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Towards the genderless society: equitable for female wellbeing and male health?

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Towards the genderless society: equitable for female wellbeing and male health?

Abstract

Despite the gender system that disadvantages women, in most countries women live longer than men. Women typically have higher morbidity, but this does not cancel out their advantage over a lifetime period, so that women still have a higher level of expected lifetime health than men. At the same time, the gender gap in lifetime health is narrowing. There is evidence to suggest that gender equality may help improve men's health more than women's health. The paper discusses the implications of moves towards a genderless, equitable world for women's wellbeing, and for current notions of high status masculinity. (97 words)

Key words

Gender, genderless society, equity, health, well-being

Towards the genderless society: equitable for female wellbeing and male health?

1. Introduction

It seems natural to assume that in an equitable world, different population subgroups will on average enjoy the same level of health¹. On the other hand, currently in many countries, women have less socioeconomic privileges than men while men have poorer lifetime health prospects than women. Pulling these together, the question of interest in this paper is: what would an “equitable and genderless society” imply for the health of men and women?

There are a few things that need to be clarified before going further. First, are all inequalities automatically inequitable? In this paper we will treat equality and inequality as a matter of description, and equity and inequity as a matter of norms. So it is not impossible for two parties to have equal health and for this to be regarded as inequitable², or for two parties to have unequal health and for this to be regarded as equitable³. Second, where equity in health calls for equality in health, does equity in health across two population groups require that they achieve the same level of average health? Sen (1992) distinguishes between “attainment equity” and “shortfall equity”. Briefly, attainment equity looks at what the two groups achieve, and for instance if they have the same level of life expectancy at birth, then attainment equity is achieved. On the other hand, shortfall equity looks at what is achieved with respect to the maximal achievable potential. If the potentials for the two groups are the same, then the implication of shortfall equity and attainment equity will be the same. But if the potentials for the two groups are not the same, then implications may be different⁴. Let us leave this as an open issue for now. Third, what is the

¹ Public health initiatives are typically concerned over different levels of lifetime health across populations. For a theoretical approach, see for example Williams (1997).

² Suppose two individuals are in equally poor health, because the Driver was driving irresponsibly and caused a traffic accident involving the Pedestrian. Both are critically injured to the same extent. Thus, they are in equal health. But there is nothing that makes this equality equitable.

³ Following the above example, there can be a combination of severities of injury where the injuries of the Pedestrian and the Driver differ and where it is regarded as equitable (which may be the point at which the Pedestrian suffers no injuries).

⁴ Suppose one individual has the potential to achieve 100 (of whatever good), whereas the second individual has the potential to achieve 200. Then, if both individuals achieved 50, this will be equal and thus equitable in terms of attainment, but not equal or equitable in terms of shortfall (which is much larger for the second individual).

measure of health used? In this paper, we use Expected Lifetime QALYs (Quality Adjusted Life Years⁵), or ELQ, as the concept representing the measure of health, over which equity is the issue⁶. This is an improvement over using life expectancy at birth (or at current age), because it incorporates health related quality of life. It is also an improvement over using incidence or prevalence of ill health and morbidity alone because it reflects the duration of the ill health. Based on globally available estimates of quality adjusted life expectancy, disability free life expectancy, and the like, men tend to have poorer ELQ than women from the same country, especially in the developed world (Cambois and Robine, 1996; Kaplan and Erickson, 2000; WHO, 2002).

Tsuchiya and Williams (2005) examined six possible arguments on how the existing inequality in lifetime health between the sexes may not be an inequity:

- (1) by challenging the data, and argue there is no inequality, by indicating that women have a higher morbidity rate, and therefore they may live longer but may have a lower lifetime health prospects overall;
- (2) by denying that men and women should be regarded as members of the same community, so that the existing inequality is not an inequity;
- (3) by asserting that the differences are largely due to biology and beyond our control, and are therefore not an equity issue;
- (4) by claiming that men are themselves the main cause of, and thus responsible for, their shorter life expectancy, and therefore the inequality is acceptable;
- (5) by pointing out that changing life styles of women are making them live more stressful lives and die earlier, so that before long there will be no more inequality in health between the sexes and therefore this discussion is unnecessary; and
- (6) by questioning the approach of considering health separately from all other sources of well-being, and by arguing that better health of women is to be weighed against their poorer socio-economic status when assessing the well-being of each sex.

⁵ The QALY is a concept widely used in health economics and is the number of years of life each adjusted for its health related quality of life where full health is weighted as 1 and dead as 0. Thus, 1 year in full health equals 1 QALY, as does 2 years in 50% health, or 4 years in 25% health.

⁶ This is the number of years a person has so far lived (ie. their current age) adjusted for the level of health related quality of life associated with each time period, plus the number of years a person is expected to live (ie. their life

Tsuchiya and Williams (2005) dismissed the first five arguments, and went on to explore the implications of the last one. Amongst others, the reasoning used to discard the fifth point was that so long as there are current inequalities that are inequitable, claiming that it will eventually go away is not a good enough argument to make the inequality not inequitable. However, the paper did not examine the factual basis of the argument, or its implications should they be found to be the case. The present paper aims to do that. Furthermore, we intend to develop the discussion of equity and inequity from the position of the genders by taking another look at some of the other points above as well.

Life spheres of women and men

Human life can be described as taking place in different 'spheres'. A key distinction of life spheres when analysing women and men is the division into a public sphere of rewarded doings and a private sphere of unrewarded doings (Kiss, 1998). These major spheres of life may then be further divided; classical sub-spheres in the literature are power, money, security, recognition, politics, and art (Walzer, 1983). Another feature of the concept of the 'sphere' is that one may define them as being of primary interest or secondary interest. For instance, Rawls (1972) defines liberty and opportunity, income and wealth, and the social bases of self-respect as being primary goods, which in effect can be interpreted as spheres of particular interest for social justice. Another illustration is Sen (1989) who states that individuals' basic capabilities to achieve their life goals should be the primary outcome (sphere) when judging societal arrangements.

If we are to examine differences in the sphere of lifetime health between women and men, a crucial concept is that of the gender system, which refers to the social structure organising human activities based on sex (Harding, 1986). The gender system involves two basic dimensions. First, structures that facilitate keeping women's and men's work, characteristics, and behaviours separate (dichotomy), and second, structures that divide the relationship between the sexes unequally into a male superiority and a female subordination (asymmetry). This means, when

expectancy) adjusted for the level of health related quality of life associated with each time period (see for example Williams, 1997). We are fully aware empirical data are not always available in terms of ELQ.

combined with a capitalist system, that men's primary role in life becomes working in the labour market to generate cash income, while women's primary role in life becomes staying at home to look after the family. The continuation of the division of labour by sex is assisted by two other dimensions of the gender system; the symbolic division between femaleness (as private, passive, dependent, tainted, etc.) and maleness (as public, active, independent, pure, etc.), and by the fact that human identity is formed by collective opinions about what is judged appropriate for men and women respectively (Månsdotter et al., 2004).

Gender and health

The gender system may be seen as primarily counteracting men's health since many attitudes and behaviours in line with common notions of high status masculinity, often referred to as the 'hegemonic masculinity' (Connell, 1995), also tend to be health-damaging (Courtenay, 2000; also see Segal 1990; Francome, 2000; Clare, 2001). It has, for instance, been shown that an essential part of men's excess mortality is due to behaviours which are accepted or encouraged more in males than in females, e.g. working in hazardous jobs, drinking alcohol, and being seen as fearless (Waldron, 1976). At the same time, an also common view is that the gender system primarily counteracts female health supported by the vast evidence that a low socioeconomic position connects to poor health: women have less choice and control, and therefore their health must be at a disadvantage. However, as Johansson (1991) points out, women's subordinated position in wealthy settings has probably protected them, relative to men, from non-infectious death causes.

Despite the highly complex nature of the relationship between the gender system and women's and men's mortality and morbidity patterns, it seems reasonable to expect that a move towards a equitable and genderless society will result in a much smaller difference in ELQ between the sexes (Backhans, Lundberg, and Månsdotter, 2007). To examine this view, we first need to clarify what we mean by an equitable and genderless society. For instance, if, in order to "correct" for some residual social/cultural inequity, policy treated the two genders differently (e.g. people received different social benefits and privileges depending on their biological sex), would that still count as equitable and as genderless?

Let us assume that when the gender system is abolished, women and men will participate in more or less equal numbers in every sphere of life “from infant care to high-level politics” (Okin 1987), and that social privileges and burdens will be distributed independently of one’s sex. Since once the gender system is abolished, not only the dichotomous and descriptive distinction but the asymmetric and normative distinction will also no longer exist, the above assumption of equal participation across different spheres of life seems reasonable. However, during the transition towards the genderless society, we are likely to see interventions that are not themselves genderless; let us illustratively imagine a highly relevant gendered issue. If it is found that men demand higher wages to work in some traditionally “female” jobs such as childcare, then decision makers may decide that it is acceptable for the purpose of equalising the numbers of female and male employees in such jobs to subsidise male wages⁷. With time, people will get used to seeing men working in childcare, so that higher wages will start to attract excess male applicants, and that will be the time when the wage differential should be withdrawn, and equity and genderlessness can be regarded as having been achieved (at least, in this market).

Biology and health

Differences that arise from individual preferences and choices can thus be led by appropriate motivations and incentives, but what about differences that arise from biologically determined factors as well? In other words, females and males might have different potential for ELQ because of their different genetic and biologic constitution. A common suggestion is for example that women have a natal advantage in the lifespan dimension of health. Waldron (1983) reviewed the evidence concerning biological causes to the female/male gap in mortality: the hypothesis that males have higher foetal mortality was rejected; the hypothesis that X-linked genes contribute to greater female resistance to infections was supported; and the idea that male sex hormones may affect differences between the sexes in behaviours possibly leading to accidents and other violent deaths was accepted. She concluded that women may have an inherent advantage in life span; but

⁷ On the other hand, the asymmetry between the genders means that there will be relatively fewer cases where women will require higher wages to take up traditionally “male” occupations.

also, that it was impossible to make even a preliminary quantitative estimate of the biological contribution to the mortality gap.

2. The normative setting

Health equity or inequity in the genderless society

There are in principle three possibilities regarding life time health of women and men in the genderless society, each relating to the debate on attainment equity and shortfall equity:

- (a) if an inequality in ELQ remains due to biological factors, and health is seen as a primary sphere that should be equally divided between the sexes, the genderless society will require different health-related resources, treatments, privileges, etc. to women and men --- since the recognition that health is a primary sphere of human life will then imply that everybody should have equal access to it, this case requires the use of the attainment approach to equity;
- (b) if an inequality in ELQ remains due to biological factors, and health is seen as a secondary sphere of interest, the genderless society will expose, and accept as fair, the health difference between women and men as long as it is in line with the extent of the biological gap --- since the recognition of health as a secondary sphere will allow for certain differential attainment to be equitable, this case supports the use of differential potential under the shortfall approach to equity⁸; or
- (c) if the genderless society exposes no difference in ELQ between women and men, and hence no difference in biological potential for ELQ, a genderless distribution of both health and health-related resources is possible --- in this case the issue of attainment equity versus differentiated shortfall equity disappears.

If a positive health gap remained in the genderless society, an essential question to ask would be: should we regard this as inequitable, and therefore aim to diminish this? Or should this be regarded as not inequitable, and therefore acceptable? The third discussion point by Tsuchiya and Williams (2005) above challenged the view that if an inequality is biological and is caused

⁸ For an example of differentiated potential by sex, see for example UNDP (1995) or World Bank (1993).

by nature it is unavoidable and therefore not inequitable, and argued that biological inequality can still be an inequity. A biologically caused disadvantage need not be an unavoidable disadvantage, and even an unavoidable disadvantage does not mean the disadvantage itself does not command special attention towards compensating it. Imagine an individual born with an incurable permanent disability with no known cause (viz. the disability is “caused by nature”). If this disadvantage is regarded as inequitable, this individual can then be given priority and privileges in other areas of life to compensate for their disability and thus lower ELQ. If, on the other hand, this lower ELQ was not regarded as inequitable because it was caused by nature, then it is not obvious how such compensations and support could be justified. To appeal to the argument that everybody is entitled to some basic level of functioning that is “normal” for humans in order to justify such support will not work, since it presupposes that disadvantage caused by nature should not be left unsupported. So, if inequalities caused by nature could be inequitable, then, as is pointed out above, a crucial point would be whether or not the disadvantage in health is regarded as one in a primary sphere in life.

When one hears the argument that sex inequality in ELQ is not an inequity because it is biologically determined and there is nothing we can do about it, it is at curious odds with the fact that the whole enterprise of medicine is about trying to change the course of things that are initially set by biology. It is tempting to ask what would be the case if it were established that it was actually the males that had the biological advantage in longevity, which they currently waste on culturally and/or individually motivated risk behaviour. And, suppose the genderless society, in which men lived longer than women (thanks to their biological longevity) became the reality. Would there still be support for the argument that biological inequalities are fair, and therefore it is equitable for women to die earlier than men as long as this was due to biology? This should be the case if inequalities caused by nature are not inequitable. Or is the idea of biological inequality being equitable used as a convenient argument in the struggle over the improvement of the lot of women who are currently disadvantaged in socio-economic status?

Trading off health against other domains of well-being

This discussion is also related to the sixth discussion point by Tsuchiya and Williams (2005), on why the health inequality between the genders may not be an inequity. Because men have more advantages in socio-economic status and opportunities than women, men's disadvantage in lifetime health may be compensated for if we look at their overall well-being. In other words, Tsuchiya and Williams (2005) assume that a disadvantage in a given sphere of life can be substituted or compensated for by an advantage in another sphere. On the other hand, Månsdotter et al., (2004; 2006a) state that this substitutability view clashes with the genderless society since the latter requires virtual equality of women and men in all important spheres of life and does not accommodate trade offs across different spheres. How do these two positions relate to each other?

If women have more advantages in a particular sphere of life and men have more advantages in another, this will not be regarded as genderless, even if the overall well-being of men and women across the spheres may be roughly comparable. This is because genderlessness implies that once genuinely equal opportunities are offered to men and to women, and once the asymmetric value system is removed, then there is no reason to assume biological sex will have much impact on what people aspire for in life. Thus, not only opportunities in different spheres of life will be the same for men and women, so will be the actual choices people make. Furthermore, the argument that it may not be inequitable that men have a lower ELQ provided this is compensated for in the socioeconomic domain potentially clashes with more liberal approaches in general. What about the preferences and choices of these people? Some men may want to have more lifetime health even if it meant less socio-economic opportunities. Many women actually seem to want to enjoy more socio-economic status even if it meant poorer lifetime health. The individual dimension of the gender system means that human identity is very much determined by collective opinions about "the proper woman" and "the proper man" (Harding, 1986). Could a society be regarded as equitable, where people are "forced" to live their life under a particular combination of health prospects and socioeconomic prospects, simply determined by their sex (or for that matter, any other randomly allocated accident of birth)?

In the genderless society, women and men will participate more or less equally in various spheres ranging from unpaid childcare to high-level politics. Such a future should also entail that

preferences and what is actually achieved (as a result of free informed choice), is independent of one's sex. Hence, once this state is reached, there would be no conflict between the two ethical positions regarding the substitutability across the domains of well-being. The conflict is hence, if and how society should act after a commitment towards gender equality but before reaching this stage; what is the price acceptable in terms of restricting individual freedoms for the purpose of achieving gender equality of preferences. For now, we leave this as an open issue for a public debate, and concentrate on the genderless society and possible health trends.

3. The empirical setting

As was noted above, Tsuchiya and Williams (2005) argued that as long as there are current differences between women's and men's lifetime health, the prospect that they will soon disappear is not a sufficient justification for regarding the inequality as not inequitable, but did not explore the empirical evidence regarding this point any further. One way of doing this would be to look at local, national and global trends; are we moving towards similarity between the sexes in terms of incomes, power, childcare duties, etc., and is this associated with increased similarity in sickness patterns, life expectancy at birth, and ELQ across the sexes? Some evidence on what equitable development could mean for the lifetime health of women and men is reviewed below. In our view, the concept of "gender equality" requires some comparison of women and men, and some consideration of both the private and public spheres of life.

In a well-known study based on US data, Kawachi et al. (1999) report that women experience higher mortality and morbidity in states where they have lower levels of political participation and economic autonomy; moreover, living in such states damage men's health as well. Further, a more recent cross-country study has demonstrated that patriarchy, measured by female homicide rates, is bad for men's life expectancy; and, though more implicitly stated, also for women's (Stanistreet, Bamba and Scott-Samuel, 2005). The implications seem to be that the initial steps towards a genderless society, in terms of improved female rights regarding reproduction, nutrition, education, resources, and influence, involve health gains amongst both sexes. However, a recent study on Swedish municipalities reported that the level of equality between the genders

concerning political participation, division of labour, and economic resources was generally correlated with poorer health measured in terms of overall mortality and sickness absence for both sexes (Backhans et al. 2007). One interpretation was that the positive association between gender equality and health may be interrupted if the female expansion into traditionally male activities is not supplemented with the expansion of males into traditionally female activities.

An interesting study on self reported health problems (headache, back pains, feeling low, sleeping difficulties, etc) amongst adolescents in European and North American countries found that, whereas girls report higher levels of subjective health problems than boys, the difference between the sexes was larger in countries with low scores on the Gender Development Index (viz. countries where the status of women is lower compared to that of men) (Torsheim et al., 2006). In other words, steps towards the genderless society seem also to be associated with convergence of the sexes' health in this age group.

However, these studies explore the associations between peoples' health and community level indicators of gender equality; and as such they can only investigate ecological degrees of inequality. In a more recent project, Månsdotter and colleagues have therefore carried out two empirical studies where the impact of a changing gender system was captured at the individual level. The differences between women's and men's health were assumed to be mainly caused by the gender system, and hence, the overall hypothesis was that a genderless society will imply a convergence of health (life expectancy, life time QALYs, and the like) between the sexes. The population consisted of all Swedish couples who had their first child together in 1978 (98,240 individuals). Aspects of gender (in)equality were measured during 1978-1980, while data on mortality was obtained from 1981 to 2001 and sickness leave from 1986 to 2000. The analysis used logistic regression adjusting for age and socio-economic factors, with odds ratios as estimates of relative health risks.

The first study (Månsdotter et al, 2006b) aimed at examining if "traditional couples", i.e. heterosexual couples where the man dominates in the public sphere (income and occupational position) and the woman in the domestic sphere (parental leave and temporary child care), have different health risks compared with "equal couples". Being "equal" was defined as both parents

each contributing at least 40% of the couples' total income, of parental leave, etc., while being "traditional" was defined as one or the other parent contributing less than 40%. Table 1 presents a summary of these results. It demonstrates that, in the public sphere of income and occupational position, women from traditional couples have lower health risks compared to women from equal couples, while men from traditional couples regarding occupational position (but not income) have higher health risks compared to men from equal couples. Regarding the domestic sphere, it was indicated that women, and also men measured by temporary childcare, run higher risks of death and sickness when being traditional as opposed to being equal.

<Table 1 about here>

The second study (Månsdotter et al., 2007) acknowledged that the prime motive behind the 1974 reform that granted Swedish fathers parental leave was to achieve greater gender equality in both domestic and public spheres of life, i.e. to improve the potential for males in the sphere of caring work and for females in the sphere of paid work. This was supplemented with the suggestion that this reform may have benefited men's health as well, through the development of less health-damaging lifestyles. Hence, key aim of the second study was to examine the relationship between paternity leave, which is indeed an indicator of a less traditional way of living among men, and male mortality. The results, replicated here as Table 2, demonstrate that men who took paternity leave ran statistically significant (at the 5 percent level) decreased death risks over the period 1980-2001 compared with men who were not on paternity leave.

<Table 2 about here>

It is tempting to look at this result with a causality-based interpretation: viz. fathers who took paternity leave go through the experience of childcare, and this experience itself makes them develop a less traditional male role than that held by other fathers who did not take paternity leave, i.e. less health-damaging in terms of alcohol drinking, risk-preferences, etc., and hence, this leads to lower mortality. However, although the analyses controlled for age and socio-economic factors, it is important to note that the design does not give opportunities to rule out the possibility that at least part of the results are due to self-selection. In other words, men who took

paternity leave in the late 1970s were perhaps more health-aware than other men with the same age and socio-economic status but who did not take paternity leave, and this may have exposed the former men to lower mortality risk over the following decades than the latter. Månsdotter and colleagues propose that the causality interpretation and the self-selection interpretation may both be valid.

The individually based studies do not, of course, expose whether the genderless society would expose a remaining health gap between women and men or not; basically, since this would have required the consideration of a huge number of gender-related aspects of life. Yet, they indicate directions of health trends. One conclusion that should be undisputed is that men have gained health from increased gender equality during the late 20th century in Sweden; in fact, women may have had restricted opportunities to maximise their health. The overall indication is that the process towards the genderless society is likely to involve a convergence of life expectancy, and ELQ, between the sexes.

4. Discussion: What to make of all this?

A move towards the abolition of gender will most likely involve two strands with contrasting health implications. The first is the one where women move into spheres that have traditionally been regarded as male, and as a result, expose themselves to higher levels of health risks. The second is one where men move into spheres that have traditionally been regarded as female. If men are to benefit from the lower health risks traditionally enjoyed by women, they will also have to reduce their labour market activities at the same time⁹. In this respect, a re-assessment of

⁹ If more men/fathers looked after the family and more women/mothers participated in the labour market, then this may lead to a shift from the current gender system based on biological sex to a parenthood system, which treats people differently depending on whether or not one is a parent (ie. women with children will be grouped with men with children, rather than with women without children). The new system should devise a way that treated parents and non-parents differently, but without advantaging one group systematically over the other. For instance, all part time work should be paid pro-rata to full time work, and appointments and promotions will be a function of expected performance, not a function of absolute amount of past contribution or experience per se. This will not only make career prospects fairer between parents and non-parents, but also for instance between those with and without disabilities. Or, people who simply do not want to work 8 hours a day for 5 days a week, or those who choose to take out a few years mid-career to travel or to participate in voluntary work may do so without being disproportionately penalised for doing as they want.

what constitutes high status masculinity would be good for men's health, and, to the extent that this is in line with what women want, it will be good for women's well-being as well, if not their lifetime health or ELQ.

The above seems to imply that if we are to achieve equality in ELQ between the sexes any time soon, this may well involve curbing, or even reducing female ELQ, at least in the developed world. In the developing world, it may be possible to "soft land" to a point with minimal sex gap in ELQ without going through a phase where female ELQ needs to diminish. But even then, the process will probably be associated with reduced growth in female ELQ: it cannot grow faster than male ELQ for the sex gap to reduce.

Regarding the issue of a probable natal female advantage in longevity over males, and whether or not this should be reduced or its growth curbed by policy interventions that, for example, restricted women's access to health care, Sen (2002) makes the point that trying to reduce such differences in longevity may reduce health inequality but will increase health inequity. This is because achievement of equal health is not the only issue in health equity, but also the processes by which this is achieved: if health equality is achieved by denying access to health care for whole population groups, this violates other considerations of equity. If so, would the genderless society with reduced inequality in ELQ between the sexes suffer from increased health inequity? Note that the process discussed here does not involve restricting women's access to health care that are available to men¹⁰: the process involves shifts in informed and free choices that people make in their daily life across the public and private domains, where more women take more risks than women traditionally used to, and where more men take less risks than men traditionally used to. The reduction in health inequality will be a "side-effect" of these shifts.

Why would there be such a shift? If gender barriers were removed, both in the private and public domains, we expect more women would participate in the labour market and/or work less at

¹⁰ Furthermore, not all gender-differentiated health policy needs to be in the form of restricted access by patient gender. It is not inconceivable to deliberately benefit one gender over the other by using public health interventions if it can be shown that the two sexes respond differently to different interventions. An obvious example is vaccinating all babies for a condition for which the mortality rate is different by sex.

home, and more men would participate in taking care of the family and/or work less at work¹¹. Or rather, it is only when these changes actually take place that we will acknowledge that gender barriers have indeed been removed. For men, the issue is relatively straightforward: they get to engage more with their children, they get to work less, they bear less responsibility for generating cash income, and as a result they get better health. The fact that more men do not currently make choices along these lines (“because the man should put the bread on the table”) is indirect proof that the genderless society is yet to come. On the other hand, for women, the picture is more complicated: they see less of their children, they get to work harder, they bear more responsibility for financing the family, and as a result their health will be worse. So, why would women want to do it? Arguably, this is possibly because they have internalised the asymmetric values of the gender system.

It is crucial to note that it has been predominantly women, not men, who have struggled for changes in the traditional gender system. Women have wanted to escape an exclusive occupancy in the domestic sphere because it is lonely, repetitive and boring, involving hard work, associated with low or no social status, under-rewarded and un-paid, etc., whereas men have not valued the prospect of entering closer relationships with their children for the very same reasons. With more information regarding the health consequences for men, there may be some increased interest amongst men towards gender abolition. However, unless the current conceptualisation of high status masculinity changes, this is unlikely to lead to a major movement, since the very essence of this masculinity is that “real men” should not be affected by concerns over their own health and safety. Furthermore, the public sphere of resources, independence, and politics has, in most historical and cultural settings been valued more highly than the domestic, private sphere of caring. The asymmetric power dimension of the gender system, which links the male with the public (and therefore to superiority) and the female with the private (and therefore to subordination), is highly relevant in this context.

Also of interest is how the two main spheres of life will be valued in the genderless society relative to their respective values now, and consequently, how this will affect the relative

¹¹ We do not claim that all women will want more labour market participation and all men will want less labour market participation. The proportion of labour market participation by gender will change from what they are now, and the gender gap will be smaller.

numbers of positions in each. Many women today want to go into the public domain, because that is where power and appreciation is. Note that this aspiration is caused by the asymmetric gender system. The statement that a move to a genderless society will imply more women in traditionally male positions and more men in traditionally female positions, assumes that the genderless society will maintain the same number of male and female positions, such as jobs, activities, tasks, and roles, as the current world, and it is simply a matter of reallocating these previously gendered positions to both men and women equally. However, it is quite plausible that the gender system has inflated peoples' aspirations towards male type positions and deflated the appreciation of female type ones. Therefore, it may be reasonable to expect a genderless society to have fewer positions that are currently regarded as male, and more positions that are currently regarded as female, and people therein on the whole to be happy to fill in either. If this is the case, then the move towards a genderless society will not be a simple re-allocation of currently existing positions across people, but it will be a fundamental structural shift in the type of positions available for people to begin with. The number of women moving from female positions to male ones will probably be less than the number of men moving from male positions to female ones. At the extreme, in some "developed" countries there may already be enough women who have shifted to male positions, so that equitable development is not about getting more women in high-powered positions, but it is about shifting the men (and possibly some women as well) away from these positions, and reducing their number altogether. In this respect, since the private sphere of life may be assumed to involve healthier attitudes and behaviours than the public sphere, the ultimate step regarding gender abolition could well imply health gains for individuals of both sexes.

In gendered societies, women and men have been subjected to different behavioural and aspirational norms, which seem to have long term health effects. We have pointed out that moves towards a genderless society will probably have a negative impact on women's ELQ relative to men's. An interesting question is, if health and longevity are key elements of well-being, then what does it mean, when improving well-being beyond a certain point by removing an asymmetric and inequitable social system seems to result in their reduction? It is possible that certain forms of the patriarch gender system have in effect allowed women to "exploit" men so that they do not have to shoulder the fair share of the health risks associated with human/social

life. This coexisted with a common conceptualisation of masculinity, of the strong, tough, and reliable male, which resulted in exposing individual men to the exploitation. The breaking up of the gender system will mean women giving up their undue advantages regarding life time health they have so far enjoyed, and men being released from their vulnerability.

All this may sound absurd, especially when one looks at some parts of the world where women are completely subjugated to patriarch control, with limited choices and freedoms over their own life, given lower priority in terms of nutrition and health care compared to the men in the same family, and at the same time carrying out most of the physical labour around the house and possibly also in the lower-paid end of the labour market, and/or by tending commercial crop to raise cash income for the family. However, we are not trying to argue that the patriarch gender system is inherently to the benefit of female longevity. There are two related points to make: firstly, to assume that the patriarch gender system is inherently to the disadvantage of female longevity seems wanting; and secondly, to assume that the patriarch gender system and its associated notion of high status masculinity is inherently to the advantage of the health (and well-being) of individual men also seems inadequate.

Insofar as the current gender system works to the advantage of female ELQ, moves towards abolishing this will imply women having to give up their excess lifetime health advantage, just like men having to give up their excess socio-economic advantages. Assuming full information and rational choice, if a significant proportion of women do make choices that imply reducing their own ELQ, it will mean these women do not regard mere ELQ as an absolute good: they will be better off with less health and more choices/control. Sen (2002) argues “health is among the most important conditions of human life and a critically significant constituent of human capabilities” (p660 l). We agree, but we will also like to point out that health alone is no good if there are no socio-economic opportunities to pursue.

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Table 1: Traditional females/males versus equal females/males; odds ratios for death and sickness leave adjusted for age, income and absolute levels (95-percent confidence intervals)

	Females		Males	
	Traditional vs. Equal		Traditional vs. Equal	
	Death	Sickness	Death	Sickness
Public sphere:				
Income	0.70 (0.59-0.83)	0.72 (0.68-0.76)	0.96 (0.86-1.06)	1.00 (0.95-1.04)
Occupation	0.85 (0.68-1.05)	0.73 (0.69-0.78)	1.13 (1.01-1.27)	1.20 (1.14-1.26)
Domestic sphere				
Parental leave	1.50 (0.87-2.57)	1.02 (0.86-1.20)	0.82 (0.57-1.19)	0.92 (0.77-1.11)
Temporary care	1.10 (0.83-1.46)	1.08 (0.99-1.18)	1.44 (1.15-1.81)	1.22 (1.11-1.33)

Source: Månsdotter et al. (2006a)

Table 2: Male mortality – odds ratios for paternity leave versus no paternity leave; unadjusted, and adjusted for age, income, education and birth country (95-percent confidence intervals)

	Odds ratios Unadjusted	Odds ratios Adjusted for age, income, education and birth country
Paternity leave = 0 days (n=35,817 deaths=1,718)	1	1
Paternity leave >0-10 days (n=2,397 deaths=101)	0.87 (0.71-1.07)	0.93 (0.73-1.18)
Paternity leave >10-20 days (n= 1,207 deaths=51)	0.88 (0.66-1.16)	0.95 (0.68-1.33)
Paternity leave >20-30 days (n= 1,747 deaths=60)	0.71 (0.54-0.92)	0.78 (0.57-1.05)
Paternity leave >30-60 days (n=2,229 deaths=70)	0.64 (0.50-0.82)	0.75 (0.57-0.99)
Paternity leave >60-90 days (n= 1,167 deaths=37)	0.65 (0.47-0.90)	0.71 (0.48-1.04)
Paternity leave >90 days (n= 1,237 deaths=65)	1.10 (0.85-1.42)	0.97 (0.70-1.33)

Source: Månsdotter et al. (2006b)