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

GENERAL 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

practitioner will need facts about the resources and procedures available nationally and locally for the termination of pregnancy, and facts about the outcome of differing approaches to the dilemma of women carrying unwanted fetuses (not always the same women who deliver unwanted children). The important paper published today (pp. 473-477) by Frank and Kay gives promise that some helpful answers to quite practical questions will emerge.

The Manchester Research Unit, led by Dr Clifford Kay, has pioneered a form of long-term co-operative research based on sufficient financial and personal resources to provide effective follow-up; in the case of oral contraception, we have already been given answers (RCGP, 1974) which general practitioners, and indeed all working in that field, are using daily in their work with women consulting about their contraceptive needs. This concept has now been extended logically in the Attitudes to Pregnancy Survey to a co-operative research effort involving 1,509 general practitioners and 795 gynaecologists. The data base on which the follow-up will operate is now presented to us—no solutions are yet claimed, but a few broad conclusions have been offered by the authors: women continuing with their pregnancies reduced their smoking more than those having abortions, and women having abortions seemed to have been better educated than those continuing with their pregnancies. These conclusions may seem obvious, but nevertheless offer a whole area of sociological speculation to trigger off further research.

Other important conclusions relate to the comparability of the populations recruited. Not surprisingly some reservations exist, since the general practitioners providing the data are self-selected, being those interested in the idea of such research and willing to go to the trouble of completing follow-up forms for several years. However, the prospective nature of this study, the careful collection of relevant information about the cases and the methodology of follow-up give some hope that we shall eventually obtain really firm facts about the sequelae of induced abortion.

A recent leading article in the *British Medical Journal* (1981) has reviewed the late consequences of abortion from the world literature. As was perhaps inevitable in an emotive subject, and from retrospective material, there appears to be a gross conflict of evidence as to whether there remains after termination of pregnancy an increased risk for subsequent pregnancies. For the general practitioner and for his or her patient, this aspect will often, even usually, be of paramount importance; for the Act of 1967 it nearly always has to be determined whether the continuation of that pregnancy is likely to be more harmful to the physical or mental health of the patient than its termination. There may well be serious conflicts of interest here, and all concerned with counselling such women and with making decisions about terminations for them will need precise data about relative risks.

At least a start has been made towards that goal; probably sufficient cases and controls have been recruited for the statisticians eventually to get to work, and the two Royal Colleges have shown a fine enthusiasm and a refreshing readiness to identify common aims.

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Medicines Surveillance Centre

THE College's oral contraception study has been the largest research project of its kind in the world, with 1,400 general practitioners monitoring the effects of oral contraception on some 40,000 women over a period of more than 10 years. The study disclosed the increasing danger of oral contraception for women over the age of 35, with particular reference to cardiovascular complications, and continues to provide important information about the safety and the dangers of these hormone preparations. In undertaking this study, the College has therefore demonstrated, in the most practical way possible, its capacity to use its resources to carry out post-marketing surveillance on a major scale and to allow the identification of relatively rare side-effects which may occur in less than one in 5,000 cases a year.

The College must be aware of the increasing public concern about the unwanted side-effects of new drugs which has been expressed in both press and Parliament. It is interesting to recall that it was a letter to the medical press signed by Dr E. V. Kuenssberg, past President of the College, and Professor Ian Simpson that drew attention to the potential dangers of thalidomide, while another former President, G. I. Watson, recommended at least 10 years ago that the College should use its research resources to undertake clinical trials of new medicinal products. Yet no major efforts were made until the contraception study. It is therefore appropriate that the College should have considered how best it can use its resources to serve society in this vital field of early detection of unwanted side-effects. Some 80 per cent of all medicines are prescribed by general practitioners and the majority of these are for common ailments where no serious side-effects are acceptable.

The College is aware that anyone entering this field