



# Gender, Health and Ageing

In 2000, approximately 10% of the world's people were 60 years old or older. According to the United Nations Medium Variant population projection, falling fertility and mortality rates will cause this figure to rise to over 20% by 2050. This means that 400 million older people will be living in the developed countries – and over one and a half billion in the less-developed world! Clearly, the interests of the elderly, including their health concerns, are poised to take on greater prominence in coming years.

The basic diseases which afflict older men and women are the same: cardiovascular diseases, cancers, musculoskeletal problems, diabetes, mental illnesses, sensory impairments, incontinence, and – especially in poorer parts of the world – infectious diseases and their sequelae. However, rates, trends, and specific types of these diseases differ between women and men. Perhaps more importantly, the gender picture of a given society – the complex pattern of roles, responsibilities, norms, values, freedoms, and limitations that define what is thought of as “masculine” and “feminine” in a given time and place – has a great bearing on the health of the aged.

## What do we know?

### *The diseases of old age often begin much earlier in life.*

The conditions that currently account for the bulk of mortality and morbidity among older people stem from experiences and behaviours at younger ages. Smoking, alcohol abuse, infectious disease, undernutrition and overnutrition, poverty, lack of access to education, dangerous work conditions, violence, poor health care, injuries – experience of any of these early in life and throughout the life course can lead to poor health in later years.

Since the gender pattern in a given society affects the degree to which women and men are exposed to these various risk factors, it has an effect on their health in later years, as well.

### *The patterns and impact of the major diseases of the elderly vary between men and women.*

**Cardiovascular diseases (CVD).** Since death rates from particular diseases of the heart and circulatory system are often higher among men than women at specif-

ic ages, there is a tendency to think of CVD as a “male” problem. This is misleading however, as almost everywhere in the world, CVD is the main killer of older people of *both* sexes. Among men and women 60 years and older, death rates from CVD are approximately the same, and, since older women outnumber older men, CVD actually kills a greater *number* of older women each year. The importance of focusing attention on CVD for both sexes is underlined by the fact that these diseases are at least partially preventable, resulting as they often do from smoking, sedentary lifestyles, and diets heavy in cholesterol, saturated fat, and salt, and low in fresh fruits and vegetables.

**Cancer.** Overall, men's mortality rates from cancer are some 30–50% higher than women's, with much (though not all) of this difference driven by more lung cancer among men. For men, lung, stomach, and liver cancers are the major killers, with colon and prostate cancers also important in the developed world. For women, breast and lung cancers are the deadliest overall. Colon cancer is also important in the developed world, however, while stomach, liver, and, especially, cervical cancers are major killers of women in developing countries.

Effects of gender and socioeconomic status lurk in these figures. For example, the fact that smoking has, traditionally, been a male activity has led to alarmingly high lung cancer mortality among men. Female lung cancer deaths are on the rise, however, as cigarette advertisers have successfully linked smoking to women's status and emancipation. In some developed countries, male lung cancer deaths are on the decline, while women's are still rising. Cervical cancer, on the other hand, remains the deadliest cancer for women in the developing world because effective means of screening

– such as the “Pap” smear – and related treatment services have not yet become routinely available. Even in developed countries, young women are most likely to receive Pap tests, even though regular screening of older women would prevent more cancer deaths.

**Musculoskeletal problems.** For reasons that are not entirely clear, osteoarthritis, the most prevalent musculoskeletal condition among the elderly, is more common in older women than in older men. Osteoporosis, or excessive bone tissue loss, is also more common in women. This appears to be linked to hormonal changes in women at the time of menopause, but it may be due in part to the more sedentary lifestyles and poorer nutrition that women, as compared with men, often experience.

It is not only *lack* of exercise that can lead to musculoskeletal problems. Disabling conditions are even more likely to be caused by heavy physical labour and unsafe work environments. And reducing the number of crippling accidents among people of all ages – particularly young men, who tend more often to engage in risk-taking behaviour – could also reduce disability later in life.

Finally, falls are an important cause of morbidity and mortality among the elderly. Since women, on average, live longer than men, and are more likely to be poor and thus to live in environments that are dangerous and in ill repair, older women may be especially at risk for falls.

**Mental health.** Most common mental health problems have a higher recorded prevalence in older women than in older men. At least in part, however, this could be an artefact of doctors’ greater readiness to apply a diagnosis of mental illness to women, and/or of fewer men coming forward to ask for help.

Despite older women’s higher recorded rates of depression, older men are much more likely than older women (and, usually, than younger men) to commit suicide. This may be related to the fact that, in industrialized countries, at least, women appear to have stronger social networks and better means of coping than men.

Incidence rates for dementia do not appear to differ between men and women. Since, however, women on average live longer than men, there are more older women than older men living with dementia-impaired function.

**Sensory impairments.** While there is currently no evidence that deafness affects one sex more than the other, a recent meta-analysis suggests that up to two-thirds of the world’s 40 million blind people may be women. This is partly due to the fact that women, overall, live longer than men, but much of the difference appears to be gender-related. Women apparently make less use of eye-care services particularly for cataract repair surgery than men (due, presumably, to their lower status in the family, restrictions on their public mobility, and their lack of control of economic resources). Also, their role as primary carers for children means

that they are more often exposed to trachoma, an infection which, over time, leads to blindness.

**Incontinence.** Urinary incontinence affects both sexes. Prevalence appears to be two to three times higher among older women than among older men, however, due at least in part to poorly treated sequelae of childbearing.

***Health in old age has to do not only with presence or absence of disease. Availability and quality of care are also important.***

Most older people, even those in generally good health, will eventually need more care than they did earlier in their lives. The ways societies provide or fail to provide this care can have everything to do with an older person’s quality of life. Does care allow for independence and dignity, but also social connectedness? Is it equitably accessible to all? Who provides it? How is it remunerated? Are the physical and psychological abuse of older people, or other exploitations of their vulnerability, prevented?

These questions are of concern to all older people. Since older women are often more socially and economically vulnerable than older men, however, and since older women themselves are more often called upon to be caregivers (see below), the answers may have particular salience for them.

***Women generally have higher life expectancy than men, but the picture is not simple.***

For reasons that are not entirely agreed upon, women in developed countries have higher life expectancy at birth, and at older ages, than do men.<sup>1</sup> Women usually have an advantage in developing countries as well. However, high maternal mortality, discrimination against women in nutrition, access to healthcare, and other areas, and, in some cases, the killing or neglect of girl babies mean that, in certain poor countries, women’s life expectancy is about the same as, or even lower than, men’s.

Over the next few decades, as the conditions cited above improve, women’s life expectancy in the developing world is expected to increase faster than men’s. The situation in these countries will thus come to resemble that in the developed world today.

This pattern has significant consequences for the health of older women. To begin with, women’s longer lifespans, combined with the fact that men tend to marry women younger than themselves and that widowed men remarry more often than widowed women, mean that there are vastly more widows in the world than there are widowers. Given that women in many countries rely on their husbands for the provision of

<sup>1</sup> Some of this difference is the result of men’s higher mortality from causes which, in theory at least, should be preventable: lung cancer, alcohol-related conditions, accidents, violence, suicide, cardiovascular diseases. This fact offers some hope that men need not forever have shorter average lifespans than women.

economic resources and social status, this means that a large percentage of older women are at risk of dependency, isolation, and/or dire poverty and neglect.

Moreover, even if women on average live more years than men, many of these years may be spent in the shadow of disability or illness. Indeed, if “healthy life expectancy” – that is, expected years of life “in full health” – is examined in place of overall life expectancy, women’s advantage over men often becomes smaller (Figure 1).

A further consequence of differential life expectancy is that there are simply more older women in the world than older men – especially among the “oldest old,” those 85 years of age and above (Figure 2). Given that disability rates rise with age, this means that there are substantially more older women than older men living with disabilities.

Despite these facts, however, common gender norms mean that it is women, not men, who are most likely to take care of needy relatives. Thus, it is not an uncommon occurrence for an older woman who is disabled, has lost her husband, and has no one to take care of her, to nevertheless be caring for others.

***Crisis situations can disproportionately affect older people – especially older women.***

Crises such as war, forced migration, famine, and the HIV/AIDS epidemic tend both to disrupt the fabric of society in general, and to either kill or dislocate adults at their most productive ages. These situations can adversely impact older people in at least two ways: (1) by removing younger workers and wage earners – the basis of support on which many older people must rely in the absence of public social insurance schemes; and (2) by leaving in their wake orphaned, sick, and disabled people who must be cared for. Older women are especially affected by both outcomes – on the one hand, because they generally control fewer economic resources than older men, and thus must rely more heavily on the support of younger adults; and, on the other, because the care of needy children and others is most likely to fall to them, in the absence of younger women to do the job. Thus, even when a given older person is not herself killed in a war, for example, or infected with HIV, she is still likely to be severely affected by such crises.

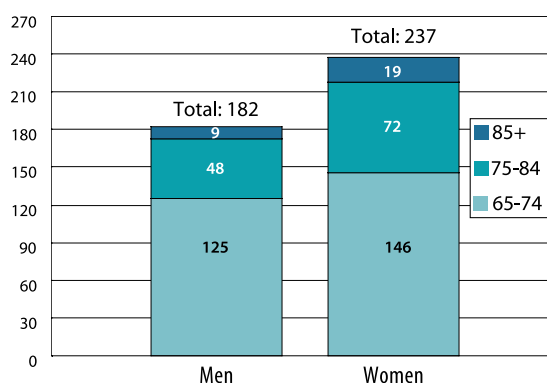
Figure 1: Overall life expectancy at birth vs. healthy life expectancy at birth: selected countries



***Current societal arrangements tend to make women less powerful than men, and less able to advocate for their own health.***

An important theme running through what has been said above is that the gender situation in most societies negatively affects women’s power and independence. Thus, for example, women’s incomes are almost always lower than men’s, and there are many more women than men among the world’s poor. Social insurance schemes usually implicitly exclude the many women who work at home or in the informal sector. Societies often tolerate intimate-partner violence against women. Girls often get less schooling than boys. Property ownership and inheritance, ability to move about in public as needed, authority to give informed consent and make important decisions, confidence and a sense of self-worth – women’s access to each of these may be restricted by current societal arrangements.

Figure 2: Number of men and women 65 and older, worldwide, by age group, 2000 (in millions).



The implications for older women's health are negative. To begin with, in her earlier years it may mean that a woman is unable to seek or receive needed medical treatment, that she subordinates her health needs to those of her family, that she has limited opportunity to form social contacts, that she suffers injuries and other health problems from violence, that she receives inadequate nutrition, and/or that she either does not get enough exercise or spends her time in hard physical labour. Each one of these can lead to illness and disability in later years. Once she is older, it may mean that the death of her husband leaves her with no means of supporting herself, let alone of receiving adequate care.

### What research is needed?

- It is often surprisingly difficult to find out if a given health problem has different incidence, prevalence, or mortality among men as compared to women, since health data are not always presented disaggregated by sex. Even if they are, gender analysis – that is, analysis of the different implications and context of a given disease for men as compared to women – is often left out of research studies. Both of these situations must be rectified if our understanding of the intersections of gender, health, and ageing is to grow.
- Most research on ageing and health has been done in developed countries. Older people in the developing world, however, may have different problems, such as infectious disease and obstetrical sequelae, or the widespread lack of social insurance protections and the erosion of traditional family patterns. Additional relevant research must be conducted in the developing world.
- Since ill health and mortality in old age often stem from events and occurrences much earlier in life, longitudinal studies on ageing and health should be conducted.
- It is not clear whether older women do, in fact, suffer more mental illness than older men, or if this is an artefact of gendered behaviour in doctors and patients. Answering this question is important, not least because it may help in addressing the high suicide rates of older men.
- Although it is clear that women, including older women, take primary responsibility for the care of others in homes and communities, few studies quantify the extent of their contribution and the ways it can affect women's own health and disability in later life. Doing so is a priority – especially as cost-cutting efforts in health systems around the world usually rely on such “free” care.

### What are the implications for programmes addressing the health of older people?

- The groundwork for a healthy old age is laid much earlier in life. An excellent way to improve the health of older people is to reduce smoking, improve nutrition, promote exercise, minimize accidents and back-breaking physical labour, ensure prevention and proper treatment of medical problems, and provide access to economic resources and education in the general population.
- To effectively reach older people, interventions must take account of gender realities. The many restrictions on women's power and autonomy detailed above mean that older women will sometimes have more difficulty than older men in accessing public services such as healthcare. On the other hand, for certain conditions – mental health problems, for example – gender norms may make it more difficult for men to come forward. The ways in which gender affects people's capacities and behaviour must be examined and addressed if interventions are to be effective.
- Quality of life, not just quantity, must be a priority. A focus on mortality and overall life expectancy can obscure the fact that a longer life is not necessarily a blessing if it is burdened with disability, disease, dependency, or abuse. Thus, intersectoral Active Ageing policies to ensure a high quality of life, participation, health, and security – which include guaranteeing adequate incomes, reducing the burden of caretaking expected of older women, helping older people to live with sensory and physical impairments, and providing dignified living options that allow for interpersonal connection – must be part of health programmes directed towards the elderly.<sup>2</sup> The use of statistics such as the “HALE” – a measure of healthy life expectancy – should be encouraged over the use of simple overall life expectancy scales.
- Interventions in crisis situations must consider the elderly. Since older people, perhaps especially older women, may experience severe adverse effects from crises even if they themselves are not killed, injured, or infected, interventions to deal with such situations should actively seek to identify and address their needs.

<sup>2</sup> See *Active Ageing: A Policy Framework* ([http://whqlibdoc.who.int/hq/2002/WHO\\_NMH\\_NPH\\_02.8.pdf](http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf); WHO, 2002) for more information on Active Ageing concepts and approaches.

