National Advisory Council on Women and Girls: Monthly Spotlight

WOMEN AND GIRLS' HEALTH

Summary

While women in Scotland have a longer life expectancy than men, they are less likely to be free of long-term health conditions. In particular, they are significantly more likely to have **limiting long-term conditions**. Overall, there is no significant difference between the **mental wellbeing** of men and women, but at ages 13-15, girls are more likely than boys to have poor mental wellbeing.

Research suggests that women are slightly less likely than men to report **positive experiences** of GP, inpatient and cancer care.

International research indicates gendered differences in standards of medical treatment. There is evidence that women are less likely to receive appropriate pain treatment or to receive CPR from a bystander following cardiac arrest, for example.

There are a number of significant **health inequalities** between different groups of women and girls. **Young carers** are more likely to experience poor mental wellbeing and emotional and behavioural problems than those who do not have caring responsibilities, for example. Women living in the most **deprived areas** of Scotland are less likely to attend routine screenings for breast and cervical cancer, and are more likely to die from these diseases. Meanwhile, **LGBT women** across the UK report experiencing significant levels of discrimination when accessing healthcare.

Key Figures

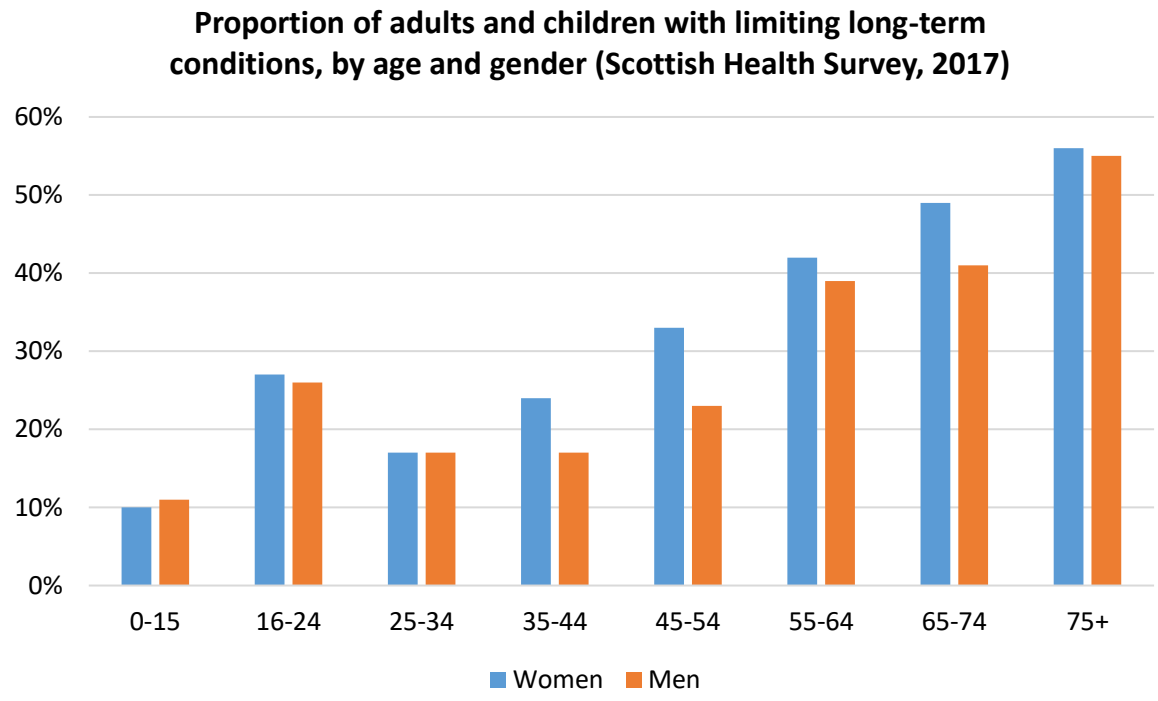
- Girls born in 2015-2017 are expected to live 81.1 years on average (77.0 years for boys).
- Girls are expected to live an average of 62.6 years being 'healthy' (62.3 healthy years for boys).
- Girls born in the 10% most deprived areas of Scotland in 2015-2017 have a life expectancy 9.6 years lower than those born in the 10% least deprived areas.
- 53% of women are free of long-term health conditions, compared to 57% of men.
- 34% of women have limiting long-term conditions, compared to 29% of men.
- 13% of women report 2 or more symptoms of anxiety, compared to 9% of men.
- 82% of women in Scotland (who have contacted their GP practice in the last year) are positive about the care that their practice provides.
- 67% of women aged 25-64 living in the most deprived areas of Scotland attend their cervical cancer screenings, compared to 78% of women in the least deprived areas.

OVERALL HEALTH OF WOMEN AND GIRLS

In 2017, 93% of girls (and 94% of boys) reported having good or very good health.[1] For girls, this was a decrease from 96% in 2016.

The most recent life expectancy estimates for Scotland are for girls born in 2015-2017 to live 81.1 years on average, and for boys to live 77.0 years on average.[2] Girls are expected to live an average of 62.6 years being 'healthy', with an estimated 62.3 healthy years for boys.[3]

Overall, the proportion of adults in Scotland reporting that they have good or very good health has dropped significantly in the last decade, from 77% in 2009 to 73% in 2017.[4] There is no significant difference in self-reported health between men and women. However, women were less likely than men to be free of long-term health conditions in 2017: 53% of women, compared to 57% of men. This is due to the significantly higher prevalence of **limiting long-term conditions** among women – overall, 34% of women have limiting long-term conditions, compared to 29% of men. As the graph below shows, the difference between the proportions of men and women with these limiting conditions is largest among those aged 35-44 and 45-54.



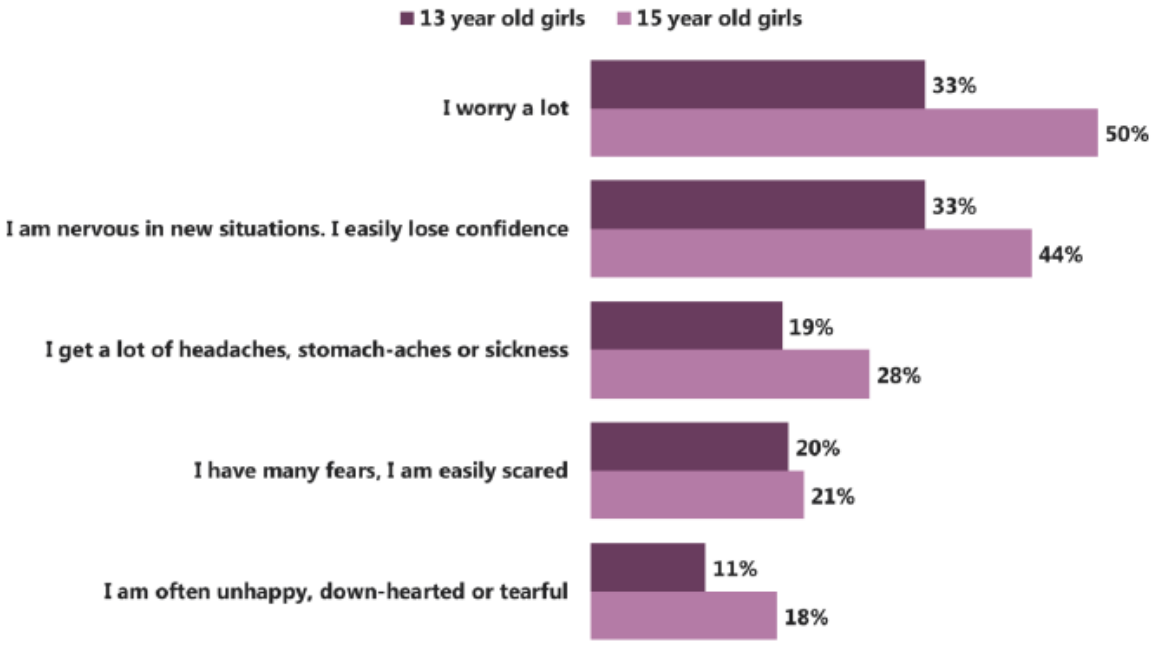
There was no significant difference overall between the **mental wellbeing** of men and women, in 2017.[5] More women than men suffer from **anxiety**, however, with 13% of women reporting 2 or more symptoms of anxiety in 2016-17, compared to 9% of men.[6]

At ages 13-15, girls were more likely than boys to have poor mental wellbeing as of 2015.[7] 15-year-old girls had poorer mental wellbeing than 13-year-olds, on average, and had also seen a greater decline in some specific aspects of their mental health,

since 2010. While 61% of girls aged 15 said that they had been 'feeling cheerful' all the time or often in 2010, this fell to 44% in 2015. The proportion of those who said that they had 'had energy to spare' fell from 43% to 28%.

At ages 13-15, girls were also significantly more likely than boys to experience **emotional problems**, with 31% of girls aged 13, and 44% of girls aged 15, showing a borderline or abnormal emotional problems score in 2015 (compared to 12% and 15% respectively of boys of the same ages).[8] The graph below shows the proportions of girls who agreed that specific statements about their emotional health were 'certainly true'.

Individual emotional problems items among girls, by age (% borderline or abnormal score), 2006-2015 (Scottish Schools Adolescent Lifestyle and Substance Use Survey)

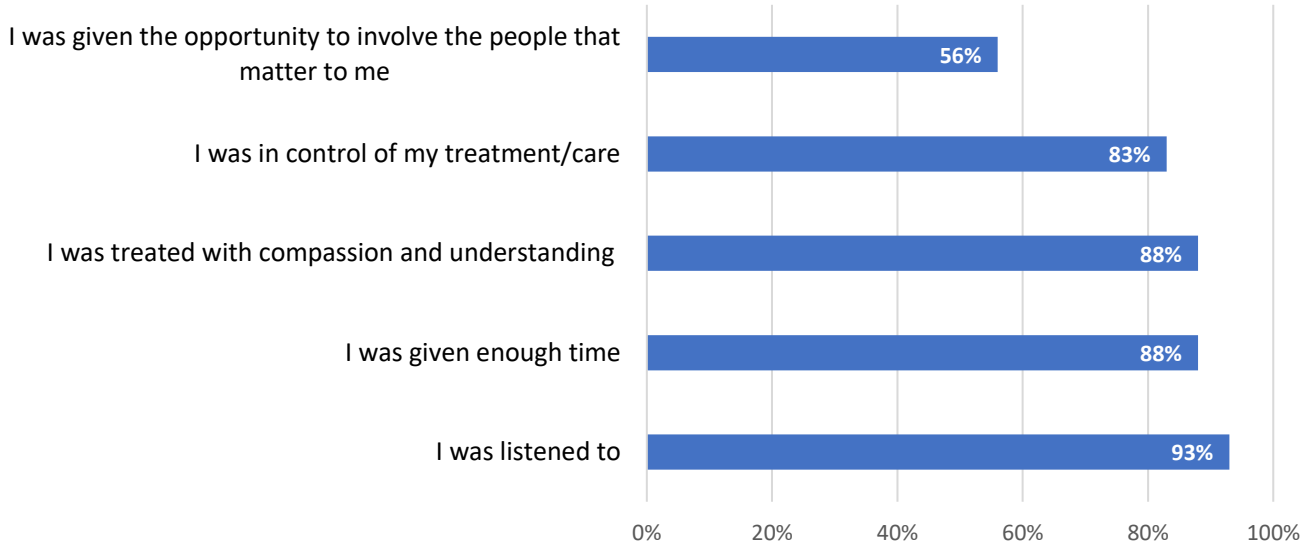


The proportion of 15-year-old girls saying it was certainly true that they worry a lot or that they were nervous in new situations and easily lose confidence increased considerably between 2006 and 2015. 29% said that they worried a lot in 2006, compared to 50% in 2015, while the proportion who said that it was certainly true that they were nervous in new situations and easily lose confidence increased from 31% in 2006 to 44% in 2015.

ACCESS TO HEALTHCARE/CONFIDENCE

82% of women in Scotland (who had contacted their GP practice in the last year) are positive about the care that their practice provides. The graph below shows the proportion of women who responded positively when asked about different aspects of the care they received.

Percentage of women who responded positively to the given statements about their GP practice, among those who had contacted their practice in the last 12 months (Health and Care Experience Survey, 2017/18)



Research conducted in 2011/12 found that men were slightly more likely than women to report a positive experience of GP and out-of-hours health services.[9] More recent research from 2015 and 2016 found that men were also more likely than women to report positive experiences both as inpatients and in relation to cancer care.[10] Reflecting on their experiences as inpatients, men were more likely than women to be positive about all aspects of their inpatient care, from hospital admission through to care and support services they received after leaving.[11]

GENDER EFFECTS IN DIAGNOSIS AND TREATMENT

Gender bias can occur in healthcare and health research, both by medical professionals or researchers assuming similarity between men's and women's health situations and risks where there are actually differences, or by assuming that differences exist without any evidence to support this.[12] Both of these can negatively affect women's health.

Internationally, research has found differences in the treatment received by men and women, such as that women are less likely to be prescribed medication or appropriate treatment for their pain than men, and that cardiovascular examinations are less likely to be performed correctly on women.[13] A US study also found that while male and female patients who had suffered heart attacks experienced similar outcomes when treated by female doctors, there was higher mortality among female patients who were treated by male physicians.[14] Men were found to be referred for cancer treatment after fewer consultations with their GP than women, on average, according to a study conducted in England.[15]

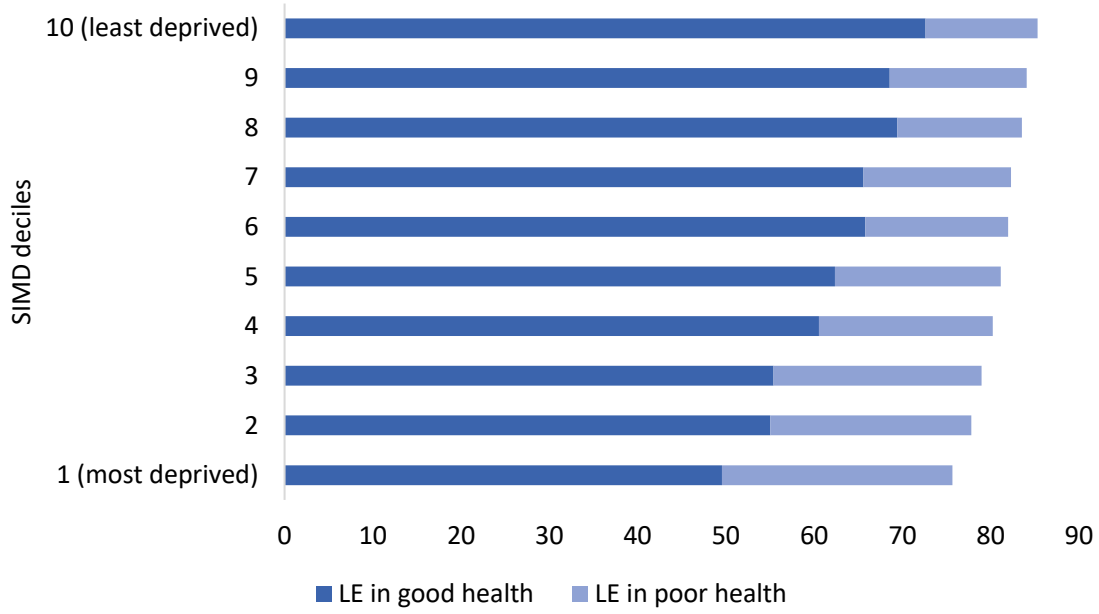
There is evidence of a tendency for findings from **medical research** conducted only, or mainly, on men, being applied to women without full understanding of whether gender differences may exist.[16] For example, girls are diagnosed less frequently with **autism** than boys, with the result that less research is conducted on autism in girls, and on possible gender variations in the condition.[17] Some of the gender imbalance in autism diagnoses may be because of differences in the ways that autistic traits appear in boys and girls, and because tests and diagnosis methods are biased towards identifying autism in boys. Research suggests that the proportion of girls being diagnosed is increasing, internationally.

Initial data shows that women in Scotland are **less likely to receive CPR** (cardiopulmonary resuscitation) from a bystander if they have a cardiac arrest out of hospital, compared to men.[18] This is important, since receiving CPR increases the chance of survival following a cardiac arrest.[19] The international research on this issue is inconclusive, with some studies also showing that women are less likely to receive CPR[20], while others contradict this.[21] One North American study found that, while women were significantly less likely than men to receive CPR in public, there was not a significant difference in private settings, suggesting that whether or not the patient and the person administering CPR are strangers or not is likely to be important.[22]

HEALTH INEQUALITIES AMONG GIRLS AND WOMEN

Health inequalities are 'the unjust and avoidable differences in people's health across the population and between specific population groups.'[23] As well as health inequalities between different genders, there are health inequalities among different groups of women and girls. For example, girls born in the 10% most deprived areas of Scotland in 2015-2017 had a life expectancy 9.6 years lower than those born in the 10% least deprived areas.[24] The difference in healthy life expectancy was even greater, as the graph below shows.[25] Between the 10% most deprived and 10% least deprived areas of Scotland, there was a difference in healthy life expectancy of 23 years for women (22.5 years for men).

Female Healthy Life Expectancy by Scottish Index of Multiple Deprivation (SIMD) deciles, 2015-2017 (National Records of Scotland, 2019)



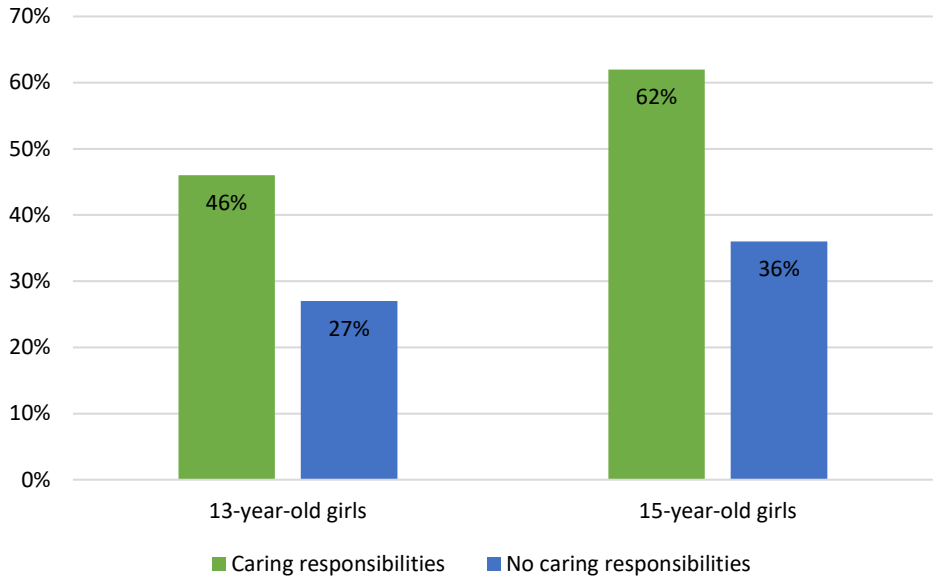
Girls born in rural areas were also expected to live longer than those born in urban areas: the life expectancy was 83.1 years for 'Remote Rural' areas and 80.5 years for both 'Large Urban' and 'Other Urban' areas.[26]

Young carers: Differences in girls' mental wellbeing and emotional and behavioural problems

As of 2015, girls aged 13 and 15 years old were more likely to experience poor mental wellbeing and emotional and behavioural problems if they were a young carer. While 13-year-old girls who were not carers had a mean score of 48.7 on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), those who were young carers had an mean score of 44.2.[27]

The relationship between caring and experiencing **emotional and behavioural problems** was particularly strong among 15-year-old girls, as the graph below shows.

Proportion of girls with borderline or abormal scores in emotional and behavioural difficulties, by age and caring status (Scottish Schools Adolescent Lifestyle and Substance Use Survey, 2015)



Data from the Scottish Health Survey suggests that the same trend may not exist among women (aged 16+) who are carers. Although this should be treated with some caution because the survey for young people asked specifically about whether girls cared for someone *in their home*, while the Scottish Health Survey asks those aged 16+ whether they 'provide regular help or care for any sick, disabled or frail person', it is nevertheless interesting that there was little difference in the mental wellbeing of women aged 16+ according to whether or not they were carers. The average WEMWBS score for female carers aged 16+ was 49.8 in 2017, compared to 49.7 for those who were not carers.[28]

Area deprivation: Differences in cancer screening, incidence and mortality

Women living in the most deprived areas of Scotland have consistently been less likely to attend routine **screenings for breast and cervical cancer**. Between 2003 and 2012, 61-65% of women aged 50-70 who lived in the most deprived 20% of areas in Scotland attended a screening, compared to 80-82% of those living in the 20% least deprived areas.[29] As of 2017-18, 67% of eligible women aged 25-64 living in the most deprived areas of Scotland had taken up their most recent cervical screenings, compared to 78% of women in the least deprived areas.[30] The highest difference between the least deprived and most deprived areas was seen in women

aged 50-64, with a 15% decrease in uptake (compared to an 8% decrease for the 25-49 age group).

The incidence and mortality rates for **cervical cancer** tend to be higher in women living in more deprived areas. This can be attributed to socio-economic differences in exposure to risk factors, as well as the lower attendance for cervical screening, which aims to prevent cervical cancer by diagnosing and treating pre-cancerous changes.[31] The age-standardised incidence rate was 8 per 100,000 for those living in the least deprived 20% of areas in 2012-16, compared to 18 per 100,000 for those living in the most deprived 20% of areas (more than double).[32] An even greater difference can be seen in mortality incidence, at 2 per 100,000 in the least deprived areas in 2013-17, compared to 7 per 100,000 for those living in the most deprived areas.

In contrast, the incidence of **breast cancer** tends to be higher in less deprived areas. In 2012-16, there were 172 incidences per 100,000 women living in the 20% least deprived areas of Scotland, compared to 160 per 100,000 among women living in the most deprived 20% of areas.[33] Again, this is likely to reflect differences in exposure to risk factors, and higher rates of attendance at breast screening in less deprived areas.[34] Unlike cervical screening, breast screening is not designed to prevent breast cancer, but rather to diagnose the disease as early as possible, when treatment is more likely to be effective. Despite a lower incidence of breast cancer in more deprived areas, the mortality rate in these areas is higher – 36 per 100,000 for the most deprived areas, and 32 for the least deprived areas (2013-2017).[35]

Lower uptake of cancer screening by women living in deprived areas – What can be done?

Research conducted in Lanarkshire found that fear and anxiety about attending cervical cancer screenings were a key deterrent for women from less affluent communities, as well as women from South Asian communities.[36] Information resources were also considered insufficient and to contain some gaps. Community Health Educators, who are 'lay' members of the community trained to deliver education, were found to improve knowledge about cervical cancer screenings among women in the communities, including where they could access this service outside of GP practices. This increased knowledge in turn made the women less anxious about attending screenings.

Disability: effect on cancer screening uptake

In addition, a study conducted in England found that **women with disabilities** were less likely to take up available screening for breast or bowel cancer, even after socio-demographic variations were taken into consideration.[37] They were found to be 36% less likely to attend breast cancer screenings, and 25% less likely to participate in bowel screening, than women without disabilities. Disabled women without access to a car were significantly less likely to go to breast screenings.

Sexual orientation and gender reassignment: Healthcare experiences

A UK-wide review in 2016 found a bias in the research on LGBT health and healthcare towards research on gay and bisexual men, with **far less research on lesbians and bisexual women**.[38] It also noted that most research examining inequalities within LGBT groups is not robust, as it tends to use non-representative samples. The lack of national and administrative data on sexual orientation or gender identity mean that it is not possible to use standard sampling methods to gain a representative sample of LGBT people.[39]

Trans women's healthcare experiences

Healthcare issues faced by trans women (aside from those encountered as part of any gender reassignment treatment) in the UK include not always being offered breast screening, and being placed on inappropriate hospital wards.[40]

An online survey run by the UK Government Equalities Office in 2017 found that, of the trans women in the UK who responded and who had accessed (or tried to access) public healthcare services in the last year due to their gender identity, 13% experienced **discrimination** or intolerant reactions from staff and 10% had to **change GP** due to negative experiences.[41]

This survey was completed by a self-selecting sample of LGBT people in the UK, and as such may not be representative of the LGBT population as a whole. The survey received 108,100 valid responses, 8% of which were from people living in Scotland.

30% of the trans women responding had accessed **mental health services** in the previous year. A further 12% had tried, but been unsuccessful. Figures were higher for trans men (40% and 15%, respectively). Overall, trans respondents identifying as heterosexual were more likely to rate mental health services as 'very easy' to access than trans respondents with a minority sexual orientation (18% of heterosexual trans respondents compared to, for example, 6% of queer trans respondents and 7% of pansexual trans respondents).

Trans women were more likely to say that their experiences of mental health services had been mostly or completely positive, compared to trans men (55% and 47% respectively of respondents who had accessed mental health services in the last year).

LGB+ women's healthcare experiences

UK-wide research has found a lack of knowledge among healthcare staff about lesbians and bisexual women's sexual practices, sometimes resulting in inadequate

treatment (such as women being told that they are at low risk of STIs or do not need a smear test).[42]

While there are significant gaps in the evidence about LGB people's health experiences of healthcare in the UK, the key issues that have been identified include **discrimination** and negative treatment, service delivery **assuming that healthcare users are straight**, and difficulties around LGB specific health and social care issues.[43]

The UK Government Equalities Office survey outlined above found that, of the **cisgender, LGB+ women** who responded, being afraid of a negative reaction, being afraid of being outed, or having had a bad experience in the past were common reasons for having not always disclosed their sexual orientation with healthcare staff.[44] Of those who had accessed mental health services in the last year, 56% said that their experiences were mainly or completely positive, while 22% said that their experience were mainly or completely negative (cisgender, GB+ men reported slightly better experiences, with figures of 62% and 18% respectively).

Among cisgender respondents, lesbians were more likely than gay men to have found it 'not easy' to access sexual health services (31% vs 24%). 4% of cisgender, LGB+ women responding said that their GP had not been supportive of them accessing sexual health services (compared to 1% of men).

While there are many gaps in the evidence about the health outcomes and healthcare experiences of LGB people as a whole, the experiences of **older LGB people** are especially under-researched.[45] Funding has often focused on men's sexual health, and less is known about older bisexual and lesbian women. Some studies have shown that practitioners are more likely to avoid talking about sexuality with older service users.[46] There is some evidence that older LGB people are more likely to rely on partners and healthcare professionals in old age, rather than family members. However, relying on healthcare services might be difficult for many older LGB people who have experienced discrimination or felt unable to be open about their sexual orientation earlier in their life.

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