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Health, Health Care, and the Sexes: A New Perspective

MANITOBA CENTRE FOR HEALTH POLICY

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based on the report:
Sex Differences in Health Status, Health Care Use, and Quality of Care: A Population-Based Analysis For Manitoba's Regional Health Authorities,
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Are women healthier, or men? Some Manitobans might think the answer is women. They live longer than men, so doesn't that mean they're healthier? Some of you might also point out that men have a lot more heart attacks than women, right? On the other hand, maybe some of you read somewhere recently that women see a doctor more often than men do. So doesn't that mean women are sicker?

Either position would be difficult to argue with. That's because very little has really been known about the differences between the sexes in Manitoba when it came to health-related issues. Much of what was "known" was based on assumptions, half-stories, or at times misinformation. There was very little hard data to back anything up.

Until now.

This report by the Manitoba Centre for Health Policy is among the first to offer Manitobans a fact-based, sex-specific, region-by-region look at health in our province (up to March 2004). We were helped greatly by a Working Group of experts in men's and women's health. Are there differences between Manitoba's men and women in health, health care use, and the quality of care each receives? This report has the story.

We undertook this study at the urging of *The Need To Know* Team: a collaboration of researchers from MCHP and high-level planners from each of the non-Winnipeg RHAs (Regional Health Authorities) and Manitoba Health.

The Need To Know Team is funded through the Canadian Institutes of Health Research. Its underpinnings are simple: by having researchers working closely with decision-makers, perhaps research can be brought closer to policy. In other words, the hope is to smooth the transition between analysis and application, between paper and practice.

The Team identified separate male and female results as vital in their planning for rural and northern RHAs. With limited budgets, it is important that programs be targeted to meet the needs of the population. Does an issue affect, say, young males? or elderly females? or all residents? Knowing the answer provides focus.

For example, heart disease has long been thought of as a "male" disease. But we are learning more and more about the large impact it also has on females. We now know it is the top cause of death for women as well as men.

We also know that physicians have typically taken a don't-take-chances approach when treating male patients who have had heart attacks. But are women receiving a similarly appropriate response? There are studies done elsewhere which suggest this isn't the case, that women are still treated differently because of the old assumption that it's males who have the heart problems. We wondered if this was happening in Manitoba.

All of which is to say that in the past, there hasn't been much comparing of the sexes done in regards to the prevalence and treatment of various illnesses. Assumptions were made about heart attacks; so too were assumptions made about other illnesses. Today, the need to

separate and compare males and females on a number of health-related measures is becoming clearer. Especially so at the RHA level, where different cultural and socioeconomic influences may also play a part.

Related to this, a few years prior to this study, and amid concerns elsewhere that women receive a different standard of care than men, Manitoba Health identified women as one of the priority populations for RHA planning. As a result, most RHAs received intensive training in "Gender-Based Analysis." This training has made RHA staff more aware of the importance of separating male and female rates in their planning. For that to be effectively done, they need sex-specific research results to work from. So this study will help RHAs to take the next step.

What we looked at

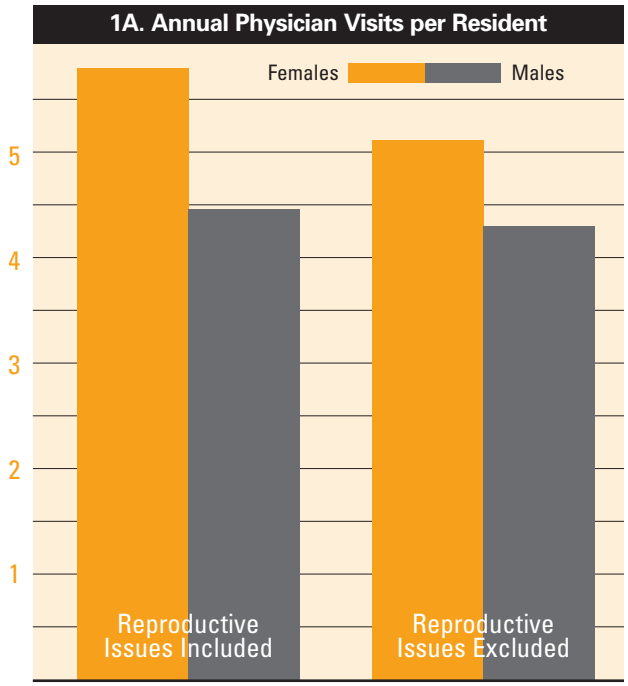
The aim of this report is to provide an overview to health planners, policy makers and health-care professionals on sex differences in health status, health care use and the quality of care. We looked at 74 different measures (indicators), most of which appear in previous reports by MCHP, but this time the results are separated into males and females. For the most part, our analysis is descriptive not explanatory; that is, the report shows what the data reveal, not how or why those results have come about.

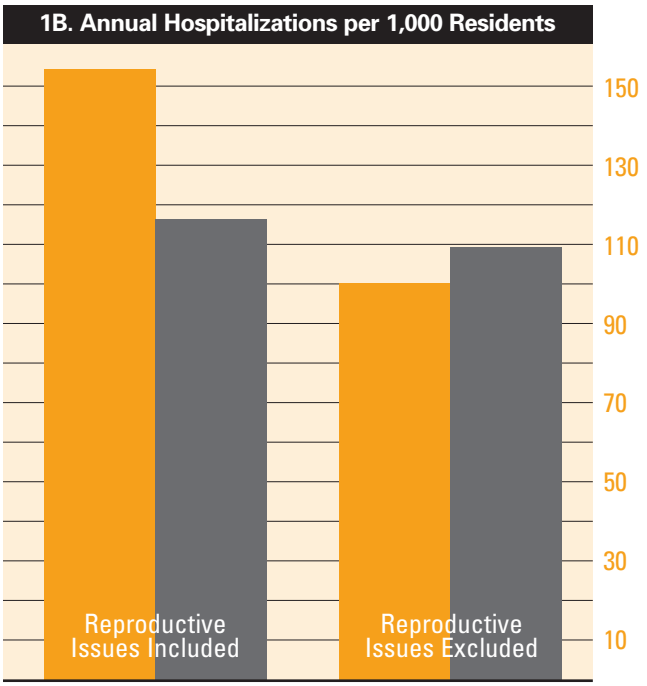
Our study uses a population-based approach. This means we look at where you live, not where you receive the treatment. For example, a person living in Churchill may be hospitalized in Winnipeg, but the hospitalization is attributed back to Churchill.

We would also like to point out that while this is a very comprehensive story on sex differences in Manitoba, the shortage of data in a couple of areas limited what we could tell. The absence of data for CT scans done at some rural hospitals is a continuing problem. We know nothing about the individuals receiving those scans—we can't compare rates, track trends or monitor outcomes.

There is also incomplete data available from some salaried physicians. While the proportion of salaried physicians in Manitoba is relatively small compared to fee-for-service physicians, having more complete data from this group would add to the picture.

It's also important to mention that mental illness is absent from this study. That's because a recent MCHP report (2004) thoroughly detailed the differences between males and females in regards to mental illness. It showed that females had higher treatment rates for many common disorders.





That being said, this report still offers an abundance of information on the health and health care use of both sexes in Manitoba. Some specific things we look at are:

- Health status and deaths
- Incidence and prevalence of several diseases
- Physician visits
- Hospitalizations
- Rates of high profile surgical procedures, and diagnostic imaging services
- Prescription drug use
- Immunizations
- The use of home care and nursing homes
- Cardiac care
- Quality of care

Items of Interest: Sickness

There's an old saying in the health community: Women are sicker, but men die quicker. This sprang from the fact that females visit doctors more often than males, suggesting they are sicker. However, males die at younger ages.

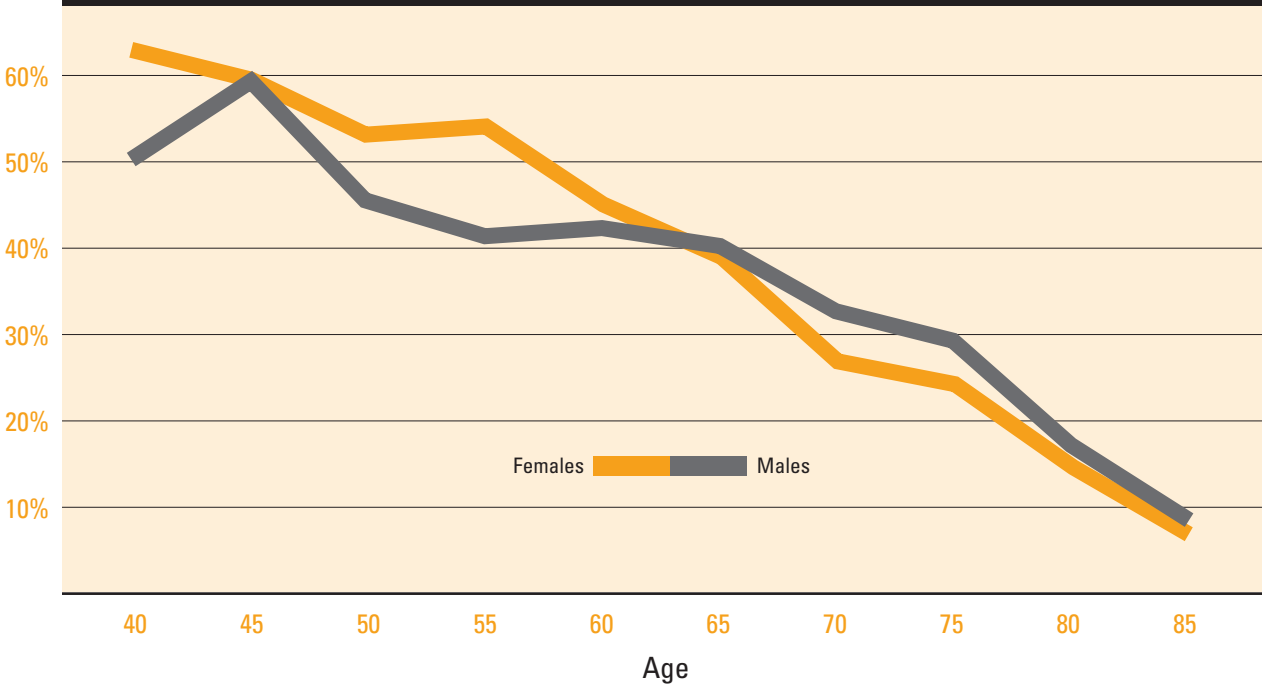
Our study suggests an update is in order: Men die quicker, but aren't any sicker. When males and females are compared across a variety of diseases, the burden of illness seems fairly even: for some diseases there is no sex difference; for some the rates are higher for males; for others the rates are higher for females. Of the 12 diseases studied:

- Two—respiratory disease and inflammatory bowel disease—show no significant sex difference;
- Four—hypertension, arthritis, hip fracture and infertility—show higher rates in women;
- Six—heart disease (and related heart attack), stroke, diabetes (and related lower limb amputation) and renal failure—show higher rates in men.

In short, women are no more or less healthy than men. Yes, females visit physicians more often, but that doesn't mean they're sicker. When we exclude visits for pregnancy, birth, and other reproductive health reasons, this difference is cut in half, and their hospitalization rates become lower than males (Fig. 1).

What's more, our quality of care indicators suggest that females may visit doctors more often for preventive services and follow-up. This might be leading to earlier detection, which might in turn be responsible for women's lower hospitalization rates and their lower rates of complications (such as diabetes-related lower limb amputation).

2. Percentage of Heart Attack Patients Receiving Cardiac Catheterization



So the more important focus for RHAs appears to be on what kinds of diseases men and women get, and when.

What about the heart attacks?

A close look at heart attacks dispels another prominent myth: that men are treated more aggressively after heart attacks—more procedures, more surgeries—than women. Cardiac catheterization (a procedure to find blocked arteries) was used for this analysis, as this procedure is the starting point for all others.

At first, it appears the rates are much higher for men than women. But, we know that men suffer heart attacks at younger ages than women. We also know that invasive procedures are more commonly done on younger patients (of both sexes). So a closer look at catheterizations by age group shows that rates for males and females are about the same (Fig. 2). That is, a female of any age is as likely as a male of the same age to be catheterized after a heart attack. So it's not that men get more procedures, it's that younger patients get more.

However, there does appear to be a sex bias when it comes to medicinal treatments for heart attack patients. Females are less likely than males to be dispensed the recommended beta-blockers within four months of hospitalization for heart attack. So this is something that needs to be looked at.

The social gradient in health

It's been known for centuries that the poorer you are, the sicker you are likely to be, and that the poor die younger than the wealthy. This pervasive and insidious pattern is seen in this report as well. The good news is that overall the health care system appears to be responding; the poor—men and women alike—are the highest users of health care services.

However, some indicators show either no relationship between use and need, or relationships in the opposite direction. For example, the rates of use of specialist physicians appear to be driven more by closeness to Winnipeg than population need. And immunization programs could use a "shot in the arm" to increase coverage among residents of lower income areas.

Our look at sterilization procedures offers perhaps one of the most interesting and curious social-gradient-related findings in this study. We're talking about rates of tubal ligation for women compared to vasectomies for men. Of the two, a vasectomy is a far less invasive procedure that requires no hospitalization. Here there is a surprisingly clear relationship between socioeconomic status and which procedure is done.

Among the wealthier Manitobans, the procedure of choice overwhelmingly is a vasectomy. We see few tubal ligations performed for this group. At the other end of the spectrum, among the poorest Manitobans, we see plenty of tubal ligations, and few vasectomies.

The reasons for these sex biases we can only speculate on. But it certainly highlights an area of interest for RHA planners.

The short story

In the end, what do we know now about health, health care and the sexes that we didn't before? Just about everything really, because now we have hard, research-based evidence.

Is one sex healthier than the other? No. Causes of death are much the same for both sexes. And physician visits and hospitalizations are comparable when rates are adjusted to exclude reproductive issues.

Are there differences between the sexes in the treatment they receive? Yes and no. Yes, because some illnesses affect females more, others affect males more. No, overall, there doesn't appear to be sex bias in treatment.

All of which should come as good news to Manitobans in general, and RHAs in particular. True, this report has highlighted some areas that need to be looked at; that was the point. But overall, the men and women in this province appear to be similarly healthy. More importantly perhaps, on the whole, the health care system is responding to their needs equally.

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