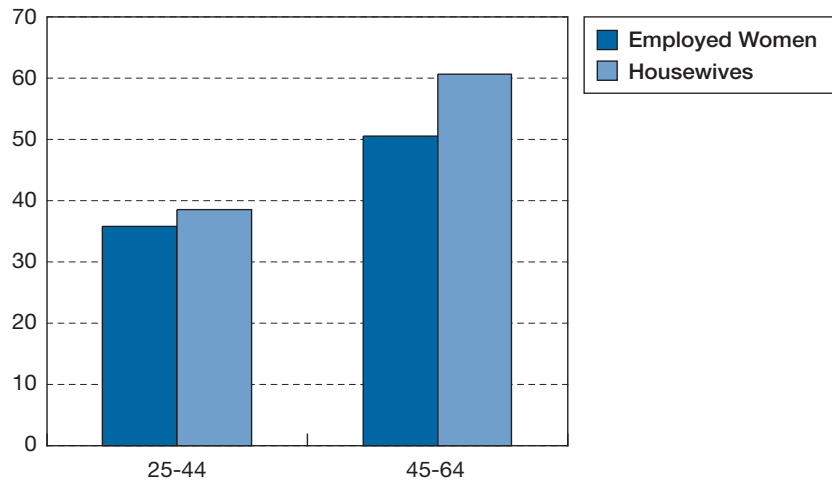
**Figure 17. Pharmaceuticals Consumption by Age and Sex**



Source: *Encuesta Nacional de Salud, 2003*. Ministry of Health and Consumers' Affairs.

and have even been denied by women themselves used to doubting their own symptoms and their own mental health, hence remaining concealed as psychosomatic or /and psychological (Valls Llobet, 2006).

**Figura 18. Percental Distribution of Pharmaceuticals Consumption in Last 15 Days as per Working Situation and Age among Married Women or Living in Couple**



Source: Artazcoz, 2005.

This course of analysis is also shared by other authors who, based on the *IBERICA (2002)* and on other prestigious research assert that in all hospital handling, diagnostic effort, therapeutic procedure, delays and waiting lists of healthcare providing, prescription of psychopharmaceuticals and psychotropic drugs, in the hospital sphere, gender bias is fairly significant (Ruiz Cantero and Verdú Delgado, 2004).

Traditional gender stereotypes associated to the depiction of a somehow weaker, passive, dependent woman, plagued by unspecific ailments, reduplicate and get conveyed and mainstreamed among healthcare professionals (Velasco, Ruiz y Álvarez Dardet, 2006d) prompting doctors to prescribe psychopharmaceuticals to women, when faced to unspecific situations (where a clear pathology seems absent) (Burín, 1991; Romo Avilés, 2004, 2006). In other words, situations connecting with vital circumstances that generate unspecific disorders are customarily diagnosed as anxiety and the rest of diagnoses on common mental disorders are also prescribed a psycho-pharmaceutical treatment; hence, given similar diagnosis and number of visits more psychopharmaceuticals are prescribed to women than to men (Márquez *et al.*, 2004). It is what Mabel Burín (1991) called «prescribed tranquility» sparking then the alert that women's unwellness was being categorised as mental disorders and was intended to

be solved with prescription psychopharmaceuticals. In the last decade, progression of the prescribed tranquillity has continued advancing firmly and steadily regardless and unaware of the fact that women are in fact somaticising in their bodies the generic inequalities of their living situations—work overload, stress, anxiety, etc.— (Pérez Blasco and Serra Desfilis, 1997; Burín, 1991; Rodríguez, 1990; Velasco, 2006b and 2006c).

In the case of medicalisation relating to psychopharmaceuticals, WHO has raised the alert on the risk of using psycho-drugs to settle social issues (WHO, 2005) clearly surfacing how gender has a bearing on unwellness perception and on attitudes to solve it. It is precisely at this level where the healthcare system should promote models of attention to unwellness from a bio-psychosocial approach (Velasco, 2006b and 2006c) targeting modification of associated gender determining factors, undertaking to limit medicalisation and find alternative solutions to this symptoms originating unwellness that leads to psycho-drugs consumption.

## 5. The Female Caregiver's Role and Health

Caregiving accounts for one of the areas in comprehensive health, where undertaking a gender approach is most urgent. In this care providing area not only does gender inequality relating to health strikes as most obvious but the foundations sustaining this inequality are laid, for caregiving underlying the very gender cultural construction basis (Vale de Almeida, 1990). Most certainly, gender arises in togetherness with sex division of work, leading to the distinct separation of the material commodities production sphere assigned to men and life reproduction and culture, within which caregiving assumes a central role, entrusted to women (Bonacorsi, 1999).

Along this line and despite recent social advances, when focusing on generations today in central stages of life, it is worth pointing out that any reference to the family, material when addressing the caregiving issue, involves reference to a social institution featuring a marked generic inequality that traditionally entails supremacy of male authority and female submissiveness and seclusion to the domestic sphere being thus compelled to undertake all related tasks, this including care to other persons.

As regards situations of dependence, this latter involves different needs for dependants as per their sex, bearing in mind old age feminisation (Pérez Díaz, 2003) and taking into consideration that broadly speaking women as they age sustain more vulnerable social and economic situations than men do (WHO, 2003).

### 5.1. The New Social and Family Organisation

Processes of modernisation, industrialisation, housing and democratisation of masses have entailed a **transition to a model of nuclear or conjugal family** integrated by the progenitor couple and their children that seems to be evolving to an even reduced model given the increase of unipersonal, single-parent families or childless couples (Pérez Díaz, 2003). However, and along this trend it becomes apparent that in Mediterranean societies such as the Spanish one changes undergone by new family models have adopted a

specific and differential dynamics featuring a model of «**family and relatives solidarity**» (Moreno, 2001; Naldini, 2003, quoted at Moreno, 2006): a supportive regime that interconnects members of the family from diverse domestic units (Ferrera, 1999) so forming a reticular structure that provides for the basic function of mutual help on the basis of relativeness and where social functions like care assume a central role (Bodoque *et al.*, 1990).

Gender division has of course played and still plays a central role in this family restructuring partly because its being a consequence of the integration of women in the work market is undeniable and also because family solidarity has sustained itself on the **hyperactivity of their women** who, apart from taking on new working responsibilities, have continued absorbing family burdens.

However, in this new network **middle-aged women** are the ones to assume, not just traditional functions but new ones and a renewed importance. They are the ones whose activities are largely devoted to the care of their nearest of kin, at present not just inside but outside the family kernel. They provide continued help with the care to children, care to the diseased and they take on responsibility for the elderly; they offer help on occasion of accidents or deaths (Bodoque *et al.*, 1990; Pérez Díaz, 2003). Such is the case of the practical help provided by «**grandmothers-mothers**» or by «**mothers-daughters**» (Moreno, 2001), and it has been precisely this role, undertaken by women between 45 and 65 years of age what has enabled new generations of women to consolidate their economic and social life: their **double role at work and at home management** coincides with their undeniable irruption as key elements in their adult children's family lives (Moreno, 2001, 2006; Pérez Díaz, 2003).

Along with the absence of State's practical help, younger women have taken for granted that middle-aged ones would take over care responsibilities at home which would result in a paradoxical outlasting of gender traditional roles among older women as a possibility of sparing the next generation (Lynch, 2005).

## 5.2. Family and Gender Faced with the New Redistribution of Ages

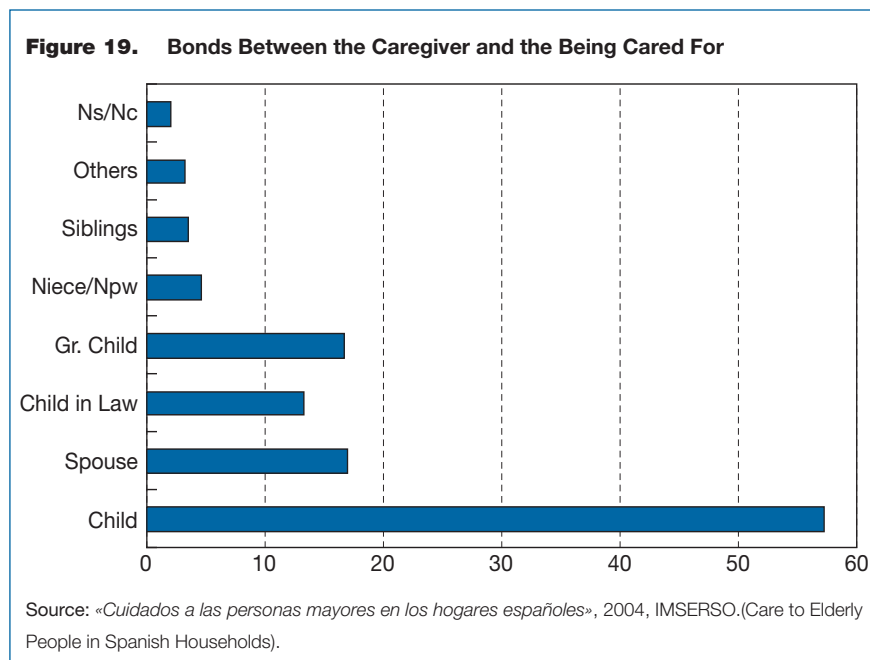
The so-called demographic modernisation of Spain arisen from the improvement of life and health conditions which have resulted in a lengthening of life expectancy along with women's integration into work closely related to the decrease in fertility rates (De Onís & Villar, 1992),

have brought about a fundamental novelty: **Cohabitation between generations** which entails a reshuffling of functions that gives rise to a new social placement of old age and above all to a readjustment of gender roles (Pérez Díaz, 2003).

Among generations born in the second half of the century reaching middle-ages from now onwards, survival of parents is already spectacularly a majority (Pérez Díaz, 2003). When faced with this phenomenon **family strategies for generational mutual care** complicate relations between sex and age and exhibit a new map that affects the well-being and health of family members especially women and pose new challenges to the promotion of comprehensive health.

This new relation of intergenerational care has in fact involved a further turn towards reinforcement of **feminine role as an equivalent to care role** or to what many female authors have called «false emancipation». With regard to informal care to the elderly data from the IMSERSO (Spanish acronym for the Institute for the Elderly and Social Affairs) point at a reinforcement of the trend towards concentrating the responsibility for care on **middle-aged women**.

The truth is that the **health decline among women of intermediate generations** is closely linked to the care system's being structured around



the invisible work of the family women all this giving rise to a scenario where older women take care of infants (grandmothers) and middle-aged female adults take care of the elderly (children and children in law), which entails a task overload for them (Conclusions of the Development Workshops on «Woman in the elderly population environment» (*Conclusiones de las Jornadas de Desarrollo sobre «La mujer en el entorno de la población mayor»*, Madrid, 2000)). This crisis of care that is being overcome at the expense of women's precariousness, as it rests on inequality and gender power foundations (Pérez Orozco, 2006), involves a worsening of intermediate generations' quality of life and has a particularly negative effect on the health of middle-aged persons.

### 5.3. Transformation of Traditional Roles in the Light of Changes in the Family

Changeovers in the work market now with a trend towards the «two salaries» model (Sarraceno *et al.*, 2005), have transformed intergenerational commitments to such an extent that, while young, adult and middle-aged men keep on assuming the same roles and tend to maintain cultural patterns of traditional masculine gender identity, women roles have changed often worsening their situation and resulting in the «**double or triple working timetable**» phenomenon (*Instituto de la Mujer-MTAS*, 2005, Report). This gender difference, that turns into inequality, seriously conditions women's socio-psycho-physical well-being, differently, according to their age.

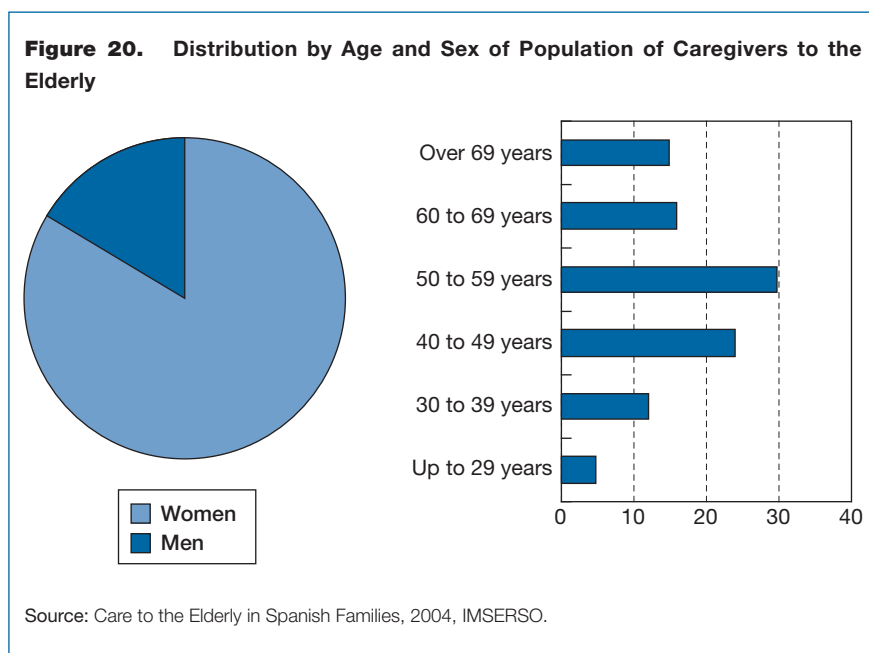
A large proportion of studies from roles literature provide evidence on the fact that employed women enjoy a better state of health than those who work full time as housewives (Sorensen, 1987, Nathanson 1975, 1980). It has also been determined that this fact does not simply owe to the «healthy worker effect» (Verbrugge, 1983; Passannante, 1985; Waldron, 1998). Some of the benefits employment provides are opportunities to develop self-esteem and confidence in one's own capacity to decide, social support for people that would otherwise be isolated and experiences that enlarge satisfaction with life (Verbrugge, 1983). In addition, salary endows women with economic independence and empowers them within the family unit. This would support the hypothesis of «role empowerment» according to which different roles may act as alternative sources of well-being.

However, other studies support hypothesis of overburdening and role conflict. Evidence has also been found that employment has beneficial effects on single women's health but not on married ones' (Passannante, 1985) or that among mothers these benefits are only limited to those who work part time (Arber, 1997; Bartley, 1992; Walters, 1996). It seems that when total workload is heavy, combining work and family lives may damage health.

**Middle-aged women are in actual terms the ones to virtually assume all the care tasks burden**, intergenerational mostly, both in ascending line as well as in descending one with children still at home or in the care of young grandchildren, they also undertake the care of the elderly as well as of dependants. These women, today aged over 45 are profoundly involved in this situation as they were raised in a society that although amidst the 60's liberation breezes was still downright traditional and where the ultimate goal in life was still unquestionably starting a family, achieving which they were awarded «the “feminine” “authority diploma” certifying their having fulfilled their duty» (Coria, 2006: 40). These scheme, sustained in the **depiction of woman as «a persons' being»** (Dio Bleichmar, 1997; Nussbaum, 2002) existentially commits women to their leading role in the family as caregivers in exchange for their «being accepted», and enables the understanding of the historical trend to subordinate professional performance to care to others and to affective relations with others especially when in their older age these women address a «role void» they compensate by continuing their caregiving role in the extended family (Freixas, 2006). This situation as evidence proclaims results in their psychophysical health decline, giving rise to situations that are diagnosed as anxiety, depression, stress, somatisations, etc.

In turn, owing to historical inequalities, women today in their old age or going on for it in the near future are in a state of higher **vulnerability** both **economic** and in terms of educational background resources, than men all this added to the fact that their role as caregivers within the home has deprived them of other social resources (WHO Gender and Health Department Report, 2003). If toppling these inequalities we consider that the proportion of women who age while being widows is higher that that of men (owing to their extended life expectancy and to their customarily marrying older men) we may conclude that older middle-aged women that will soon reach old age will be exposed to a greater **isolation, dependence and impoverishment risk**. Hence and targeting prevention it is essential to trace the implications that **care-associated work overloading** entail for middle-aged women's health bearing in mind that if such effects have not yet surfaced they will surely do and will most certainly turn more serious at their next life stage (Ibíd., 2003).

IMSERSO data fully endorse that among the caregivers' population, women aged on average 52.9 account for 84%.



Women in their middle-ages of early older age have been standing out as a key element: with no access to the work market, they have made their daughters' progressive incorporation to the market, possible and have provided for the scarcity of care services, undertaking a work overload neither recognised nor paid (*Instituto de la Mujer*, 2000). From this viewpoint, the State should regard the issue not simply as just an expense but assess profitability of an investment made in these women (Pérez Díaz, 2003).

This situation remains unchanged given **the significant socioeconomic inequality between sexes in middle-aged generations**. Education level and economic dependence are distinctly uneven for these generations; in fact for persons approaching their 60s the proportion of illiterate women is twofold that of men in the same situation (Pérez Díaz, 2003). This «compulsory» dedication of women to reproductive functions becomes apparent in their lives' second half (Valls Llobet, 2006) in that its effects are

felt in their present life opportunities and subsequent difficulty to find resources that may allow them to break free from affective dependence (Cardenal Hernández, 2003) or from the «empty nest» circle that secludes them in a world of their own ever revolving around care (Coria, 2005; Freixas, 2007). However, these statements need qualifying according to **work history and education**. Not every woman has become equally linked to caregiving tasks. For families with a greater purchasing power the option is hiring personal care and housework services in a rapidly expanding market in recent years (Moreno, 2001) and with an increasing presence of immigrant women to cover this need. For less privileged families the immediate solution is resorting to other female family members or relatives.

Various studies conclude that care given to the disabled is usually organised around a supportive network pivoting on a head caregiver who presents a distinct profile: woman aged 45 to 65, married with a low education level, exclusively devoted to non-paid care, this is to say: a housewife (Pérez Orozco, 2006). As regards children, **social level also intersects with gender**: while for nearly 40% of high socioeconomic level women, grandmother has little or no importance, for almost a quarter of low socioeconomic level women, she is essential for their keeping a paid job.

**Table 4. Type of Help Received as per Socioeconomic Level**

Type of help	SEL HIGH	SEL MEDIUM	SEL LOW
Without their help they could not work	11	13	24
Very important	32	30	20
Important or rather important	18	20	22
Little or of no importance	39	36	34

Source: Tobío Soler (2002).

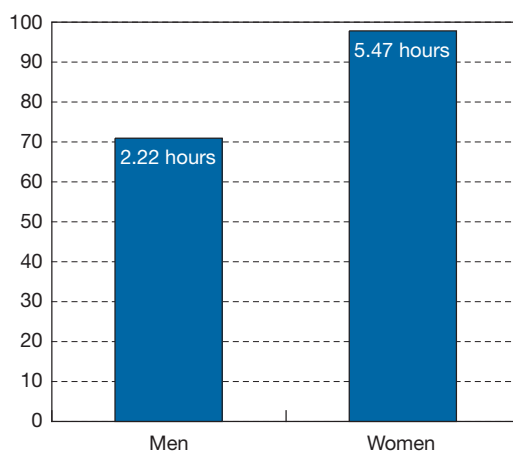
Regarding social class, a study on Catalan population aged 25 to 64 and living as a couple showed that family burdens affect working class women's health, and that on the contrary, the family burdens impact on the health of women pertaining to upper-classes is considerably cushioned; while among blue collar workers a relation surfaced between family demands according to number of people in the household and declining self-perceived state of health, presence of chronic disorders and limited activity, in the case of

upper-class women—as well as in men— family demands did not seem to influence health indicators (Artazcoz *et al.*, 2005).

But despite these different overtones, persistence of **traditional gender roles** is a fact: according to the Active Population Survey (*EPA*) outcomes between 1994 and 2004 the number of women having given up their jobs due to «personal or family reasons» has risen from 3.3% in 1992 to 5.4% in 2004 (*Instituto de la Mujer*, 2005). And according to the Time Use Survey (*Encuesta de Empleo del Tiempo INE 2002-2003*) while nearly 100% of women between 45 and 64 years of age devote about 6 hours a day to activities relating to other people’s care, only 71% of their contemporary men do the same though only devoting 2 and a half hours roughly.

In short, class intersects with sex in terms of care and health but such a relation does not prevent persistence of gender inequality: class will tell apart some women from the others when it comes to strategies for playing the current traditional gender role one way or the other.

**Figure 21. Percentage of Men and Women Engaging in Daily Care and Housework Activities**



Source: *Encuesta de Empleo del Tiempo, 2002/3. INE. (Time Spending Survey).*

## 5.4. What Does «Providing Care to Other People» Mean in This Context?

The definition of care does not altogether stand out as obvious and its history is linked to different definitions of what in gender terminology is known as reproductive work which from a gender approach has raised considerable controversy. From the Beasley List (1994) contributed by Pérez Orozco (2006), a new list is proposed that without intending to be thorough gives a good account on the array of **activities reproductive work entails**: support services work (educational tasks, time organising around family administrative, civic and legal activities), housework (home maintenance), body work (diet, physical activity, hygiene, sleep planning, etc.), infant care work, elderly care work, care to dependants work (due to accidents, chronic illness), emotional work (including husband and other family members care), and assistance work in the health field.

All these activities intersect among them and are not conducted singly, in a fenced-in space and during a set number of hours but on the contrary involve continual «presence» and it is difficult to draw the line that separates different tasks. Along this line, the definition of care work—which largely overlaps the notion of reproduction— aims at expressing also the variety and significance of activities and resources that «**sustaining life**» entails. It is deemed to be at the same time material and immaterial work bound to be conducted in both the private and public spaces and should convey the notion that in women's life routine planning there is no clean separation between work market and family.

Hence, in care work besides actual **needs of dependants**, infants or elderly people lacking autonomy to some extent other members of the family should be taken into account. As a matter of fact it must be mentioned that as a result of this extended definition «**social dependants**» should also be included, taking as such husbands or male partners who have historically depended on their female partner care and whose demands remain invisible when accounting for the effort made by women (Pérez Orozco, 2006).

Care work leads to exhaustion since, as a result of its allegedly being part of the feminine gender role it is deemed to be performed round the clock 365 days a year; in fact family women **do not work as caregivers but are caregivers** (García Calvente *et al.*, 2004, quoted in OSM, 2005).

Specialised care of dependants, infants and elderly people with some degree of autonomy impairment is just a specific aspect of this activity. But it is precisely from this broad-range redefinition of care that the why and how the actual case of care to dependants has remained invisible despite its

specificity, emerge more clearly. The **informal health system** within which the highlight is the part of it that occurs in the domestic sphere, accounts for 88% of global care that people with some degree of dependence need; however, activity and costs this informal system involves have only been taken into account whenever it has failed (Durán, 1983).

## 5.5. Caregiver Role Effects on Health

The fact that community health is almost exclusively in the hands of women is in itself an item of gender inequality in health and the case of caregivers' unwellness is a milestone in the still long journey to go to achieve a more equitable health policy. In fact, the caregiver role entails an impact on quality of life and health itself, a reason why caregivers themselves turn into healthcare services patients (García Calvente, 2002).

Amid other surfacing symptoms are depression, exhaustion, back pain, anxiety, sadness, joint osteoarthritis, chronic pain and frequent misconstrued symptoms such as headaches, dyspepsia, asthenia, motion sickness or fibromyalgia. From the usual healthcare biologicist approach it is difficult to establish that all these symptoms arise from gender psychosocial processes among which being subjected to the role of caregiver is probably the most relevant among middle-aged women (Arbesú Fernández *et al.*, 2002; Velasco, López Dóriga, Tourné, 2006c). This failure to tune in is partly responsible for chronicity of pharmacological treatment in the care to mental health (Mosquera Tenreiro *et al.*, 2005; Velasco, 2006b y 2006c) (7). In a study conducted in the Murcia Region the main psychosocial factor identified in women being treated after having been diagnosed of diverse disorders included in the concept of psychosocial unwellness, was traditional role overburdening and caregiving work (Velasco, López-Dóriga, Tourné, 2006c). In fact and along with these considerations it is broadly agreed in Psychology that informal care to elderly people with health disorders generates chronic stress in people providing such care this entailing important consequences for their physical, psychological and social well being (Losada *et al.*, 2003).

Along with exhaustion, the self-sacrifice caregiving involves certainly affects caregivers' health above all concerning their mental health.

(7) A study conducted in Asturias concludes that the main problem ailing women aged 30 to 60's health is their role as caregivers within the family.

Postponement of one's own **personal care** very often **exclusion from working life** and other **social roles**, repercussions on availability and time assigning, difficulty to organise one's own life and future planning, together with **lack of recognition and reciprocity** from the person being given care will undoubtedly have consequences that may well promote development of depression and anxiety processes stemming from the sensation of lack of autonomy and loss of control over one's own life (WHO, 2002; García Calvente, 2002).

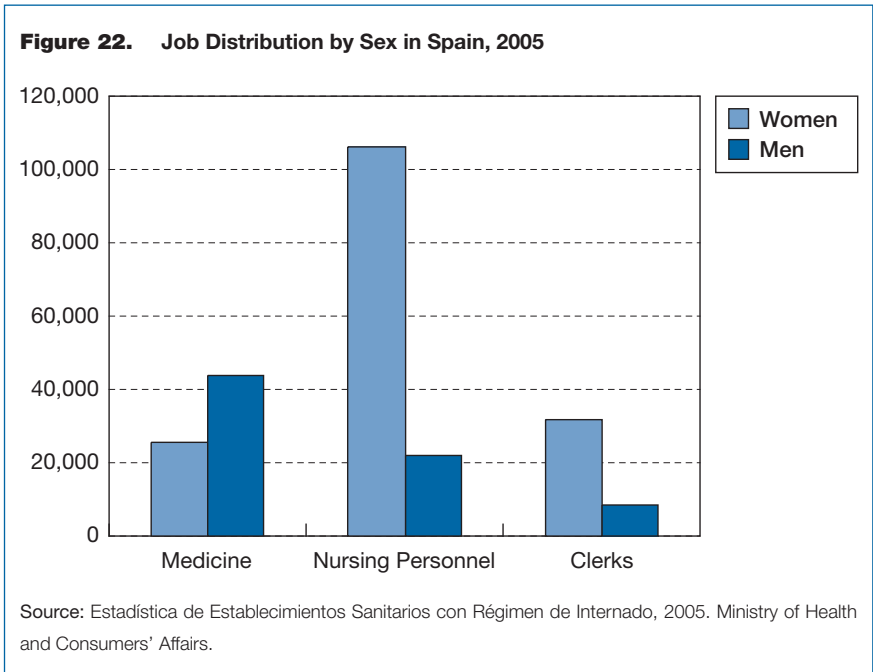
The bio-psychosocial care model (Engel, 1977; Tizón, 1988) from a gender perspective (Velasco, 2006b), would allow addressing the effects on health of women subjected to the role of caregiver, thus enabling them in the first place to question their compulsory continuing to provide care to others and secondly, to unblock their traditional ideals of femininity so that they would be able to opt for giving up their caregivers role. Their solely being assigned this function is a gender inequality that has to be mended through comprehensive attention and not through medicalising the issue.



# 6. Women in Healthcare Careers

University degrees relating to Health are today clearly feminised although in very different ways. By way of example, 84% of Nursing students in 2005-2006 were women. Preferences for different study branches, arising from personal or social questions more or less obvious (as reproduction of care in the professional sphere) explain partly different professional categories between men and women and their hierarchical position in the healthcare system, as can be seen in figure 22.

Analysis by sex and chartered professionals in the different specialties reveals not only that present is feminine in specialties as Pharmacy or Nursing but that future is feminine too in specialties like Medicine a male domain up until two decades ago. At present the proportion of women chartered in Medicine account for 43% of the total although among people under 35 years of age, female Chartered General Practitioners double the



number of their male fellow GPs, which outlines a future distinctly different from the present situation.

Women are also majority in Medicine studies, something that has been occurring since the 80's: Female students registered in the 2005-2006 year amounted to 74%, 3 points beyond 1998 figures and 73 points beyond 1955 (Ortiz-Gómez, 1985, 2007).

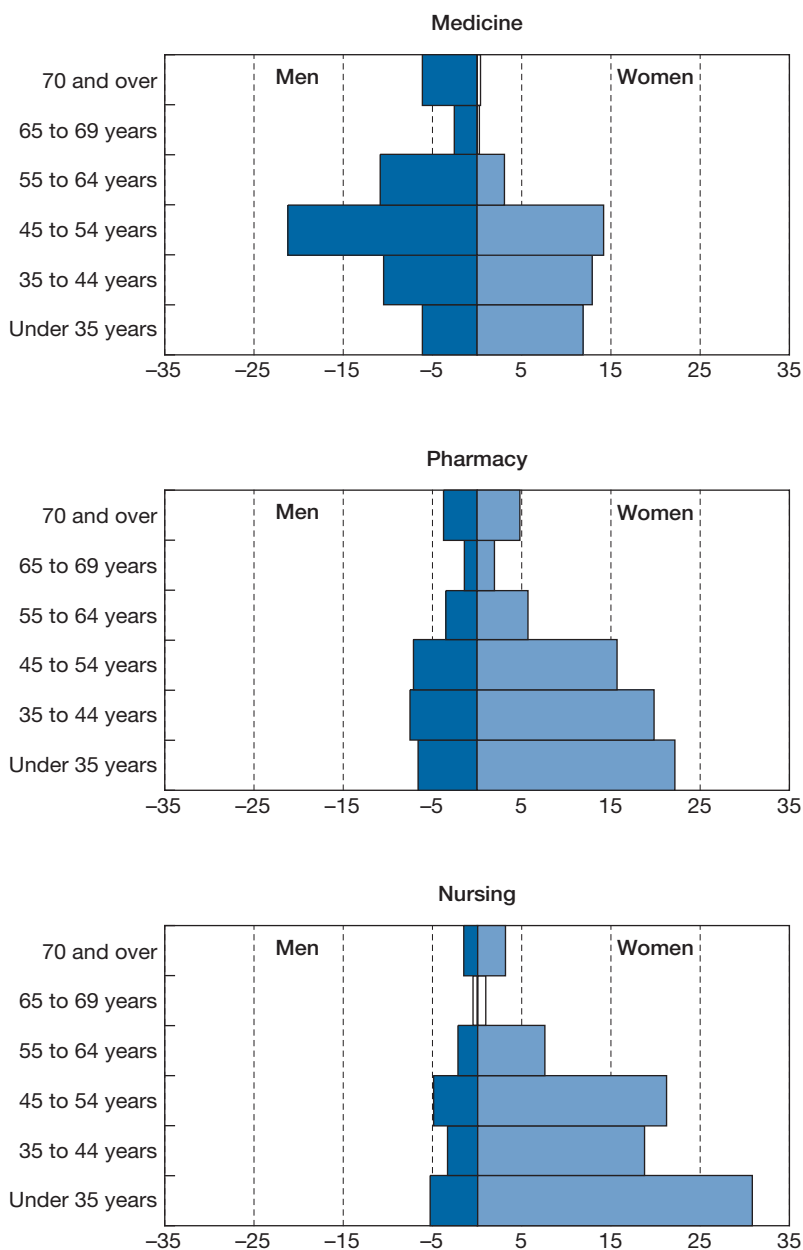
Análisis of the *Estadística de Establecimientos Sanitarios con Régimen de Internado (ESCRI)* (Boarding School Regime Healthcare Establishments Statistics) reveals that women are a majority in these centres with more of 51% of total personnel. Nevertheless, presence of women in different medical specialties is uneven: the highest presence occurs in Rehabilitation although in absolute figures they reach peaks in Internal Medicine and Central Services. Orthopedics and Intensive Care are the specialties with the lowest presence of women. It is worth mentioning that specialties that might be thought to be feminised like Pediatrics or Obstetrics are where men are the majority although with differences, that in the case of Pediatrics are minimal.

Presence of female Pharmacists in boarding school regime establishments differs greatly from female Chartered Pharmacists. The sign is reversed, men being here the majority even though female Chartered Pharmacists account for 70% of the total.

Female Nursing Professionals are a majority especially in Registered Nursing and Midwifery where female percentages go beyond 80 and 90% respectively

A recent study conducted among a representative sample of Catalonian Female and Male Physicians reveals that in keeping with different distribution of genders in different specialties there exist differences among women and men in terms of centres where they work. Most female doctors work in Primary Care centres while male doctors work mostly in hospitals. Likewise most male doctors work in more than one centre whereas women doctors work for the most part in just one centre. The same study points out that as long as female doctors live by themselves they devote more time to paid work than their fellow male doctors; however, tables are turned when they live in couple and the difference enlarges when they live with children, an outcome clearly consistent with sex division of tasks (Rohlf's *et al.*, 2007).

**Figure 23. Age Pyramids in Medicine, Pharmacy and Medicine Chartered Professionals in 2006**



Source: Profesionales de la Salud Colegiados, 2006. INE.

**Table 5. Healthcare Specialties by Sex, 2005**

Specialties	Women	Men	Total
<b>Medical</b>			
Internal Medicine and Medical Specialties	6,992	11,845	18,837
General Surgery and Surgical Specialties	2,633	8,929	11,562
Orthopedics	474	3,737	4,211
Obstetrics and Gynecology	1,666	2,434	4,100
Pediatrics	1,412	1,785	3,197
Psychiatry	1,140	1,588	2,728
Central Services	6,966	7,870	14,836
Intensive Care	760	1,667	2,427
Rehabilitation	673	574	1,247
Emergency Services and Shifts	2,633	3,485	6,118
<b>Chemists</b>	1,159	1,637	478
<b>Other College Degrees and Healthcare Resour</b>	2,171	3,358	1,187
<b>Nursing Personnel</b>	106,076	127,819	21,743
Registered Nurses	99,852	19,969	119,821
Midwives	2,844	291	3,135
Physiotherapists	3,380	1,483	4,863
Hospital Assistants	5,678	97,213	102,891
Healthcare Experts	14,198	3,986	18,184

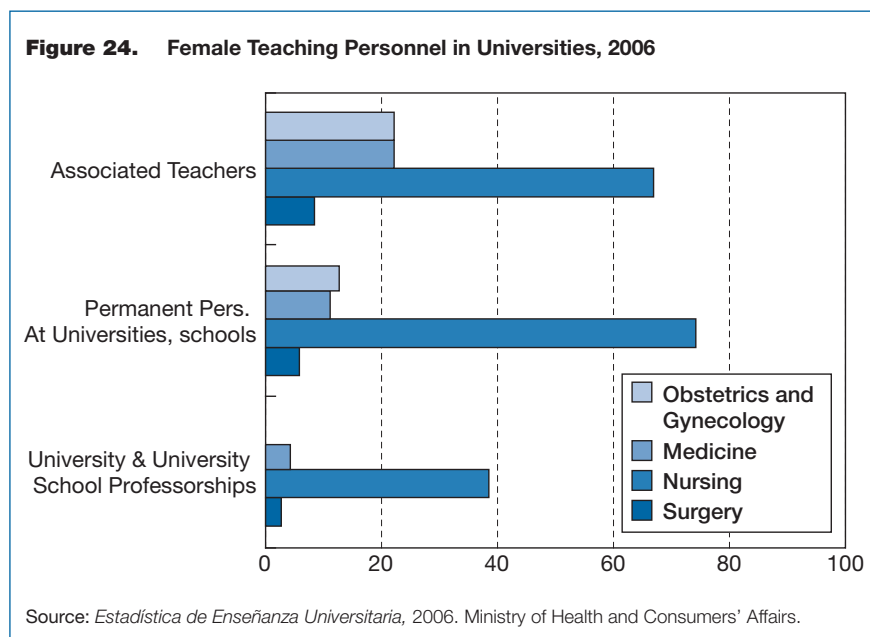
Source: Estadística de Establecimientos Sanitarios con Régimen de Internado, 2005. Ministry of Health and Consumers' Affairs

In contrast to the massive presence of women in Health Science Degrees (8) where they reach beyond 74%, teaching professionals are still mostly men. According to University Teaching Statistics the rate is of 62% male teachers versus 38% of female teachers, Nursing (67.4%), Pharmacy (59.4%) and Physiotherapy (59%) being the most feminised specialties

Surgery (7.6%), Obstetrics and Gynecology (17.5%) and Medicine (18.9%) register the lowest presence of women. By professional category it is worth noting the scarce presence of female University Professors even in highly feminised specialties like Nursing or the absence of Professors in Obstetrics and Gynecology. The largest number of teachers are concentrated

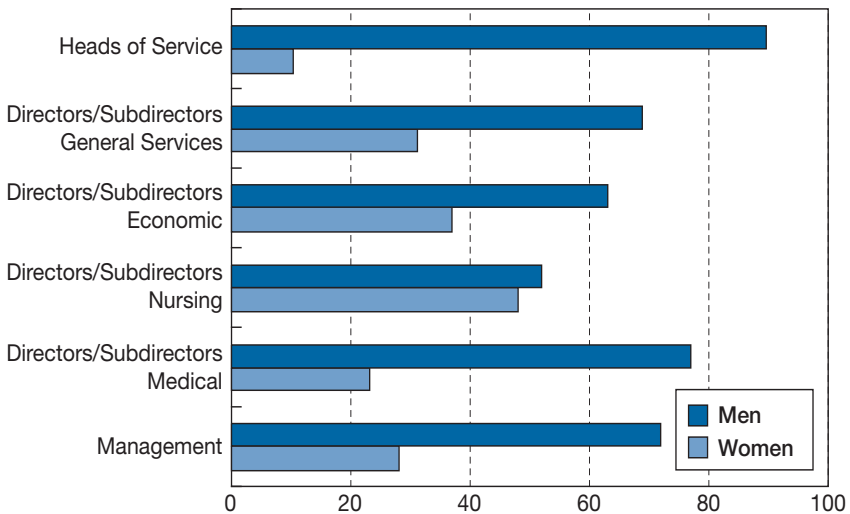
(8) Science related studies include Pathological Anatomy; Compared Anatomy and Path. Anatomy; Human Anatomy and Embriology, Surgery, Nursing, Stomatology, Pharmacy and Pharmaceutical Technology, Pharmacology, Physiology Physiotherapy, Genetics, Histology, Immunology, Medicine, Legal and Forensic Medicine, Preventive Medicine and Public Health, Animal Medicine and Surgery, Obstetrics and Gynecology, Ophthalmology,, Optistry, Otolaryngology Pediatrics and Toxicology.

in posts of less recognition as lecturers or assistant or associate teachers. In short, although students profile is clearly feminine, teaching still is a male redoubt especially in highest categories.



Women percentages at Public Hospitals Management has improved over the years although this responsibility is still largely in the hands of men: from 7% of Hospital Heads in 2001 (Arrizabalaga and Valls-Llobet, 2005) 18% was reached in 2007. At present the percentage of women holding managerial and directive posts according to ESCRI is nearing 45% although total percentages might be omitting substantial differences. In the case of the Andalusian Health Service (*Servicio Andaluz de Salud* (Delgado, 2007) the presence of women in managerial and technical posts is low and is concentrated in Economic and Nursery Directorates and Sub-Directorates while the lowest figures correspond to posts with the highest professional recognition: Services Head Offices, Bureaux and Medical Managements. The Nursing case is significant: only 48% of Andalusian Nursery Directorates and Sub-Directorates are held by women while 82% of nursery personnel are women (IIS, 2007). Likewise, the difference also surfaces in hospital medical personnel: the highest proportion of women appears in Interns while in Services Head Offices women's presence goes down to hardly 10% of the total.

**Figure 25. Directive and Clinical Posts in Andalusian Hospitals, 2007**



Source: Ana Delgado Sánchez (2007).

On the other hand, presence of women in professional societies is still far from equality. In a study on the *Sociedad Española de Salud Pública y Administración Sanitarias (SESPAS)* (Spanish Society for Public Health and Healthcare Administrations) it was concluded that although presence of female associates is of 40%, their participation in Management Organs and Professional Recognition Activities was much lower (Colomer and Peiró, 2002). The same problem surfaces in other professional societies like the Spanish Society of Epidemiology (*SEE*) or the Association of Health Economists (*AES*) (Ortiz-Gómez *et al.*, 2004).

Finally, women are less represented than men on publishing teams of main periodical publications of the healthcare sphere. Likewise, the first signatories of most articles published in them are men with the added difficulty of identifying sex of the author when the only references are initials frequent in this kind of publications.

## 7. Conclusions

1. In 2006, women's life expectancy was 83.8 years and men's 77.2 years resulting in 6.6 years women outliving men
2. Between age 45 to 65 premature deaths are significantly higher among men than among women.
3. First cause of death in middle-aged people are tumours (breast in women and lung in men) and circulatory system disorders.
4. Among men, respiratory system diseases, cirrhosis and other liver diseases take the lead in terms of mortality probably due to risk conducts of a greater incidence in men owing to gender socialisation models.
5. **Health perception** is worse in women than in men, referring to it as good or excellent 54% of females and 63% of males.
6. Ways in which men and women manifest their **health complaints** are different. Although the kind of chronic complaints is similar for both sexes, frequency in women doubles or triples that of men in all main categories (osteoarthritis and rheumatoid disorders, bad circulation, headaches, migraines, and depression).
7. There are chances of improvement in the care to **cardio-circulatory diseases** in women, both relating to perception of the risk of suffering from them as well as in healthcare personnel at all healthcare levels for early detection and treatment optimising.
8. At this stage in life the onset of climacteric occurs and given the trend to consider life cycle and reproductive life as equivalent, it tends to be interpreted as a situation of decline and loss of femininity and women's main functions. This kind of association should be avoided as well as the medicalising this period, bearing in mind that many of the malaises it entails derive from the inherited gender socialisation process and not from biological changes.
9. Increase in population life expectancy in addition to birth rates and delayed youth emancipation are conducive to shifting most of the social care burden onto middle-aged people. This burden is however unevenly distributed among women and men which entails serious consequences for their state of health
10. Incorporation of women into the job market (roughly 47% in 2006) has not brought about a significant integration of men in the domestic reproductive and care spheres and hence women are taking on multitasking and double or triple working

timetables. These, housewife, dependants caregiver and paid worker, roles involve a functions overburdening likely to have harmful effects on women's health.

11. This stage in life usually coincides with professional maturity. Upon analysis of the healthcare professional field it emerges that although its feminisation is important in university studies and in lower categories work posts, women are less represented than men in responsibility, more prestigious and better paid posts.

## 8. Proposals for action

Within its area of responsibility and relying on the cooperation of other Ministries, Autonomous Institutions and public and private organisations the Ministry of Health and Consumers' Affairs proposes the actions that follow:

- To continue promoting research on health and gender and mainstreaming gender approach into all research lines, and into all processes of management of research. Cooperative work with the *CIBER* will be especially encouraged with an aim to generating excellence knowledge on gender as health determining factor in all specific subjects under investigation.
- To elaborate and disseminate support materials targeting the mainstreaming of the gender approach in healthcare and in health programmes addressed to middle-aged people as an element of healthcare quality.
- To develop informative and educational materials targeting awareness and training of the health sphere personnel so that they may contribute to banish gender bias and medicalisation in the healthcare to middle-aged women and men.
- To develop and circulate information accessible to general population on key health and gender issues in middle-ages.
- To keep on strengthening the inclusion of the gender perspective in health strategies —particularly in the ischemic cardiopathy strategy— and disseminating relevant information in cooperation with professional societies in order to improve perception of risk among women, general population and healthcare services.
- To study distribution of men and women within the National Health System's healthcare personnel, gathering and spreading good practice to promote equality.



## 9. Bibliography

*Whenever possible surnames apart from names of men and women signatories of works compiled in this Bibliography have been included. This way we intend to make their contributions visible.*

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# 10. Appendix

## Glossary on gender <sup>(9)</sup>

The term **gender** is used to describe those men and women's traits based upon social factors whereas sex refers to biologically determined characteristics. Individuals are born with feminine or masculine sex but learn to be boys and girls who later become men and women. This learned behaviour makes up gender identity and determines genders roles.

**Gender analysis** defines, analyses and informs the measures aimed at confronting inequalities deriving from the different roles ascribed to women and men or from unequal power relations between them and the consequences of such inequalities in their lives, their health and well-being. The way in which power is distributed in most societies makes less accessible to women and beyond their control the necessary resources to protect their health and fewer the probabilities of their intervening in decision making. Gender analysis in the healthcare sphere usually reveals the way in which inequalities will result in harm to women's health, limitations they will have to confront to achieve good health and ways to face and overcome such limitations. Gender analysis also highlights the health risks and problems males have to face up as a result of the social playing of their role.

**Gender equality** is tantamount to absence of sex-based discrimination in terms of opportunities, allocation of resources and benefits or access to services

**Gender equity** refers to impartiality and justice in the distribution of benefits and responsibilities between men and women. The concept recognizes that men and women have different needs and enjoy different powers and that such differences must be determined and addressed with a view to correcting the unbalance between sexes

**Gender issues incorporation.** United Nations Economic and Social Council Resolution defines incorporation of gender issues as «... the process of evaluating the consequences that any planned action has for men and women, including legislation and policies or programmes in any sector and at all levels. It is a strategy to make women and men's problems and experiences an integrated dimension of the design, implementation, follow-

(9) WHO POLICY IN GENDER ISSUES. Integration of gender perspectives in WHO activities. Glossary on Gender. <http://www.who.int/gender/mainstreaming/ESPwhole.pdf>

up and assessment of measures, in all political, economic and social spheres in such a way that women and men result equally benefited and so that inequality is not perpetuated. The ultimate aim is to achieve gender equality». «Incorporation of gender issues is a process both technical and political that demands the introduction of changes in organization cultures and mentalities as well as in objectives, structures and resources allocation...Incorporating gender issues calls for changes at different levels within institutions, at the setting up of programmes, designing of policies, planning, implementation and evaluation. Among the tools available for incorporation purposes stand new practices of personnel assignment and budgets preparation, training programmes, political proceedings and guidelines».









This report is in keeping with the Ministry of Health and Consumers' Affairs' line of action relating to gender mainstreaming as a constant feature of healthcare policies that has been sustained for the last three years. It is equally one of the goals envisaged in the Quality Plan for the National Health System.

This second report is also in line with the Spanish Government's undertakings; in actual terms with the development of Organic Law 3/2007 of 22nd March, for effective equality of women and men, which in Article 27 compels to «integration of the principle of equality in the health policy». If the previous report focused on general aspects of the connections between health and gender, this year the focal point is health of women and men in central ages of their life span.

