

Health inequalities and women – addressing unmet needs

Dr Jessica Allen

Deputy director, UCL Institute of Health Equity

Dr Flavia Sesti

Civil servant, Italian National Institute for Health, Migration and Poverty (NIHMP)



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Key messages:

- There are clear and stark inequalities in health between women, which are related to socio-economic status, ethnicity and geographic region.
- Across different stages of women's lives there are different social and economic factors which drive health and associated health inequalities; including experiences during early childhood, education, family building and working life and through retirement and into older age.
- The broad health workforce must take full account of the social and economic factors which shape women's lives and health at different stages of life.

Introduction

There are marked and persistent health inequalities across the United Kingdom (UK) in both length of life and in length of healthy life, for both men and women. These inequalities are closely related to socio-economic position.¹ Figures 1 and 2 show life expectancy and disability free life expectancy related to level of neighbourhood deprivation. Each dot on the graphs is a neighbourhood in England. It is clear that inequalities in life expectancy and healthy life expectancy impact on everyone below the highest socio-economic status, not just the most deprived. The social gradient in health is shown for men in figure 1 and women in figure 2, both of which clearly show gradients in disability free life expectancy and life expectancy related to levels of deprivation in neighbourhoods.

Figure 1. Life expectancy and disability free life expectancy, males, based on 2011 Census

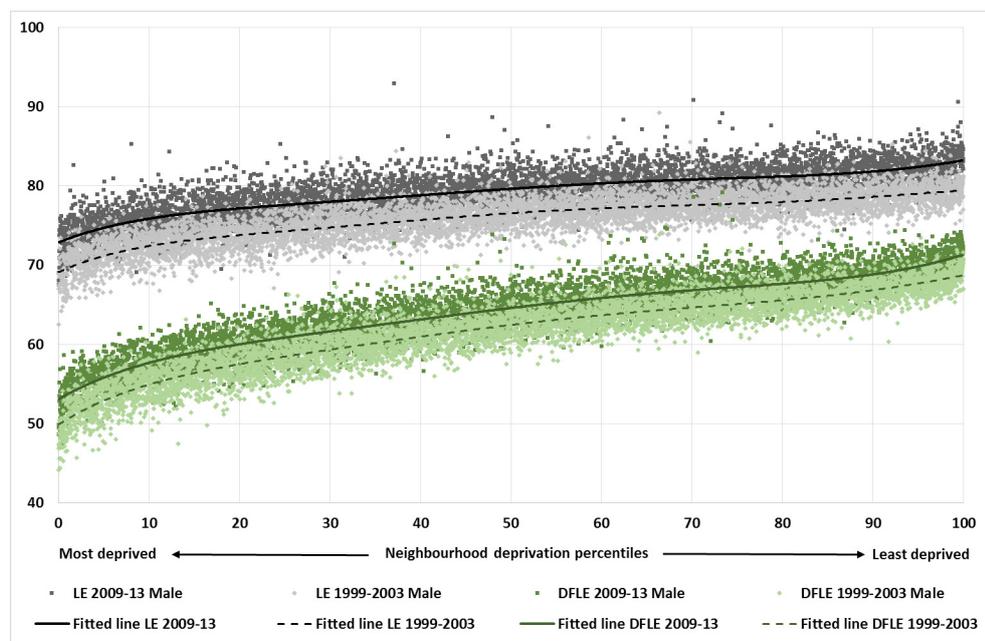
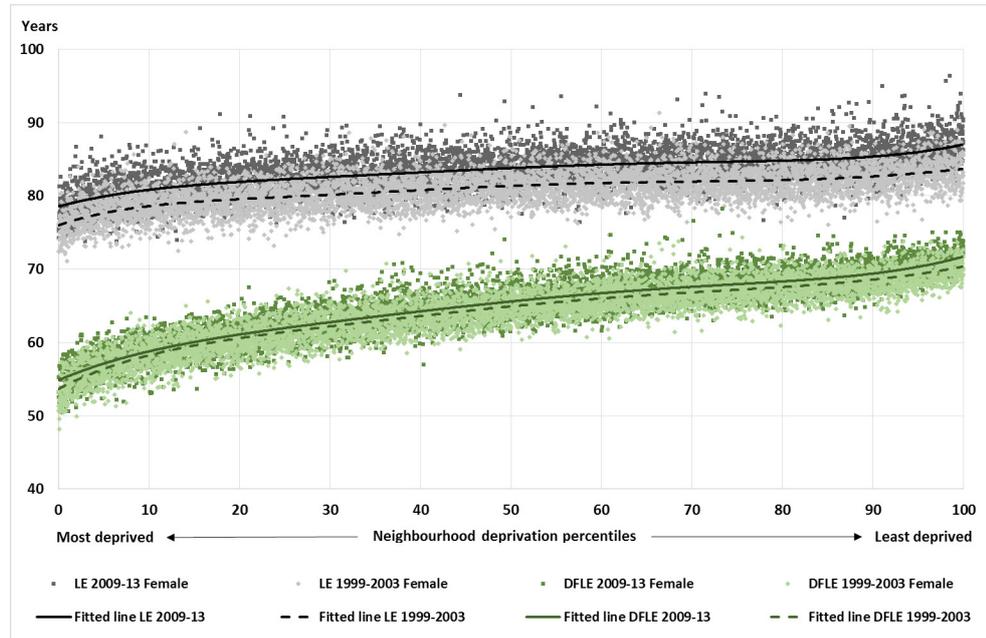


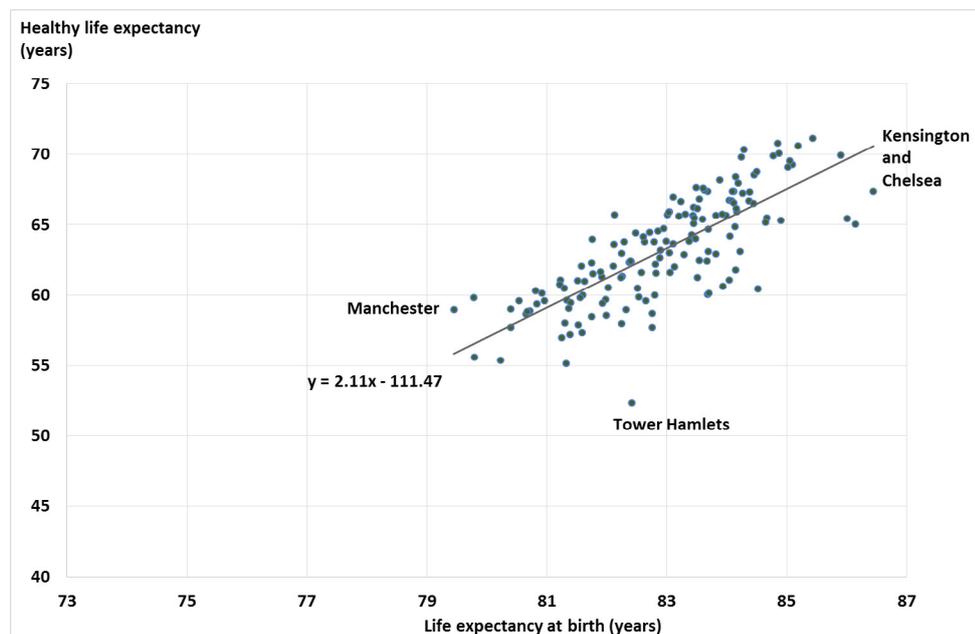
Figure 2. Life expectancy and disability free life expectancy, females, based on the 2011 Census



There have been several major global reviews of evidence,^{2,3} which describe close relationships between social, economic, environmental, cultural and political factors and health outcomes – known as the social determinants of health. There is now widespread and increasing recognition that most inequalities in health are caused by inequalities in the conditions in which people are born, grow, live, work and age.

Local authority data show that for both men and women there are inequalities in health within, as well as, between local authorities⁴ As Figure 3 shows, between local authorities there is a female life expectancy difference of seven years ranging from 79 years in Manchester to 86 in Kensington and Chelsea.

Figure 3. Female life expectancy at birth and healthy life expectancy by local authority, 2013-2015



Moreover, within local authorities there is a significant inequality in life expectancy for women, based on level of neighbourhood deprivation. This ranges from less than two years in Islington to 12 years or more in Stockton on Tees and Middlesbrough.

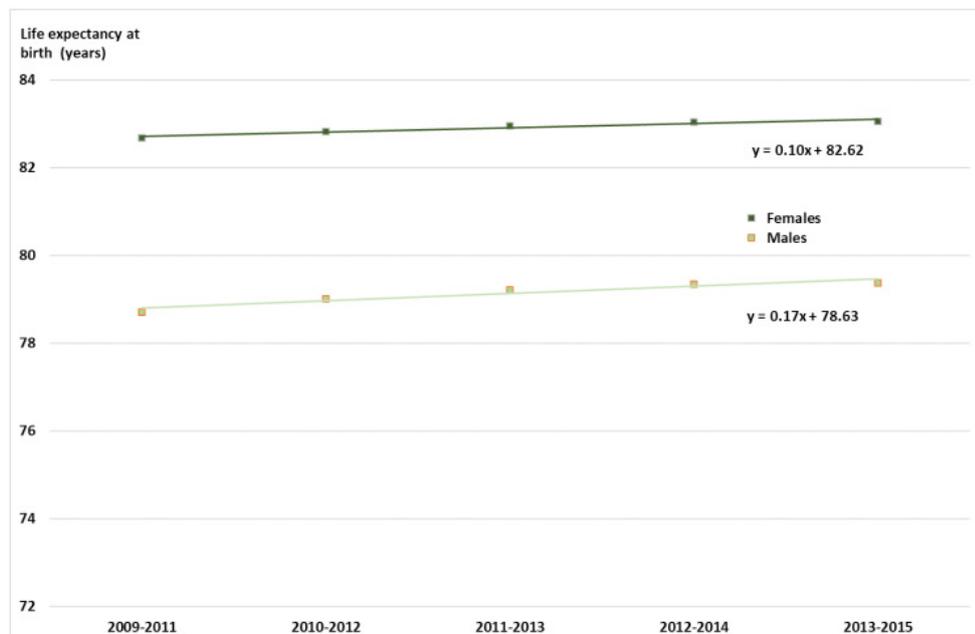
European countries are experiencing an ageing population, and the UK has seen dramatic increases in life expectancy, with a longer life expectancy for both men and women. However, the trend now seems to be changing, raising new challenges in terms of policies and healthcare with life expectancy in England stalling and declining for women in some areas.⁵ To improve health and tackle health inequities effectively and at the necessary scale, the role of policy makers, health professionals and practitioners in other sectors (education, early years, work for instance) is fundamental.

A discussion of the evidence

At European level, even though life expectancy is increasing, it has registered a slowdown in the rate of increase in all countries since the global financial crisis, with the United Kingdom showing one of the worst trends. Compared to other countries, in the United Kingdom the increase in life expectancy from 2011 to 2015 was the slowest in Europe. For women there was no increase – the lowest in Europe – and there was second slowest increase among men (0.08%).⁶ As shown in Figure 4 this trend is confirmed by the recent Marmot indicators in England, which show that the improvements in life expectancy at birth have slowed.⁷ In particular, looking at the period 2000-2015 the trend for women is worse than that of men: female life expectancy increased by one year every five years, while for men the increase was one year every three and a half years.

Taking the period since 2010, the trend for women shows further deterioration: life expectancy at birth for women rose one year every 10 years while for men the figure was one year every six years. For female life expectancy at age 65 in England, life expectancy increased one year every six years, compared to one year every five years for men in the period 2000-2015. Moreover, from 2010 to 2015 life expectancy at age 65 slowed to a one year increase every 16 years for women and every nine years for men.⁸

Figure 4. Life expectancy at birth, England, 2009-2015

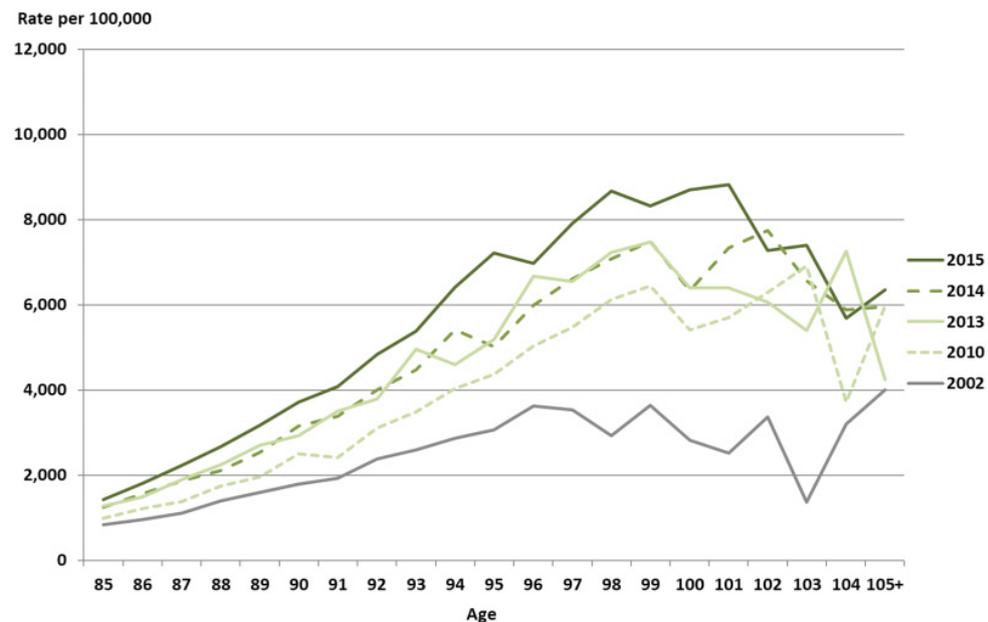


Leaving aside specific biological factors, such as reproduction, men and women also tend to have differing experiences of social determinants across life shaped partly by gender roles – the socially constructed characteristics of women and men, such as the norms and relationships which exist between them.

Considering the average age of death: three-quarters of female deaths are at age 75 and over, with two-thirds of these occurring at ages 85 and over. In contrast, for men three-fifths of deaths are at ages 75 and over, half of which are at ages 85 and over.⁹ For disability-free life expectancy (DFLE) which estimates the average number of years an individual is expected to spend free from a limiting long-term illness or disability, in England from 2012 to 2014 females at birth could expect to spend a lesser proportion (76.0%) of their lives free from disability compared with males (79.5%).¹⁰ Moreover, the inequalities in DFLE across upper tier local authorities is wider for females (19.4 years) than males (16.8 years).

The leading cause of death for women aged 80 and over is dementia and Alzheimer disease (37,252 deaths) and for men aged 85 and over (12,248 deaths). Since 2002 the rates of dementia and Alzheimer among women aged 85 and over have been rising. In particular, from 2002 to 2015 there was an increase of around 175% in dementia as the cause of death in women aged 85, as shown in Figure 5.¹¹

Figure 5. Deaths due to dementia, females by single years of age, England and Wales, 2002-2015



For both men and women, lower socioeconomic groups have a higher incidence of poor mental health and are more likely to have earlier onset of dementia compared to the higher socioeconomic groups. Women represent two thirds of all people with dementia, with higher dementia prevalence rates than men (62.7% for males and 71.2% for females).¹² Women are more likely than men to experience the death of their partner, move into residential care and experience physical ill health and poor mental health and cognitive decline. Depression can be a risk indicator for converting cognitive impairment to dementia and women have higher rates of depression than men.¹³

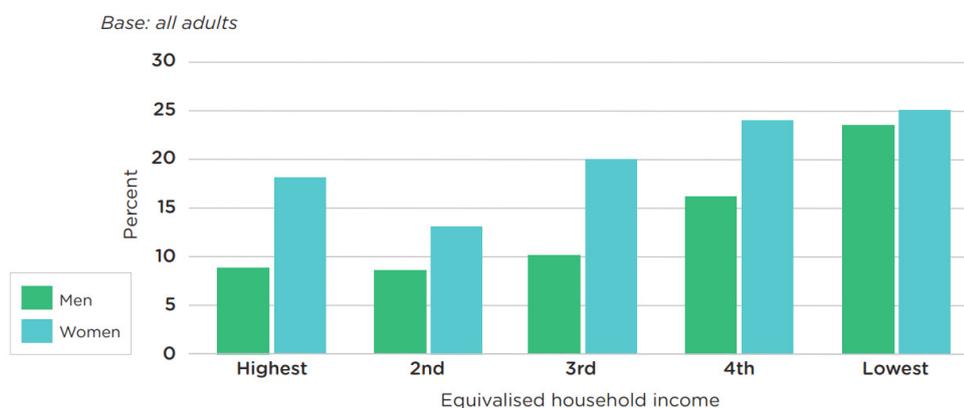
Evidence suggests that women with dementia have fewer visits to the GP, receive less health monitoring and take more potentially harmful medication than men with dementia. Furthermore, women were found to be at particular risk of staying on antipsychotic or sedative medication for longer, probably due to the lower number of appointments where their treatment can be reviewed.¹⁴

A study of socioeconomic position as a risk factor for death due to dementia showed that in women there is an association between leaving full-time education at a younger age and dementia-related death, which is not evident in men.¹⁵

Research found a positive association between poverty measures and common mental disorders.^{16,17} For example, in England, Wales, and Scotland it has been shown that some forms of mental disorder are correlated with levels of debt the individual has.¹⁸ As shown in Figure 6, in women the pattern of social distribution of common mental disorders follows the social class gradient more markedly than men.¹⁹ Women have a higher percentage of mental disorders than men in each income bracket reported.

Figure 6. Prevalence of any common mental disorder by household income, England 2007

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Additionally, there are wider factors that may influence gender differences in health in older age: women live longer than men and with more limiting illnesses which affects their ability to continue in employment, and women have higher rates of poverty in old age than male pensioners. Single retired women have higher risk of poverty than married retired women.²⁰ Women have on average only 57% of men's income with fewer women (60%) having pensions compared to men (80%).²¹ Moreover, a 2016 study found that, at age 60–64 a third of women, compared with half of men, continued to work part-time after the state retirement age and the employment rates further declined with age, with a gap between men and women, for whom just 5% continued to work between the ages of 70 and 74 compared with 10% of men at the same age.²²

There are also clear inequalities in health between migrant women and the host population. Migrants are 13.3% of the UK population and they contributed to more than half of the increase in the UK population between 1991 and 2014,²³ being younger²⁴ and with a higher fertility rate than native British.²⁵

An analysis of migrant health for people aged 60 years and more reveals that there are no significant differences among UK and non-UK born men. In contrast, non-UK-born older women, who have spent between 10 and 39 years in the UK, have 71% higher odds than UK-born women of reporting that health is limiting their typical activities.²⁶

As shown in Table 1, non-UK-born women have a slightly higher rate of maternal mortality (MM rate of 8.8) than UK born (7.87) women, the figure is even worse when analysing the specific country of origin. In this case, women born in certain countries have a significantly higher risk of death compared to UK-born women. For Jamaicans, for example, the relative risk (RR) compared with UK-born women (RR=1) is 6.36 and for Nigerians or Pakistanis the relative risk is respectively 2.25 and 2.24. Looking at the same phenomenon in terms of UK born ethnic minority groups, Black and Asian groups' RR is 4.19 and 1.36 compared with Whites (RR=1).²⁷

Table 1. Maternal mortality rates according to mother's country of birth (selected countries)

WOMAN'S COUNTRY OF BIRTH	RATE PER 100,000 MATERNITIES	95% CI	RELATIVE RISK (RR)	95% CI
UK	7.87	6.62 to 9.30	1 (Ref)	
Outside UK	8.85	6.59 to 11.64	1.12	0.80 to 1.56
SPECIFIC COUNTRIES				
Bangladesh	12.5	2.57 to 36.5	1.58	0.32 to 4.73
Pakistan	17.6	8.44 to 32.4	2.24	1.05 to 4.24
Jamaica	50.0	10.3 to 146.2	6.36	1.29 to 18.9
Nigeria	17.7	4.83 to 45.4	2.25	0.60 to 5.89
Poland	5.78	1.57 to 14.8	0.73	0.20 to 1.92

A quarter of women who died during maternity in 2012–14 were born outside the UK and 46% of these women were not UK citizens. More particularly, the women who died had arrived in the UK on average 4 years previously, with 65% from Asia (mostly Pakistan, Sri Lanka and Bangladesh) and Africa (mostly Nigeria, Somalia and Democratic Republic of Congo), about 14% from Eastern Europe (mainly from Poland) and the remainder from other parts of Europe, North America and the Caribbean.²⁸ There has been no change in this rate between 2009–2011, suggesting that there was no significant or successful effort to narrow the striking differences in maternal mortality risks for migrant women.

There are also inequalities in health for women related to ethnicity in England and Wales where women of over half of the ethnic minorities for whom data is available (9/16) have lower DFLE at birth than White British (64.1 years), particularly among Black, Asian and mixed ethnic groups. Pakistani women registered the lowest DFLE (55.1 years) while Indian women, whose LE was similar to that of White British women, had in contrast 4.3 fewer disability-free years.²⁹

A recent Scottish study showed that the life expectancy of White females was 79.4, overlapping with Mixed Background (79.3) but shorter than some specific ethnic groups, such as Pakistani (84.6), Chinese (83.4), Indian (83.3), Other White British (82.6), Other White (82.0) and White Irish (81.0).³⁰

To summarise, there are clear inequalities in health related to gender – as well as to socio-economic status and ethnicity – and these factors are all interlinked. Poorer, migrant women suffer the worst health of all and there are differences in health outcomes between ethnic groups for women. For all these groups poorer women have relatively low health outcomes.

Actions required

There are clear, systematic differences in health between genders and there are clear and stark inequalities in health between women in different socio-economic groups, ethnicities and geographic regions. There are important actions which can be taken by policy makers nationally and locally and by those within the health system to help reduce those inequalities.

Policy makers can help reduce health inequities, maintaining and improving universal health and welfare systems. A proportionate universal approach to policy interventions and welfare should be central to the development of policies and approaches. A proportionate universal approach includes everyone – the universal element, with actions on a scale and at an intensity that is proportionate to need. This means addressing women's health with specific actions to take into account women's different needs at different stages of life and for those with different levels of risk.

The Marmot Review³¹ presented the following six policy objectives with specific policy recommendations that could be implemented at national and local level:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

At national and local levels policy makers must be committed to creating conditions in which individuals, communities and the public take control of their own lives.

The life-course approach shows that there is an accumulation of positive and negative effects on health and well-being, among all phases of life (prenatal, pre-school, school, training, employment and retirement). Consequently, equity policies must follow the life course perspective in order to address the inequalities between women and between women and men which are appropriate to each stage and aim to prevent an accumulation of inequities over the life course.

Case study: MAMTA

A good example of actions tackling health inequities between women in England is the recent experience of Coventry as a Marmot city. To address the first and the sixth Marmot review recommendations during the first Marmot city phase 2013-2015, Coventry implemented the MAMTA ('motherly love' in Hindi) peer model to improve Child and Maternal Health outcomes and ill-health prevention for BME (Black and Minority Ethnic) women. The MAMTA model existed before the Marmot city interventions, and was initiated in 2001.³² It was adapted to the Marmot City objectives, focusing on peer workers' support for women in the community.

In particular, for child and maternal health care the Foleshill Women's Training (FWT) staff supported antenatal clinics; postnatal clinics; parent craft sessions at FWT centre; and work in partnership with midwives, health visiting teams and other health professionals, educating women on key health messages. The project was implemented across community settings in specific areas to educate women on child and maternal health, and encourage women to access services and book early into maternity services.

Addressing the sixth Marmot review recommendation, FWT provided culturally-oriented education and support regarding cervical screening in migrant women by the MAMTA model. In particular, migrant women supported other women and explained the importance of the exam and booking the test, using communication material in different languages.³³

As the data shows, life expectancy in women is no longer increasing and in some parts of the country is actually decreasing. Women also have a higher probability of living in disability than men and women with lower socio-economic status are likely to spend longer living with a disability than women with higher economic status, as well as dying earlier.

The greater risk of dementia in women, particularly poorer women, requires particular focus including strategies throughout life, such as 'improved workplace health in mid-life; supporting social interactions and lifelong learning and stimulation in later life; and supportive care from services and from carers/families'³⁴ and appropriate strategies to reduce poverty for women in later life.

Although much of the required action lies outside health care, health professionals play a key, if so far, underdeveloped, role in reducing health inequalities between women and men and between women. The following approaches should be adopted to strengthen health professionals' roles in tackling health inequalities:^{35,36}

- Improving education and training. Undergraduate and postgraduate education could include social determinants of health as a mandatory topic and could provide specific practice-based skills such as communication, partnership and advocacy. Student placements in a range of health and non-health organisations could be included in the course.
- Building evidence through international, national and locally disaggregated (by sex, socio-economic status and ethnicity) data to design appropriate services.
- Working with and for individuals and communities by building relationships of trust and respect with patients, effective and appropriate social prescribing and creating networks in neighbourhoods.
- Enhancing healthcare organisations by means of equitable recruitment and good quality employment.
- Working in partnership and as advocates, by promoting partnerships inside and outside health services (local organizations, cross governmental sectors) and at the same time working as advocates for health improvement, rather than just health care at all levels – from local to international level.

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British Medical Association, BMA House,
Tavistock Square, London WC1H 9JP
bma.org.uk

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