

# Official statistics and women's health

“NOW that the industrial employment of women elsewhere than in the home has come to be so largely regulated by the State, there is a manifest need for definite information respecting the occupational mortality amongst female workers.” So wrote John Tatham (Registrar General, 1908) commenting on the occupational mortality statistics for the years 1900, 1901 and 1902. Only eight per cent of women who died in those years had their occupations recorded, even though the 1901 census recorded occupations for 34.5 per cent of women over 15. Seventy years later, death registrations for single and divorced women reflected their occupations accurately, but the situation for married women and widows remained much as it was at the turn of the century. According to the 1971 census, 42.2 per cent of married women had occupations which could be coded into social classes, but this was true for only 7.8 per cent of death registrations for married women between 1970 and 1972 (OPCS, 1978).

These figures illustrate one of the many gaps in official statistics used as sources of information about women's morbidity and mortality. Another example is the exclusion of those who are not in paid employment and paying full national insurance contributions from morbidity statistics based on claims for sickness benefits. Unemployment figures similarly omit those (mainly married women) who have not registered as being unemployed. These and other reasons for the under-representations of women in official statistics have been examined by Macfarlane (1980).

### *Medical statistics*

The 1981 census has recently served as a sharp reminder that we are all included in government statistics. It should perhaps spur us into thinking about the kind of information that is collected about us, the reasons why it is collected and the methods used.

Health statistics tell us not about health but about its absence, that is illness and death. Macfarlane (1980) suggests the more appropriate term 'medical statistics'. Such statistics are necessary for studying the epidemiology of disease and as a basis for rational planning of facilities and resource allocation within the National Health Service. They may be used to identify problems

which need further study, to suggest aetiological factors of disease and to monitor the exposure of the population to known health hazards. This information may be important in the development of preventive measures.

Statistics cannot be evaluated without an understanding of the original purpose for which the data were collected and of the methods of collection and analysis which were used. Some medical statistics are gathered for political or financial reasons rather than for research into health problems. It must also be remembered that there are many important health matters which are unsuitable subjects for official statistics or for which the figures will be misleading. Considerable distortion results from people's reluctance to reveal information about taboo or illegal matters, for instance incest, marital violence or drug abuse. In addition, some subjects, such as patients' satisfaction with a service, cannot be easily quantified. Statistics about such matters must be interpreted with caution.

### *Social class*

It is well established that social class is a major factor in determining the incidence of many health problems. However, the present classification system makes a prior distinction for women, that of marital status. Single and divorced women are classed according to their own occupations, but the social class of married women and widows is based on their husbands' occupations. Such a system makes it impossible to find out about women's occupational health problems from data based on social class. For instance, two women doing identical jobs may be classed differently and any individual may jump from one class to another as her marital status alters. The validity of the system is further brought into question when it is realized that, on the basis of their own occupations, only 28 per cent of employed married women are in the same social class as their husbands; 40 per cent are in a higher class.

The time has come for officialdom to stop seeing married women merely as extensions of their husbands. Can it really be more important to know about the father's occupation in relation to maternal and perinatal mortality than to know how the mother has been occupied before and during her pregnancy? If occupation is important, why not record the occupations of both parents? Similar arguments can be applied to the information required on the cervical cytology form.

*Are women healthier than men?*

Official medical statistics about women tend to concentrate on the morbidity and mortality associated with reproduction. Perhaps this reflects the way government statisticians and the medical profession (both male dominated) see women. Without denying their importance, there is more to a woman's health than obstetrics and gynaecology. Overall, women consult their general practitioners and are admitted to hospital more often than men (Royal College of General Practitioners, Office of Population Censuses and Surveys, DHSS, 1974; DHSS, Office of Population Censuses and Surveys, Welsh Office, 1980), but does this necessarily mean they are less healthy? They have a lower mortality rate than men in every age group and have a greater expectation of life, which suggests that they are healthier than men, or at least suffer fewer life-threatening conditions. Women consult general practitioners as often as men for conditions other than those specific to their sex, and when pregnancy and childbirth are excluded, those aged 15-44 have only marginally increased rates of admission to non-psychiatric hospitals compared with men. It should be remembered that for similar medical conditions, a man may be less likely to be admitted to hospital since he is more likely to have someone at home (usually a woman) to look after him.

Up to 1976, women interviewed in the General Household Survey were no more likely than men to report chronic ill health. Since then, however, the question has been changed to include a checklist and, as a result, reported chronic ill health has become commoner, particularly among women. This raises the possibility that the checklist has either introduced some distortion into the comparison between men and women or has altered their perceptions of what constitutes ill health. Using prescriptions as a measure of doctors' perceptions of illness, it would appear that women are again perceived to be less healthy since, even when contraceptives are excluded, they still receive more prescribed medication than men. Yet they live longer. Are doctors better at keeping their female patients alive? Perhaps we should be looking more closely at the

social and cultural factors underlying the definitions and perceptions of illness made by men and women.

*Definitions of 'an occupation'*

Official statistics are likely to continue to record as occupations only those which are paid. It is time for the term 'occupation' to be expanded to include unpaid occupations such as bringing up a family, looking after an elderly or handicapped relative and voluntary work. All of these have health implications. General practitioners are in the unique position of being in contact with the women who are unknown to official statisticians and could carry out research on the relationship between their occupations and morbidity. The medical model which groups patients by age and sex overlooks the overwhelming importance of social and economic factors causing illness and death. Perhaps there is a case for practices to have an occupational register in addition to an age/sex register and diagnostic index. At the very least we could all make full use of the section headed 'Occupation' which is on the medical record envelope, not just for the men but also the women.

There is much information which could be gained from looking at the ways in which women are occupied during their lives as well as at what men do. This could help us understand some of the reasons behind the different incidences of diseases that men and women have in common. Not all differences can be accounted for by hormones.

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## Attitudes to pregnancy

**G**ENERAL practitioners as a class come into contact with almost all unwanted pregnancies, either at the stages where decisions about abortion are made, or at any stage thereafter, from early complications to later effects on fertility, childbirth and on mental health. General practitioners' attitudes and feelings from their personal lives as well as from their direct experience of abortion will have a large influence on both the process of abortion (what proportion are aborted, where they

are aborted and by whom—NHS or private) and on how that process is perceived by those most concerned—the women themselves and their families—and also by society as a whole.

The general practitioner dealing with a woman seeking or enquiring about abortion will need two kinds of facts; firstly, those about the woman herself, her physical health and her 'worldly self and her inner self' (Tunnadine and Green, 1978). Secondly, the general